ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2935

State of Washington 55th Legislature 1998 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Dyer, Cody, Huff and Backlund)

Read first time 02/09/98. Referred to Committee on .

AN ACT Relating to nursing home payment rates; amending RCW 74.46.010, 74.46.020, 74.46.040, 74.46.050, 74.46.060, 74.46.080, 74.46.090, 74.46.100, 74.46.190, 74.46.220, 74.46.230, 74.46.270, 74.46.280, 74.46.300, 74.46.410, 74.46.475, 74.46.610, 74.46.620, 74.46.630, 74.46.640, 74.46.650, 74.46.660, 74.46.680, 74.46.690, 74.46.770, 74.46.780, 74.46.800, 74.46.820, 74.46.840, 74.09.120, and 72.36.030; adding new sections to chapter 74.46 RCW; creating a new section; repealing RCW 74.46.105, 74.46.115, 74.46.130, 74.46.150, 74.46.160, 74.46.170, 74.46.180, 74.46.210, 74.46.670, and 74.46.595; prescribing penalties; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 74.46.010 and 1980 c 177 s 1 are each amended to read as follows:

This chapter may be known and cited as the "nursing ((~~Homes Auditing and Cost Reimbursement Act of 1980~~)) facility medicaid payment system."

Sec. 2. RCW 74.46.020 and 1995 1st sp.s. c 18 s 90 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Accrual method of accounting" means a method of accounting in which revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) ((~~"Ancillary care" means those services required by the individual, comprehensive plan of care provided by qualified therapists.~~

~~(3)~~)) "Appraisal" means the process of estimating the fair market value or reconstructing the historical cost of an asset acquired in a past period as performed by a professionally designated real estate appraiser with no pecuniary interest in the property to be appraised. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

((~~(4)~~)) (3) "Arm's-length transaction" means a transaction resulting from good-faith bargaining between a buyer and seller who are not related organizations and have adverse positions in the market place. Sales or exchanges of nursing home facilities among two or more parties in which all parties subsequently continue to own one or more of the facilities involved in the transactions shall not be considered as arm's-length transactions for purposes of this chapter. Sale of a nursing home facility which is subsequently leased back to the seller within five years of the date of sale shall not be considered as an arm's-length transaction for purposes of this chapter.

((~~(5)~~)) (4) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

((~~(6)~~)) (5) "Audit" or "department audit" means an examination of the records of a nursing facility participating in the medicaid payment system, including but not limited to: The contractor's financial and statistical records, cost reports and all supporting documentation and schedules, receivables, and resident trust funds, to be performed as deemed necessary by the department and according to department rule.

(6) "Bad debts" means amounts considered to be uncollectible from accounts and notes receivable.

(7) ((~~"Beds" means the number of set-up beds in the facility, not to exceed the number of licensed beds.~~

~~(8)~~)) "Beneficial owner" means:

(a) Any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

(i) Voting power which includes the power to vote, or to direct the voting of such ownership interest; and/or

(ii) Investment power which includes the power to dispose, or to direct the disposition of such ownership interest;

(b) Any person who, directly or indirectly, creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device with the purpose or effect of divesting himself or herself of beneficial ownership of an ownership interest or preventing the vesting of such beneficial ownership as part of a plan or scheme to evade the reporting requirements of this chapter;

(c) Any person who, subject to ((~~subparagraph~~)) (b) of this subsection, has the right to acquire beneficial ownership of such ownership interest within sixty days, including but not limited to any right to acquire:

(i) Through the exercise of any option, warrant, or right;

(ii) Through the conversion of an ownership interest;

(iii) Pursuant to the power to revoke a trust, discretionary account, or similar arrangement; or

(iv) Pursuant to the automatic termination of a trust, discretionary account, or similar arrangement;

except that, any person who acquires an ownership interest or power specified in ((~~subparagraphs~~)) (c)(i), (ii), or (iii) of this ((~~subparagraph (c)~~)) subsection with the purpose or effect of changing or influencing the control of the contractor, or in connection with or as a participant in any transaction having such purpose or effect, immediately upon such acquisition shall be deemed to be the beneficial owner of the ownership interest which may be acquired through the exercise or conversion of such ownership interest or power;

(d) Any person who in the ordinary course of business is a pledgee of ownership interest under a written pledge agreement shall not be deemed to be the beneficial owner of such pledged ownership interest until the pledgee has taken all formal steps necessary which are required to declare a default and determines that the power to vote or

to direct the vote or to dispose or to direct the disposition of such pledged ownership interest will be exercised; except that:

(i) The pledgee agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of the contractor, nor in connection with any transaction having such purpose or effect, including persons meeting the conditions set forth in ((~~subparagraph~~)) (b) of this subsection; and

(ii) The pledgee agreement, prior to default, does not grant to the pledgee:

(A) The power to vote or to direct the vote of the pledged ownership interest; or

(B) The power to dispose or direct the disposition of the pledged ownership interest, other than the grant of such power(s) pursuant to a pledge agreement under which credit is extended and in which the pledgee is a broker or dealer.

((~~(9)~~)) (8) "Capitalization" means the recording of an expenditure as an asset.

((~~(10)~~)) (9) "Case mix" means a measure of the intensity of care and services needed by the residents of a nursing facility or a group of residents in the facility.

(10) "Case mix index" means a number representing the average case mix of a nursing facility.

(11) "Case mix weight" means a numeric score that identifies the relative resources used by a particular group of a nursing facility's residents.

(12) "Contractor" means ((~~an~~)) a person or entity ((~~which contracts~~)) licensed under chapter 18.51 RCW to operate a medicare and medicaid certified nursing facility, responsible for operational decisions, and contracting with the department to provide services to ((~~medical care~~)) medicaid recipients residing in ((a)) the facility ((~~and which entity is responsible for operational decisions~~)).

((~~(11)~~)) (13) "Default case" means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

(14) "Department" means the department of social and health services (DSHS) and its employees.

((~~(12)~~)) (15) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

((~~(13)~~)) (16) "Direct care" means nursing care and related care provided to nursing facility residents. Therapy care shall not be considered part of direct care.

(17) "Direct care supplies" means medical, pharmaceutical, and other supplies required for the direct ((~~nursing and ancillary~~)) care of ((~~medical care recipients~~)) a nursing facility's residents.

((~~(14)~~)) (18) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

((~~(15)~~)) (19) "Equity" means the net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

((~~(16)~~)) (20) "Facility" or "nursing facility" means a nursing home licensed in accordance with chapter 18.51 RCW, excepting nursing homes certified as institutions for mental diseases, or that portion of a multiservice facility licensed as a nursing home, or that portion of a hospital licensed in accordance with chapter 70.41 RCW which operates as a nursing home.

((~~(17)~~)) (21) "Fair market value" means the replacement cost of an asset less observed physical depreciation on the date for which the market value is being determined.

((~~(18)~~)) (22) "Financial statements" means statements prepared and presented in conformity with generally accepted accounting principles including, but not limited to, balance sheet, statement of operations, statement of changes in financial position, and related notes.

((~~(19)~~)) (23) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB).

((~~(20) "Generally accepted auditing standards" means auditing standards approved by the American institute of certified public accountants (AICPA).~~

~~(21)~~)) (24) "Goodwill" means the excess of the price paid for a nursing facility business over the fair market value of all ((~~other~~)) net identifiable((~~,~~)) tangible((~~,~~)) and intangible assets acquired, as measured in accordance with generally accepted accounting principles.

((~~(22)~~)) (25) "Grouper" means a computer software product that groups individual nursing facility residents into case mix classification groups based on specific resident assessment data and computer logic.

(26) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

((~~(23)~~)) (27) "Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.

((~~(24)~~)) (28) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(25)~~)) (29) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

((~~(26)~~)) (30) "Medical care program" or "medicaid program" means medical assistance, including nursing care, provided under RCW 74.09.500 or authorized state medical care services.

((~~(27)~~)) (31) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided ((~~in~~)) under chapter 74.09 RCW.

((~~(28)~~)) (32) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

(33) "Net book value" means the historical cost of an asset less accumulated depreciation.

((~~(29)~~)) (34) "Net invested funds" means the net book value of tangible fixed assets employed by a contractor to provide services

under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles, plus an allowance for working capital which shall be five percent of the product of the per patient day rate multiplied by the prior calendar year reported total patient days of each contractor.

((~~(30)~~)) (35) "Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with generally accepted accounting principles.

((~~(31)~~)) (36) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

((~~(32)~~)) (37) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form which such beneficial ownership takes.

((~~(33)~~)) (38) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A "((~~client day~~)) medicaid day" or "recipient day" means a calendar day of care provided to a ((~~medical care~~)) medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

((~~(34)~~)) (39) "Professionally designated real estate appraiser" means an individual who is regularly engaged in the business of providing real estate valuation services for a fee, and who is deemed qualified by a nationally recognized real estate appraisal educational organization on the basis of extensive practical appraisal experience, including the writing of real estate valuation reports as well as the passing of written examinations on valuation practice and theory, and who by virtue of membership in such organization is required to subscribe and adhere to certain standards of professional practice as such organization prescribes.

((~~(35)~~)) (40) "Qualified therapist" means:

(a) ((~~An activities specialist who has specialized education, training, or experience as specified by the department;~~

~~(b) An audiologist who is eligible for a certificate of clinical competence in audiology or who has the equivalent education and clinical experience;~~

~~(c)~~)) A mental health professional as defined by chapter 71.05 RCW;

((~~(d)~~)) (b) A mental retardation professional who is ((~~either a qualified therapist or~~)) a therapist approved by the department who has had specialized training or one year's experience in treating or working with the mentally retarded or developmentally disabled;

((~~(e) A social worker who is a graduate of a school of social work;~~

~~(f)~~)) (c) A speech pathologist who is eligible for a certificate of clinical competence in speech pathology or who has the equivalent education and clinical experience;

((~~(g)~~)) (d) A physical therapist as defined by chapter 18.74 RCW;

((~~(h)~~)) (e) An occupational therapist who is a graduate of a program in occupational therapy, or who has the equivalent of such education or training; and

((~~(i)~~)) (f) A respiratory care practitioner certified under chapter 18.89 RCW.

((~~(36) "Questioned costs" means those costs which have been determined in accordance with generally accepted accounting principles but which may constitute disallowed costs or departures from the provisions of this chapter or rules and regulations adopted by the department.~~

~~(37)~~)) (41) "Real property," whether leased or owned by the contractor, means the building, allowable land, land improvements, and building improvements associated with a nursing facility.

(42) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost rebasing payment rates under the provisions of this chapter.

((~~(38)~~)) (43) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(39)~~)) (44) "Related organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by, the contractor.

(a) "Common ownership" exists when an entity is the beneficial owner of five percent or more ownership interest in the contractor and any other entity.

(b) "Control" exists where an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution, whether or not it is legally enforceable and however it is exercisable or exercised.

((~~(40)~~)) (45) "Related care" means only those services that are directly related to providing direct care to nursing facility residents. These services include, but are not limited to, nursing direction and supervision, medical direction, medical records, pharmacy services, activities, and social services.

(46) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

(47) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident's potential problems and risk areas.

(48) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

(49) "Restricted fund" means those funds the principal and/or income of which is limited by agreement with or direction of the donor to a specific purpose.

((~~(41)~~)) (50) "Secretary" means the secretary of the department of social and health services.

((~~(42)~~)) (51) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.

(52) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under their supervision, including related costs as designated by the department.

(53) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

(((~~(43) "Physical plant capital improvement" means a capitalized improvement that is limited to an improvement to the building or the related physical plant.~~)))

Sec. 3. RCW 74.46.040 and 1985 c 361 s 4 are each amended to read as follows:

(1) Not later than March 31st of each year, each contractor shall submit to the department an annual cost report for the period from January 1st through December 31st of the preceding year.

(2) Not later than one hundred twenty days following the termination of a contract, the terminating contractor shall submit to the department a cost report for the period from January 1st through the date the contract terminated.

(3) Two extensions of not more than thirty days each may be granted by the department upon receipt of a written request setting forth the circumstances which prohibit the contractor from compliance with a report due date; except, that the ((~~secretary~~)) department shall establish the grounds for extension in rule ((~~and regulation~~)). Such request must be received by the department at least ten days prior to the due date.

Sec. 4. RCW 74.46.050 and 1985 c 361 s 5 are each amended to read as follows:

(1) If the cost report is not properly completed or if it is not received by the due date, all or part of any payments due under the contract may be withheld by the department until such time as the required cost report is properly completed and received.

(2) The department may impose civil fines, or take adverse rate action against contractors and former contractors who do not submit properly completed cost reports by the applicable due date. The department is authorized to adopt rules addressing fines and adverse rate actions including procedures, conditions, and the magnitude and frequency of fines.

Sec. 5. RCW 74.46.060 and 1985 c 361 s 6 are each amended to read as follows:

(1) Cost reports shall be prepared in a standard manner and form, as determined by the department((~~, which shall provide for an itemized list of allowable costs and a preliminary settlement report~~)). Costs

reported shall be determined in accordance with generally accepted accounting principles, the provisions of this chapter, and such additional rules ((~~and regulations as are~~)) established by the ((~~secretary~~)) department. In the event of conflict, rules adopted and instructions issued by the department take precedence over generally accepted accounting principles.

(2) The records shall be maintained on the accrual method of accounting and agree with or be reconcilable to the cost report. All revenue and expense accruals shall be reversed against the appropriate accounts unless they are received or paid, respectively, within one hundred twenty days after the accrual is made. However, if the contractor can document a good faith billing dispute with the supplier or vendor, the period may be extended, but only for those portions of billings subject to good faith dispute. Accruals for vacation, holiday, sick pay, payroll, and real estate taxes may be carried for longer periods, provided the contractor follows generally accepted accounting principles and pays this type of accrual when due.

Sec. 6. RCW 74.46.080 and 1985 c 361 s 7 are each amended to read as follows:

(1) All records supporting the required cost reports, as well as trust funds established by RCW 74.46.700, shall be retained by the contractor for a period of four years following the filing of such reports at a location in the state of Washington specified by the contractor. ((~~All records supporting the cost reports and financial statements filed with the department before May 20, 1985, shall be retained by the contractor for four years following their filing.~~))

(2) The department may direct supporting records to be retained for a longer period if there remain unresolved questions on the cost reports. All such records shall be made available upon demand to authorized representatives of the department, the office of the state auditor, and the United States department of health and human services.

((~~(2)~~)) (3) When a contract is terminated, all payments due will be withheld until accessibility and preservation of the records within the state of Washington are assured.

Sec. 7. RCW 74.46.090 and 1985 c 361 s 8 are each amended to read as follows:

The department will retain the required cost reports for a period of one year after final settlement or reconciliation, or the period required under chapter 40.14 RCW, whichever is longer. Resident assessment information and records shall be retained as provided elsewhere in statute or by department rule.

Sec. 8. RCW 74.46.100 and 1985 c 361 s 9 are each amended to read as follows:

((~~The principles inherent within RCW 74.46.105 and 74.46.130 are~~)) (1) The purposes of department audits under this chapter are to ascertain, through department audit of the financial and statistical records of the contractor's nursing facility operation, that:

((~~(1) To ascertain, through department audit, that the~~)) (a) Allowable costs for each year for each medicaid nursing facility are accurately reported((~~, thereby providing a valid basis for future rate determination~~));

((~~(2) To ascertain, through department audits of the cost reports, that~~)) (b) Cost reports ((~~properly~~)) accurately reflect the true financial condition, revenues, expenditures, equity, beneficial ownership, related party status, and records of the contractor((~~, particularly as they pertain to related organizations and beneficial ownership, thereby providing a valid basis for the determination of return as specified by this chapter~~));

((~~(3) To ascertain, through department audit that compliance with the accounting and auditing provisions of this chapter and the rules and regulations of the department as they pertain to these accounting and auditing provisions is proper and consistent~~)) (c) The contractor's revenues, expenditures, and costs of the building, land, land improvements, building improvements, and movable and fixed equipment are recorded in compliance with department requirements, instructions, and generally accepted accounting principles; and

((~~(4) To ascertain, through department audits, that~~)) (d) The responsibility of the contractor has been met in the maintenance and disbursement of patient trust funds.

(2) The department shall examine the submitted cost report, or a portion thereof, of each contractor for each nursing facility for each report period to determine if the information is correct, complete, reported in conformance with department instructions and generally accepted accounting principles, the requirements of this chapter, and

rules as the department may adopt. The department shall determine the scope of the examination.

(3) If the examination finds that the cost report is incorrect or incomplete, the department may make adjustments to the reported information for purposes of establishing payment rates or in determining amounts to be recovered in direct care, therapy care, and support services under section 10 (3) and (4) of this act or in any component rate resulting from undocumented or misreported costs. A schedule of the adjustments shall be provided to the contractor, including dollar amount and explanations for the adjustments. Adjustments shall be subject to review if desired by the contractor under the appeals or exception procedure established by the department.

(4) Examinations of resident trust funds and receivables shall be reported separately and in accordance with the provisions of this chapter and rules adopted by the department.

(5) The contractor shall:

(a) Provide access to the nursing facility, all financial and statistical records, and all working papers that are in support of the cost report, receivables, and resident trust funds. To ensure accuracy, the department may require the contractor to submit for departmental review any underlying financial statements or other records, including income tax returns, relating to the cost report directly or indirectly;

(b) Prepare a reconciliation of the cost report with (i) applicable federal income and federal and state payroll tax returns; and (ii) the records for the period covered by the cost report;

(c) Make available to the department's auditor an individual or individuals to respond to questions and requests for information from the auditor. The designated individual or individuals shall have sufficient knowledge of the issues, operations, or functions to provide accurate and reliable information.

(6) If an examination discloses material discrepancies, undocumented costs, or mishandling of resident trust funds, the department may open or reopen one or both of the two preceding cost report or resident trust fund periods, whether examined or unexamined, for indication of similar discrepancies, undocumented costs, or mishandling of resident trust funds.

(7) Any assets, liabilities, revenues, or expenses reported as allowable that are not supported by adequate documentation in the

contractor's records shall be disallowed. Documentation must show both that costs reported were incurred during the period covered by the report and were related to resident care, and that assets reported were used in the provision of resident care.

(8) When access is required at the facility or at another location in the state, the department shall notify a contractor of its intent to examine all financial and statistical records, and all working papers that are in support of the cost report, receivables, and resident trust funds.

(9) The department is authorized to assess civil fines and take adverse rate action if a contractor, or any of its employees, does not allow access to the contractor's nursing facility records.

(10) RCW 74.46.100 through 74.46.130, and rules adopted by the department pursuant thereto prior to January 1, 1998, shall continue to govern the medicaid nursing facility audit process for periods prior to January 1, 1997, as if these statutes and rules remained in full force and effect.

NEW SECTION. **Sec. 9.** (1) The department shall reconcile medicaid resident days to billed days and medicaid payments for each medicaid nursing facility for the preceding calendar year, or for that portion of the calendar year the provider's contract was in effect.

(2) The contractor shall make any payment owed the department, determined by the process of reconciliation, by the process of settlement at the lower of cost or rate in direct care, therapy care, and support services component rates, as authorized in this chapter, within sixty days after notification and demand for payment is sent to the contractor.

(3) The department shall make any payment due the contractor within sixty days after it determines the underpayment exists and notification is sent to the contractor.

(4) Interest at the rate of one percent per month accrues against the department or the contractor on an unpaid balance existing sixty days after notification is sent to the contractor. Accrued interest shall be adjusted back to the date it began to accrue if the payment obligation is subsequently revised after administrative or judicial review.

(5) The department is authorized to withhold funds from the contractor's payment for services, and to take all other actions

authorized by law, to recover amounts due and payable from the contractor, including any accrued interest. Neither a timely filed request to pursue any administrative appeals or exception procedure that the department may establish in rule, nor commencement of judicial review as may be available to the contractor in law, to contest a payment obligation determination shall delay recovery from the contractor or payment to the contractor.

NEW SECTION. **Sec. 10.** (1) Contractors shall be required to submit with each annual nursing facility cost report a proposed settlement report showing underspending or overspending in each component rate during the cost report year on a per-resident day basis. The department shall accept or reject the proposed settlement report, explain any adjustments, and issue a revised settlement report if needed.

(2) Contractors shall not be required to refund payments made in property, return on investment, and financing allowance component rates, nor shall they be required to refund payments made in operations component rates, in excess of the adjusted costs of providing services corresponding to these components.

(3) The facility will return to the department any overpayment amounts in each of the nursing services, administrative, and operational component rates. The facility will return to the department any overpayment amounts in each of the direct care, therapy care, and support services rate components that the department identifies following the audit and settlement procedures as described in chapter . . ., Laws of 1998 (this act), provided that the contractor may retain any overpayment that does not exceed 1.0% of the facility's direct care, therapy care, and support services component rate. Facilities that are not in substantial compliance, as defined by federal survey regulations during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's direct care, therapy care, and support services component rate.

(4) Determination of unused rate funds, including the amounts of direct care, therapy care, and support services to be recovered, shall be done separately for each component rate, and neither costs nor rate payments shall be shifted from one component rate or corresponding

service area to another in determining the degree of underspending or recovery, if any.

(5) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and those rules as the department may adopt, shall represent the maximum payment for nursing facility services rendered to medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

(6) RCW 74.46.150 through 74.46.180, and rules adopted by the department prior to the effective date of this section, shall continue to govern the medicaid settlement process for nursing facilities, including refunds, interest obligations, and other rights of the parties, for periods prior to January 1, 1999, as if these statutes and rules remained in full force and effect.

(7) For calendar year 1999, the department shall calculate split settlements covering January 1, 1999, through June 30, 1999, and July 1, 1999, through December 31, 1999. For the first half of calendar year 1999, rules specified in subsection (6) of this section shall apply and for the second half of calendar year 1999, the provisions of this chapter shall apply. The department shall, by rule, determine the division of calendar year 1999 adjusted costs for settlement purposes.

Sec. 11. RCW 74.46.190 and 1995 1st sp.s. c 18 s 96 are each amended to read as follows:

(1) The substance of a transaction will prevail over its form.

(2) All documented costs which are ordinary, necessary, related to care of medical care recipients, and not expressly unallowable under this chapter or department rule, are to be allowable. Costs of providing ((~~ancillary~~)) therapy care are allowable, subject to any applicable ((~~cost center~~)) limit contained in this chapter, provided documentation establishes the costs were incurred for medical care recipients and other sources of payment to which recipients may be legally entitled, such as private insurance or medicare, were first fully utilized.

(3) ((~~Costs applicable to services, facilities, and supplies furnished to the provider by related organizations are allowable but at the cost to the related organization, provided they do not exceed the~~

~~price of comparable services, facilities, or supplies that could be purchased elsewhere.~~

~~(4) Beginning January 1, 1985,~~)) The payment for property usage is to be independent of ownership structure and financing arrangements.

((~~(5) Beginning July 1, 1995,~~)) (4) Allowable costs shall not include costs reported by a ((~~nursing care provider~~)) contractor for a prior period to the extent such costs, due to statutory exemption, will not be incurred by the nursing facility in the period to be covered by the rate.

Sec. 12. RCW 74.46.220 and 1980 c 177 s 22 are each amended to read as follows:

(1) Costs applicable to services, facilities, and supplies furnished by a related organization to the contractor shall be allowable only to the extent they do not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere.

(2) Documentation of costs to the related organization shall be made available to the ((~~auditor at the time and place the records relating to the entity are audited~~)) department. Payments to or for the benefit of the related organization will be disallowed where the cost to the related organization cannot be documented.

Sec. 13. RCW 74.46.230 and 1993 sp.s. c 13 s 3 are each amended to read as follows:

(1) The necessary and ordinary one-time expenses directly incident to the preparation of a newly constructed or purchased building by a contractor for operation as a licensed facility shall be allowable costs. These expenses shall be limited to start-up and organizational costs incurred prior to the admission of the first patient.

(2) Start-up costs shall include, but not be limited to, administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, and training; except, that they shall exclude expenditures for capital assets. These costs will be allowable in the ((~~administrative~~)) operations cost center if they are amortized over a period of not less than sixty months beginning with the month in which the first patient is admitted for care.

(3) Organizational costs are those necessary, ordinary, and directly incident to the creation of a corporation or other form of

business of the contractor including, but not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation; except, that they do not include costs relating to the issuance and sale of shares of capital stock or other securities. Such organizational costs will be allowable in the ((~~administrative~~)) operations cost center if they are amortized over a period of not less than sixty months beginning with the month in which the first patient is admitted for care.

Sec. 14. RCW 74.46.270 and 1983 1st ex.s. c 67 s 13 are each amended to read as follows:

(1) The contractor shall disclose to the department:

(a) The nature and purpose of all costs which represent allocations of joint facility costs; and

(b) The methodology of the allocation utilized.

(2) Such disclosure shall demonstrate that:

(a) The services involved are necessary and nonduplicative; and

(b) Costs are allocated in accordance with benefits received from the resources represented by those costs.

(3) Such disclosure shall be made not later than September ((~~30, 1980,~~)) 30th for the following calendar year ((~~and not later than September 30th for each year thereafter~~)); except that a new contractor shall submit the first year's disclosure ((~~together with the submissions required by RCW 74.46.670. Where a contractor will make neither a change in the joint costs to be incurred nor in the allocation methodology, the contractor may certify that no change will be made in lieu of the disclosure required in subsection (1) of this section~~)) at least sixty days prior to the date the new contract becomes effective.

(4) The department shall ((~~approve such methodology not later than~~)) by December 31st, ((~~1980, and not later than December 31st for each year thereafter~~)) for all disclosures that are complete and timely submitted, either approve or reject the disclosure. The department may request additional information or clarification.

(5) Acceptance of a disclosure or approval of a joint cost methodology by the department may not be construed as a determination that the allocated costs are allowable in whole or in part. However, joint facility costs not disclosed, allocated, and reported in conformity with this section and department rules are unallowable.

(6) An approved methodology may be revised or amended subject to approval as provided in rules and regulations adopted by the department.

Sec. 15. RCW 74.46.280 and 1993 sp.s. c 13 s 4 are each amended to read as follows:

(1) Management fees will be allowed only if:

(a) A written management agreement both creates a principal/agent relationship between the contractor and the manager, and sets forth the items, services, and activities to be provided by the manager; and

(b) Documentation demonstrates that the services contracted for were actually delivered.

(2) To be allowable, fees must be for necessary, nonduplicative services.

(3) A management fee paid to or for the benefit of a related organization will be allowable to the extent it does not exceed the lower of the actual cost to the related organization of providing necessary services related to patient care under the agreement or the cost of comparable services purchased elsewhere. Where costs to the related organization represent joint facility costs, the measurement of such costs shall comply with RCW 74.46.270.

(4) A copy of the agreement must be received by the department at least sixty days before it is to become effective. A copy of any amendment to a management agreement must also be received by the department at least thirty days in advance of the date it is to become effective. Failure to meet these deadlines will result in the unallowability of cost incurred more than sixty days prior to submitting a management agreement and more than thirty days prior to submitting an amendment.

(5) The scope of services to be performed under a management agreement cannot be so extensive that the manager or managing entity is substituted for the contractor in fact, substantially relieving the contractor/licensee of responsibility for operating the facility.

Sec. 16. RCW 74.46.300 and 1980 c 177 s 30 are each amended to read as follows:

Rental or lease costs under arm's-length operating leases of office equipment shall be allowable to the extent the cost is necessary and

ordinary. The department may adopt rules to limit the allowability of office equipment leasing expenses.

Sec. 17. RCW 74.46.410 and 1995 1st sp.s. c 18 s 97 are each amended to read as follows:

(1) Costs will be unallowable if they are not documented, necessary, ordinary, and related to the provision of care services to authorized patients.

(2) Unallowable costs include, but are not limited to, the following:

(a) Costs of items or services not covered by the medical care program. Costs of such items or services will be unallowable even if they are indirectly reimbursed by the department as the result of an authorized reduction in patient contribution;

(b) Costs of services and items provided to recipients which are covered by the department's medical care program but not included in ((~~care services~~)) the medicaid per-resident day payment rate established by the department under this chapter;

(c) Costs associated with a capital expenditure subject to section 1122 approval (part 100, Title 42 C.F.R.) if the department found it was not consistent with applicable standards, criteria, or plans. If the department was not given timely notice of a proposed capital expenditure, all associated costs will be unallowable up to the date they are determined to be reimbursable under applicable federal regulations;

(d) Costs associated with a construction or acquisition project requiring certificate of need approval, or exemption from the requirements for certificate of need for the replacement of existing nursing home beds, pursuant to chapter 70.38 RCW if such approval or exemption was not obtained;

(e) Interest costs other than those provided by RCW 74.46.290 on and after January 1, 1985;

(f) Salaries or other compensation of owners, officers, directors, stockholders, partners, principals, participants, and others associated with the contractor or its home office, including all board of directors' fees for any purpose, except reasonable compensation paid for service related to patient care;

(g) Costs in excess of limits or in violation of principles set forth in this chapter;

(h) Costs resulting from transactions or the application of accounting methods which circumvent the principles of the ((~~cost-related reimbursement~~)) payment system set forth in this chapter;

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere;

(j) Bad debts of non-Title XIX recipients. Bad debts of Title XIX recipients are allowable if the debt is related to covered services, it arises from the recipient's required contribution toward the cost of care, the provider can establish that reasonable collection efforts were made, the debt was actually uncollectible when claimed as worthless, and sound business judgment established that there was no likelihood of recovery at any time in the future;

(k) Charity and courtesy allowances;

(l) Cash, assessments, or other contributions, excluding dues, to charitable organizations, professional organizations, trade associations, or political parties, and costs incurred to improve community or public relations;

(m) Vending machine expenses;

(n) Expenses for barber or beautician services not included in routine care;

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

(q) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except those used in patient activity programs;

(r) Fund-raising expenses, except those directly related to the patient activity program;

(s) Penalties and fines;

(t) Expenses related to telephones, televisions, radios, and similar appliances in patients' private accommodations;

(u) Federal, state, and other income taxes;

(v) Costs of special care services except where authorized by the department;

(w) Expenses of an employee benefit not in fact made available to all employees on an equal or fair basis, for example, key-man insurance and other insurance or retirement plans ((~~not made available to all employees~~));

(x) Expenses of profit-sharing plans;

(y) Expenses related to the purchase and/or use of private or commercial airplanes which are in excess of what a prudent contractor would expend for the ordinary and economic provision of such a transportation need related to patient care;

(z) Personal expenses and allowances of owners or relatives;

(aa) All expenses of maintaining professional licenses or membership in professional organizations;

(bb) Costs related to agreements not to compete;

(cc) Amortization of goodwill, lease acquisition, or any other intangible asset, whether related to resident care or not, and whether recognized under generally accepted accounting principles or not;

(dd) Expenses related to vehicles which are in excess of what a prudent contractor would expend for the ordinary and economic provision of transportation needs related to patient care;

(ee) Legal and consultant fees in connection with a fair hearing against the department where a decision is rendered in favor of the department or where otherwise the determination of the department stands;

(ff) Legal and consultant fees of a contractor or contractors in connection with a lawsuit against the department;

(gg) Lease acquisition costs ((~~and~~)), goodwill, the cost of bed rights, or any other ((~~intangibles not related to patient care~~)) intangible assets;

(hh) All rental or lease costs other than those provided in RCW 74.46.300 on and after January 1, 1985;

(ii) Postsurvey charges incurred by the facility as a result of subsequent inspections under RCW 18.51.050 which occur beyond the first postsurvey visit during the certification survey calendar year;

(jj) Compensation paid for any purchased nursing care services, including registered nurse, licensed practical nurse, and nurse assistant services, obtained through service contract arrangement in excess of the amount of compensation paid for such hours of nursing care service had they been paid at the average hourly wage, including related taxes and benefits, for in-house nursing care staff of like classification at the same nursing facility, as reported in the most recent cost report period;

(kk) For all partial or whole rate periods after July 17, 1984, costs of land and depreciable assets that cannot be reimbursed under

the Deficit Reduction Act of 1984 and implementing state statutory and regulatory provisions;

(ll) Costs reported by the contractor for a prior period to the extent such costs, due to statutory exemption, will not be incurred by the contractor in the period to be covered by the rate;

(mm) Costs of outside activities, for example, costs allocated to the use of a vehicle for personal purposes or related to the part of a facility leased out for office space;

(nn) Travel expenses outside the states of Idaho, Oregon, and Washington and the province of British Columbia. However, travel to or from the home or central office of a chain organization operating a nursing facility is allowed whether inside or outside these areas if the travel is necessary, ordinary, and related to resident care;

(oo) Moving expenses of employees in the absence of demonstrated, good-faith effort to recruit within the states of Idaho, Oregon, and Washington, and the province of British Columbia;

(pp) Depreciation in excess of four thousand dollars per year for each passenger car or other vehicle primarily used by the administrator, facility staff, or central office staff;

(qq) Costs for temporary health care personnel from a nursing pool not registered with the secretary of the department of health;

(rr) Payroll taxes associated with compensation in excess of allowable compensation of owners, relatives, and administrative personnel;

(ss) Costs and fees associated with filing a petition for bankruptcy;

(tt) All advertising or promotional costs, except reasonable costs of help wanted advertising;

(uu) Outside consultation expenses required to meet department-required minimum data set completion proficiency;

(vv) Interest charges assessed by any department or agency of this state for failure to make a timely refund of overpayments and interest expenses incurred for loans obtained to make the refunds; and

(ww) All home office or central office costs, whether on or off the nursing facility premises, and whether allocated or not to specific services, in excess of the median of those costs for all reporting facilities for the most recent report period.

NEW SECTION. **Sec. 18.** (1) Effective July 1, 1998, nursing facility medicaid payment rates shall be facility-specific and shall have six components: Direct care, therapy care, support services, operations, property, and return on investment rate. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) All component rates shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. That portion of a facility's costs associated with or calculated on an occupancy lower than eighty-five percent shall be unallowable.

(3) Adjustments to direct care, therapy care, support services, and operations component rates for economic trends and conditions shall utilize changes in the nursing home input price index without capital costs published by the health care financing administration of the United States department of health and human services (HCFA index), to be applied as specified in this section. The department is authorized to use alternate indexes as selected by the department if any index specified in this section ceases to be published, is altered or superseded, or if another index is deemed more appropriate by the department.

(4) Information and data sources used in determining medicaid payment rates, including formulas, procedures, cost report periods, resident assessment instrument formats, resident assessment methodologies, and resident classification and case mix weighting methodologies, may be substituted or altered from time to time as determined by the department.

(5)(a) Direct care component rates shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for July 1, 1998, through June 30, 2001, direct care component rates; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2004, direct care component rates.

(b) Direct care component rates based on 1996 cost report data shall be adjusted for economic trends and conditions as described in this subsection (5)(b); except that facilities whose direct care component rate, as calculated under section 24 of this act, is greater than the ceiling, as described in section 24(5)(g)(ii) of this act, for

July 1, 1998, shall receive an adjustment to the direct care component rate for economic trends and conditions, which is equal to the change in the HCFA index from July 1, 1995, to July 1, 1996. For every fiscal year beginning July 1, 1999, and thereafter, facilities whose direct care component rate, as calculated under section 24 of this act, is greater than the ceiling, as described in section 24(5)(g)(ii) of this act, shall receive an adjustment to the direct care component rate for economic trends that is equal to the change in the HCFA index from July 1st of the calendar year two years prior to the adjustment to July 1st of the calendar year one year prior to the adjustment.

(i) The July 1, 1998, direct care component shall be adjusted by the change in the HCFA index from July 1, 1996, to July 1, 1997, multiplied by a factor of one and one-half;

(ii) The July 1, 1999, direct care component shall be adjusted by the change in the HCFA index from July 1, 1997, to July 1, 1998, multiplied by no factor; and

(iii) The July 1, 2000, direct care component shall be adjusted by the change in the HCFA index from July 1, 1998, to July 1, 1999, multiplied by no factor.

(c) Direct care component rates based on 1999 cost report data shall be adjusted for economic trends and conditions as described in this subsection (5)(c); except that facilities whose direct care component rate, as calculated under section 24 of this act, is greater than the ceiling, as described in section 24(7) of this act, for July 1, 2001, shall receive an adjustment to the direct care component rate for economic trends and conditions, which is equal to the change in the HCFA index from July 1, 1999, to July 1, 2000. For every fiscal year beginning July 1, 1999, and thereafter, facilities whose direct care component rate, as calculated under section 24 of this act, is greater than the ceiling, as described in section 24(5)(g)(ii) of this act, shall receive an adjustment to the direct care component rate for economic trends that is equal to the change in the HCFA index from July 1st of the calendar year two years prior to the adjustment to July 1st of the calendar year one year prior to the adjustment:

(i) The July 1, 2001, direct care component shall be adjusted by the change in the HCFA index from July 1, 1999, to July 1, 2000, multiplied by a factor of one and one-half;

(ii) The July 1, 2002, direct care component shall be adjusted by the change in the HCFA index from July 1, 2000, to July 1, 2001, multiplied by no factor; and

(iii) The July 1, 2003, direct care component shall be adjusted by the change in the HCFA index from July 1, 2001, to July 1, 2002, multiplied by no factor.

(6)(a) Therapy care component rates shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for July 1, 1998, through June 30, 2001, therapy care component rates; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2004, therapy care component rates.

(b) Therapy care component rates based on 1996 cost report data shall be adjusted for economic trends and conditions as described in this subsection (6)(b).

(i) The July 1, 1998, therapy care component shall be adjusted by the change in the HCFA index from July 1, 1996, to July 1, 1997, multiplied by a factor of one and one-half;

(ii) The July 1, 1999, therapy care component shall be adjusted by the change in the HCFA index from July 1, 1997, to July 1, 1998, multiplied by no factor; and

(iii) The July 1, 2000, therapy care component shall be adjusted by the change in the HCFA index from July 1, 1998, to July 1, 1999, multiplied by no factor.

(c) Therapy care component rates based on 1999 cost report data shall be adjusted for economic trends and conditions as follows:

(i) The July 1, 2001, therapy care component shall be adjusted by the change in the HCFA index from July 1, 1999, to July 1, 2000, multiplied by a factor of one and one-half;

(ii) The July 1, 2002, therapy care component shall be adjusted by the change in the HCFA index from July 1, 2000, to July 1, 2001, multiplied by no factor; and

(iii) The July 1, 2003, therapy care component shall be adjusted by the change in the HCFA index from July 1, 2001, to July 1, 2002, multiplied by no factor.

(7)(a) Support services component rates shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for July 1, 1998, through June 30,

2001, support services component rates; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004.

(b) Support services component rates based on 1996 cost report data shall be adjusted for economic trends and conditions as follows:

(i) The July 1, 1998, support services component shall be adjusted by the change in the HCFA index from July 1, 1996, to July 1, 1997, multiplied by a factor of one and one-half;

(ii) The July 1, 1999, support services component shall be adjusted by the change in the HCFA index from July 1, 1997, to July 1, 1998, multiplied by no factor; and

(iii) The July 1, 2000, support services component shall be adjusted by the change in the HCFA index from July 1, 1998, to July 1, 1999, multiplied by no factor.

(c) Support services component rates based on 1999 cost report data shall be adjusted for economic trends and conditions as follows:

(i) The July 1, 2001, support services component shall be adjusted by the change in the HCFA index from July 1, 1999, to July 1, 2000, multiplied by a factor of one and one-half;

(ii) The July 1, 2002, support services component shall be adjusted by the change in the HCFA index from July 1, 2000, to July 1, 2001, multiplied by no factor; and

(iii) The July 1, 2003, support services component shall be adjusted by the change in the HCFA index from July 1, 2001, to July 1, 2002, multiplied by no factor.

(8)(a) Operations component rates shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for July 1, 1998, through June 30, 2001, operations component rates; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2004.

(b) Operations component rates based on 1996 cost report data shall be adjusted for economic trends and conditions as follows:

(i) The July 1, 1998, operations component shall be adjusted by the change in the HCFA index from July 1, 1996, to July 1, 1997, multiplied by a factor of one and one-half;

(ii) The July 1, 1999, operations component shall be adjusted by the change in the HCFA index from July 1, 1997, to July 1, 1998, multiplied by no factor; and

(iii) The July 1, 2000, operations component shall be adjusted by the change in the HCFA index from July 1, 1998, to July 1, 1999, multiplied by no factor.

(c) Operations component rates based on 1999 cost report data shall be adjusted for economic trends and conditions as follows:

(i) The July 1, 2001, operations component shall be adjusted by the change in the HCFA index from July 1, 1999, to July 1, 2000, multiplied by a factor of one and one-half;

(ii) The July 1, 2002, operations component shall be adjusted by the change in the HCFA index from July 1, 2000, to July 1, 2001, multiplied by no factor; and

(iii) The July 1, 2003, operations component shall be adjusted by the change in the HCFA index from July 1, 2001, to July 1, 2002, multiplied by no factor.

(9) The property and return on investment component rates shall be rebased annually, with no further adjustments, using adjusted cost report data from the prior calendar year covering at least six months of data.

(10) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

(11) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of five dollars and fifteen cents per hour or the federal minimum wage.

(12) The department shall establish in rule procedures, principles, and conditions for determining rates for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(13) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting

rates to reflect capital improvements or new requirements imposed by the department or the federal government.

NEW SECTION. **Sec. 19.** The department shall disclose to any member of the public all rate-setting information consistent with requirements of state and federal laws.

Sec. 20. RCW 74.46.475 and 1985 c 361 s 13 are each amended to read as follows:

(1) The department shall analyze the submitted cost report or a portion thereof of each contractor for each report period to determine if the information is correct, complete, ((~~and~~)) reported in conformance with department instructions and generally accepted accounting principles, the requirements of this chapter, and such rules ((~~and regulations~~)) as the ((~~secretary~~)) department may adopt. If the analysis finds that the cost report is incorrect or incomplete, the department may make adjustments to the reported information for purposes of establishing ((~~reimbursement~~)) payment rates. A schedule of such adjustments shall be provided to contractors and shall include an explanation for the adjustment and the dollar amount of the adjustment. Adjustments shall be subject to review and appeal as provided in this chapter.

(2) The department shall accumulate data from properly completed cost reports, in addition to assessment data on each facility's resident population characteristics, for use in:

(a) Exception profiling; and

(b) Establishing rates.

(3) The department may further utilize such accumulated data for analytical, statistical, or informational purposes as necessary.

NEW SECTION. **Sec. 21.** (1) The department shall employ the resource utilization group III case mix classification methodology. The department shall use the forty-four group index maximizing model for the resource utilization group III grouper version 5.10, but the department may revise or update the classification methodology to reflect advances or refinements in resident assessment or classification, subject to federal requirements.

(2) A default case mix group shall be established for cases in which the resident dies or is discharged for any purpose prior to

completion of the resident's initial assessment. The default case mix group and case mix weight for these cases shall be designated by the department.

(3) A default case mix group may also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases shall be designated by the department.

NEW SECTION. **Sec. 22.** (1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility for each calendar quarter shall be based on data from resident assessment instruments completed for the resident and weighted by the number of days the resident was in each case mix classification group. Days shall be counted as provided in this section.

(2) The case mix weights shall be based on the average minutes per registered nurse, licensed practical nurse, and certified nurse aide, for each case mix group, and using the health care financing administration of the United States department of health and human services 1995 nursing facility staff time measurement study stemming from its multistate nursing home case mix and quality demonstration project. Those minutes shall be weighted by state-wide ratios of registered nurse to certified nurse aide, and licensed practical nurse to certified nurse aide, wages, including salaries and benefits, which shall be based on 1995 cost report data for this state.

(3) The case mix weights shall be determined as follows:

(a) Set the certified nurse aide wage weight at 1.000 and calculate wage weights for registered nurse and licensed practical nurse average wages by dividing the certified nurse aide average wage into the registered nurse average wage and licensed practical nurse average wage;

(b) Calculate the total weighted minutes for each case mix group in the resource utilization group III classification system by multiplying the wage weight for each worker classification by the average number of minutes that classification of worker spends caring for a resident in that resource utilization group III classification group, and summing the products;

(c) Assign a case mix weight of 1.000 to the resource utilization group III classification group with the lowest total weighted minutes

and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. The case mix weights shall be revised, but only when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate. However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.

(5) Case mix weights shall be revised when direct care component rates are cost-rebased every three years as provided in section 18(5)(a) of this act.

NEW SECTION. **Sec. 23.** (1) From individual case mix weights for the applicable quarter, the department shall determine two average case mix indexes for each medicaid nursing facility, one for all residents in the facility, known as the facility average case mix index, and one for medicaid residents, known as the medicaid average case mix index.

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or medicaid residents, as applicable, who were physically in the facility during the quarter in question (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

(b) The facility average case mix index shall exclude all default cases as defined in this chapter. However, the medicaid average case mix index shall include all default cases.

(3) Both the facility average and the medicaid average case mix indexes shall be determined by multiplying the case mix weight of each resident, or each medicaid resident, as applicable, by the number of days, as defined in this section and as applicable, the resident was at each particular case mix classification or group, and then averaging.

(4)(a) In determining the number of days a resident is classified into a particular case mix group, the department shall determine a start date for calculating case mix grouping periods as follows:

(i) If a resident's initial assessment for a first stay or a return stay in the nursing facility is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the later of either the first day of the quarter or the resident's facility admission or readmission date;

(ii) If a resident's significant change, quarterly, or annual assessment is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the date the assessment is completed;

(iii) If a resident's significant change, quarterly, or annual assessment is not timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the due date for the assessment.

(b) If state or federal rules require more frequent assessment, the same principles for determining the start date of a resident's classification in a particular case mix group set forth in subsection (4)(a) of this section shall apply.

(c) In calculating the number of days a resident is classified into a particular case mix group, the department shall determine an end date for calculating case mix grouping periods as follows:

(i) If a resident is discharged before the end of the applicable quarter, the end date shall be the day before discharge;

(ii) If a resident is not discharged before the end of the applicable quarter, the end date shall be the last day of the quarter;

(iii) If a new assessment is due for a resident or a new assessment is completed and transmitted to the department, the end date of the previous assessment shall be the earlier of either the day before the assessment is due or the day before the assessment is completed by the nursing facility.

(5) The cutoff date for the department to use resident assessment data, for the purposes of calculating both the facility average and the medicaid average case mix indexes, and for establishing and updating a facility's direct care component rate, shall be one month and one day after the end of the quarter for which the resident assessment data applies.

(6) A threshold of ninety percent, as described and calculated in this subsection, shall be used to determine the case mix index each quarter. The threshold shall also be used to determine which facilities' costs per case mix unit are included in determining the ceiling, floor, and price. If the facility does not meet the ninety percent threshold, the department may use an alternate case mix index to determine the facility average and medicaid average case mix indexes for the quarter. The threshold is a count of unique minimum data set assessments, and it shall include resident assessment instrument tracking forms for residents discharged prior to completing an initial assessment. The threshold is calculated by dividing the count of unique minimum data set assessments by the average census for each facility. A daily census shall be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department shall use the facility's licensed beds as the denominator in computing the threshold.

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used only every three years in combination with cost report data as specified by this section, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate quarterly.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes.

(i) For July 1, 1998, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1997.

(ii) For July 1, 2000, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1998.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate quarterly shall be from the calendar quarter commencing six months prior to the effective date of the quarterly rate. For example, July 1, 1998,

through September 30, 1998, direct care component rates shall use medicaid case mix averages from the January 1, 1998, through March 31, 1999, calendar quarter; October 1, 1998, through December 31, 1998, direct care component rates shall utilize case mix averages from the April 1, 1998, through June 30, 1998, calendar quarter, and so forth.

NEW SECTION. **Sec. 24.** (1) The direct care component rate corresponds to the provision of nursing care for one resident of a nursing facility for one day, including direct care supplies. Therapy services and supplies, which correspond to the therapy care component rate, shall be excluded. The direct care component rate includes elements of case mix determined consistent with the principles of this section and other applicable provisions of this chapter.

(2) Beginning July 1, 1998, the department shall determine and update quarterly for each nursing facility serving medicaid residents a facility-specific per-resident day direct care component rate, to be effective on the first day of each calendar quarter. In determining direct care component rates the department shall utilize, as specified in this section, minimum data set resident assessment data for each resident of the facility, as transmitted to, and if necessary corrected by, the department in the resident assessment instrument format approved by federal authorities for use in this state.

(3) The department may question the accuracy of assessment data for any resident and utilize corrected or substitute information, however derived, in determining direct care component rates. The department is authorized to impose civil fines and to take adverse rate actions against a contractor, as specified by the department in rule, in order to obtain compliance with resident assessment and data transmission requirements and to ensure accuracy.

(4) Cost report data used in setting direct care component rates shall be 1996 and 1999, for rate periods as specified in section 18(5)(a) of this act.

(5) Beginning July 1, 1998, the department shall rebase each nursing facility's direct care component rate as described in section 18 of this act, adjust its direct care component rate for economic trends and conditions as described in section 18 of this act, and update its medicaid average case mix index, consistent with the following:

(a) Reduce total direct care costs reported by each nursing facility for the applicable cost report period specified in section 18(5)(a) of this act to reflect any department adjustments, and to eliminate reported resident therapy costs and adjustments, in order to derive the facility's total allowable direct care cost;

(b) Divide each facility's total allowable direct care cost by its adjusted resident days for the same report period, increased if necessary to a minimum occupancy of eighty-five percent; that is, the greater of actual or imputed occupancy at eighty-five percent of licensed beds, to derive the facility's allowable direct care cost per resident day;

(c) Adjust the facility's per resident day direct care cost by the applicable factor specified in section 18(5) (b) and (c) of this act to derive its adjusted allowable direct care cost per resident day;

(d) Divide each facility's adjusted allowable direct care cost per resident day by the facility average case mix index for the applicable quarters specified by section 23(7)(b) of this act to derive the facility's allowable direct care cost per case mix unit;

(e) Divide nursing facilities into two peer groups: Those located in metropolitan statistical areas as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government, and those not located in a metropolitan statistical area;

(f) Array separately the allowable direct care cost per case mix unit for all metropolitan statistical area and for all nonmetropolitan statistical area facilities, and determine the median allowable direct care cost per case mix unit for each peer group;

(g) Determine each facility's allowable direct care cost per case mix unit. For July 1, 1998, through June 30, 2000, direct care component rates:

(i) A facility's direct care cost per case mix unit shall not be set below the floor of eighty-five percent of the facility's metropolitan statistical area or nonmetropolitan statistical area peer group median cost per case mix unit;

(ii) A facility's direct care cost per case mix unit shall not be set above the ceiling of one hundred fifteen percent of the facility's metropolitan statistical area or nonmetropolitan statistical area peer group median cost per case mix unit. Except that for those facilities whose cost per case mix unit is above the ceiling described in (g)(ii)

of this subsection, the direct care component rate shall be set equal to the nursing services component rate in effect on June 30, 1998, in accordance with RCW 74.46.481 as it existed prior to the effective date of this section, less therapy costs, plus any exceptional care offsets as reported on the cost report, adjusted for economic trends and conditions as described in section 18 of this act; and after June 30, 1999, shall be set equal to the direct care component rate in effect at the end of the immediately preceding fiscal year, adjusted for economic trends and conditions as described in section 18 of this act;

(h) Multiply each nursing facility's allowable direct care cost per case mix unit by that facility's medicaid average case mix index from the applicable quarter specified by section 23(7)(c) of this act to arrive at the facility's quarterly direct care component rate.

(6) For July 1, 2000, through June 30, 2002, direct care component rates, for metropolitan statistical area and nonmetropolitan statistical area facilities, the ceiling for each facility within each peer group shall be one hundred ten percent of the peer group's median allowable direct care cost per case mix unit, and the floor shall be ninety percent of the peer groups' median allowable direct care cost per case mix unit; except that for those facilities whose cost per case mix unit is above the ceiling described in this subsection (6), the direct care component rate shall be set equal to the nursing services component rate in effect at the end of the immediately preceding fiscal year, adjusted for economic trends and conditions as described in section 18 of this act.

(7) For July 1, 2002, through June 30, 2004, direct care component rates, for metropolitan statistical area and nonmetropolitan statistical area facilities, the ceiling for each facility within each peer group shall be one hundred five percent of the peer group's median allowable direct care cost per case mix unit, and the floor shall be ninety-five percent of the peer group's median allowable direct care cost per case mix unit; except that for those facilities whose cost per case mix unit is above the ceiling described in this subsection (7), the direct care component rate shall be set equal to the nursing services component rate in effect at the end of the immediately preceding fiscal year, adjusted for economic trends and conditions as described by section 18 of this act.

NEW SECTION. **Sec. 25.** (1) The therapy care component rate corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate for July 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate for July 1, 2001, through June 30, 2004, shall be based on adjusted therapy costs and days from calendar year 1999. The therapy care component rate shall be adjusted for economic trends and conditions as specified in section 18(6)(b) of this act, and shall be determined in accordance with this section.

(2) In rebasing, as provided in section 18(6)(a) of this act, the department shall take from the cost reports of facilities the following reported information:

(a) Direct one-on-one therapy charges for all residents by payer including charges for supplies;

(b) The total units or modules of therapy care for all residents by type of therapy provided, for example, speech or physical. A unit or module of therapy care is considered to be fifteen minutes of one-on-one therapy provided by a qualified therapist or support personnel; and

(c) Therapy consulting expenses for all residents.

(3) The department shall determine for all residents the total cost per unit of therapy for each type of therapy by dividing the total adjusted one-on-one therapy expense for each type by the total units provided for that therapy type.

(4) The department shall divide medicaid nursing facilities in this state into two peer groups:

(a) Those facilities located within a metropolitan statistical area; and

(b) Those not located in a metropolitan statistical area.

Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States office of management and budget or other applicable federal office. The department shall array the facilities in each peer group from highest to lowest based on their total cost per unit of therapy for each therapy type. The department shall determine the median total cost per unit of therapy for each therapy type and add ten percent of median total cost per unit of therapy. The cost per unit of therapy for each therapy type at a

nursing facility shall be the lesser of its cost per unit of therapy for each therapy type or the median total cost per unit plus ten percent for each therapy type for its peer group.

(5) The department shall calculate each nursing facility's therapy care component rate as follows:

(a) To determine the allowable total therapy cost for each therapy type, the allowable cost per unit of therapy for each type of therapy shall be multiplied by the total therapy units for each type of therapy;

(b) The medicaid allowable one-on-one therapy expense shall be calculated taking the allowable total therapy cost for each therapy type times the medicaid percent of total therapy charges for each therapy type;

(c) The medicaid allowable one-on-one therapy expense for each therapy type shall be divided by total adjusted medicaid days to arrive at the medicaid one-on-one therapy cost per patient day for each therapy type;

(d) The medicaid one-on-one therapy cost per patient day for each therapy type shall be multiplied by total adjusted patient days for all residents to calculate the total allowable one-on-one therapy expense. The lesser of the total allowable therapy consultant expense for the therapy type or a reasonable percentage of allowable therapy consultant expense for each therapy type, as established in rule by the department, shall be added to the total allowable one-on-one therapy expense to determine the allowable therapy cost for each therapy type;

(e) The allowable therapy cost for each therapy type shall be added together, the sum of which shall be the total allowable therapy expense for the nursing facility;

(f) The total allowable therapy expense will be divided by the greater of adjusted total patient days from the cost report on which the therapy expenses were reported, or patient days at eighty-five percent occupancy of licensed beds. The outcome shall be the nursing facility's therapy care component rate.

NEW SECTION. **Sec. 26.** (1) The support services component rate corresponds to the provision of food, food preparation, dietary, housekeeping, and laundry services for one resident for one day.

(2) Beginning July 1, 1998, the department shall determine each medicaid nursing facility's support services component rate using cost report data specified by section 18(7) of this act.

(3) To determine each facility's support services component rate, the department shall:

(a) Array facilities' adjusted support services costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area, and for those not located in any metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's support services component rate at the lower of the facility's per resident day adjusted support services costs from the applicable cost report period or the adjusted median per resident day support services cost for that facility's peer group, either metropolitan statistical area or nonmetropolitan statistical area, plus ten percent; and

(c) Adjust each facility's support services component rate for economic trends and conditions as provided in section 18(7) of this act.

NEW SECTION. **Sec. 27.** (1) The operations component rate corresponds to the general operation of a nursing facility for one resident for one day, including but not limited to management, administration, utilities, office supplies, accounting and bookkeeping, minor building maintenance, minor equipment repairs and replacements, and other supplies and services, exclusive of direct care, therapy care, support services, and capital return.

(2) Beginning July 1, 1998, the department shall determine each medicaid nursing facility's operations component rate using cost report data specified by section 18(8)(a) of this act.

(3) To determine each facility's operations component rate the department shall:

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within a metropolitan statistical area and for those not located in a metropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's operations component rate at the lower of the facility's per resident day adjusted operations costs from the applicable cost report period or the adjusted median per resident day general operations cost for that facility's peer group, metropolitan statistical area or nonmetropolitan statistical area; and

(c) Adjust each facility's operations component rate for economic trends and conditions as provided in section 18(8)(b) of this act.

NEW SECTION. **Sec. 28.** (1) The property cost center rate for each facility shall be determined by dividing the sum of the reported allowable prior period actual depreciation, subject to RCW 74.46.310 through 74.46.380, adjusted for any capitalized additions or replacements approved by the department, and the retained savings from such cost center, by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on ninety or eighty-five percent facility occupancy as applicable. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the property cost center rate shall be adjusted to anticipated resident day level.

(2) A nursing facility's property rate shall be rebased annually, effective July 1st, in accordance with this section and this chapter.

(3) When a certificate of need for a new facility is requested, the department, in reaching its decision, shall take into consideration per-bed land and building construction costs for the facility which shall not exceed a maximum to be established by the secretary.

(4) For the purpose of calculating a nursing facility's property component rate, if a contractor elects to bank licensed beds or to convert banked beds to active service, under chapter 70.38 RCW, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity. However, in no case shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after banking or conversion.

NEW SECTION. **Sec. 29.** (1) The department shall establish for each medicaid nursing facility a return on investment rate composed of two parts: A financing allowance and a variable return allowance. The financing allowance part of a facility's return on investment component

rate shall be rebased annually, effective July 1st, in accordance with the provisions of this section and this chapter.

(a) The financing allowance shall be determined by multiplying the net invested funds of each facility by .085, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on ninety percent or eighty-five percent facility occupancy as applicable. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the financing and variable return allowances shall be adjusted to the anticipated resident day level.

(b) In computing the portion of net invested funds representing the net book value of tangible fixed assets, the same assets, depreciation bases, lives, and methods referred to in RCW 74.46.330, 74.46.350, 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets, shall be utilized, except that the capitalized cost of land upon which the facility is located and such other contiguous land which is reasonable and necessary for use in the regular course of providing resident care shall also be included. Subject to provisions and limitations contained in this chapter, for land purchased by owners or lessors before July 18, 1984, capitalized cost of land shall be the buyer's capitalized cost. For all partial or whole rate periods after July 17, 1984, if the land is purchased after July 17, 1984, capitalized cost shall be that of the owner of record on July 17, 1984, or buyer's capitalized cost, whichever is lower. In the case of leased facilities where the net invested funds are unknown or the contractor is unable to provide necessary information to determine net invested funds, the secretary shall have the authority to determine an amount for net invested funds based on an appraisal conducted according to RCW 74.46.360(1).

(c) In determining the variable return allowance:

(i) For all rate setting periods beginning July 1st, the department, without utilizing peer groups, shall first rank all facilities in numerical order from highest to lowest according to their per resident day adjusted or audited, or both, allowable costs for nursing services, food, administrative, and operational costs combined for the 1994 calendar year cost report period.

(ii) The department shall then compute the variable return allowance by multiplying the appropriate percentage amounts, which shall not be less than one percent and not greater than four percent, by the sum of the facility's nursing services, food, administrative, and operational rate components. The percentage amounts will be based on groupings of facilities according to the rankings prescribed in (c)(i) of this subsection. The percentages calculated and assigned will remain the same for the variable return allowance paid in all July 1, 1996, and July 1, 1997, rates as well. Those groups of facilities with lower per diem costs shall receive higher percentage amounts than those with higher per diem costs.

(d) The sum of the financing allowance and the variable return allowance shall be the return on investment rate for each facility, and shall be added to the prospective rates of each contractor as determined in sections 18 through 27 of this act.

(e) In the case of a facility that was leased by the contractor as of January 1, 1980, in an arm's-length agreement, which continues to be leased under the same lease agreement, and for which the annualized lease payment, plus any interest and depreciation expenses associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property cost center determined according to section 28 of this act, is more than the return on investment rate determined according to (d) of this subsection, the following shall apply:

(i) The financing allowance shall be recomputed substituting the fair market value of the assets as of January 1, 1982, as determined by the department of general administration through an appraisal procedure, less accumulated depreciation on the lessor's assets since January 1, 1982, for the net book value of the assets in determining net invested funds for the facility. A determination by the department of general administration of fair market value shall be final unless the procedure used to make such a determination is shown to be arbitrary and capricious.

(ii) The sum of the financing allowance computed under (e)(i) of this subsection and the variable allowance shall be compared to the annualized lease payment, plus any interest and depreciation associated with contractor-owned assets, for the period covered by the prospective rates, divided by the contractor's total resident days, minus the property cost center rate determined according to section 28 of this

act. The lesser of the two amounts shall be called the alternate return on investment rate.

(iii) The return on investment rate determined according to (d) of this subsection or the alternate return on investment rate, whichever is greater, shall be the return on investment rate for the facility and shall be added to the prospective rates of the contractor as determined in sections 18 through 27 of this act.

(f) In the case of a facility that was leased by the contractor as of January 1, 1980, in an arm's-length agreement, if the lease is renewed or extended under a provision of the lease, the treatment provided in (e) of this subsection shall be applied, except that in the case of renewals or extensions made subsequent to April 1, 1985, reimbursement for the annualized lease payment shall be no greater than the reimbursement for the annualized lease payment for the last year prior to the renewal or extension of the lease.

(2) For the purpose of calculating a nursing facility's return on investment component rate, if a contractor elects to bank beds or to convert banked beds to active service, under chapter 70.38 RCW, the department shall use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity. However, in no case shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after banking or conversion.

(3) Each biennium the secretary shall review the adequacy of return on investment rates in relation to anticipated requirements for maintaining, reducing, or expanding nursing care capacity. The secretary shall report the results of a such review to the legislature and make recommendations for adjustments in the return on investment rates utilized in this section, if appropriate.

NEW SECTION. **Sec. 30.** (1) The department may adjust component rates for errors or omissions made in establishing component rates and determine amounts either overpaid to the contractor or underpaid by the department.

(2) A contractor may request the department to adjust its component rates because of:

(a) An error or omission the contractor made in completing a cost report; or

(b) An alleged error or omission made by the department in determining one or more of the contractor's component rates.

(3) A request for a rate adjustment made on incorrect cost reporting must be accompanied by the amended cost report pages prepared in accordance with the department's written instructions and by a written explanation of the error or omission and the necessity for the amended cost report pages and the rate adjustment.

(4) The department shall review a contractor's request for a rate adjustment because of an alleged error or omission, even if the time period has expired in which the contractor must appeal the rate when initially issued, pursuant to rules adopted by the department under RCW 74.46.780. If the request is received after this time period, the department has the authority to correct the rate if it agrees an error or omission was committed. However, if the request is denied, the contractor shall not be entitled to any appeals or exception review procedure that the department may adopt under RCW 74.46.780.

(5) The department shall notify the contractor of the amount of the overpayment to be recovered or additional payment to be made to the contractor reflecting a rate adjustment to correct an error or omission. The recovery from the contractor of the overpayment or the additional payment to the contractor shall be governed by the reconciliation, settlement, security, and recovery processes set forth in this chapter and by rules adopted by the department in accordance with this chapter and RCW 74.46.800.

Sec. 31. RCW 74.46.610 and 1983 1st ex.s. c 67 s 33 are each amended to read as follows:

(1) A contractor shall bill the department each month by completing and returning a facility billing statement as provided by the department ((~~which shall include, but not be limited to:~~

~~(a) Billing by cost center;~~

~~(b) Total patient days; and~~

~~(c) Patient days for medical care recipients~~)).

The statement shall be completed and filed in accordance with rules ((~~and regulations~~)) established by the ((~~secretary~~)) department.

(2) A facility shall not bill the department for service provided to a recipient until an award letter of eligibility of such recipient under rules established under chapter 74.09 RCW has been received by the facility. However a facility may bill and shall be reimbursed for

all medical care recipients referred to the facility by the department prior to the receipt of the award letter of eligibility or the denial of such eligibility.

(3) Billing shall cover the patient days of care.

Sec. 32. RCW 74.46.620 and 1980 c 177 s 62 are each amended to read as follows:

(1) The department will ((~~reimburse~~)) pay a contractor for service rendered under the facility contract and billed in accordance with RCW 74.46.610.

(2) The amount paid will be computed using the appropriate rates assigned to the contractor.

(3) For each recipient, the department will pay an amount equal to the appropriate rates, multiplied by the number of ((~~patient~~)) medicaid resident days each rate was in effect, less the amount the recipient is required to pay for his or her care as set forth by RCW 74.46.630.

Sec. 33. RCW 74.46.630 and 1980 c 177 s 63 are each amended to read as follows:

(1) The department will notify a contractor of the amount each medical care recipient is required to pay for care provided under the contract and the effective date of such required contribution. It is the contractor's responsibility to collect that portion of the cost of care from the patient, and to account for any authorized reduction from his or her contribution in accordance with rules ((~~and regulations~~)) established by the ((~~secretary~~)) department.

(2) If a contractor receives documentation showing a change in the income or resources of a recipient which will mean a change in his or her contribution toward the cost of care, this shall be reported in writing to the department within seventy-two hours and in a manner specified by rules ((~~and regulations~~)) established by the ((~~secretary~~)) department. If necessary, appropriate corrections will be made in the next facility statement, and a copy of documentation supporting the change will be attached. If increased funds for a recipient are received by a contractor, an amount determined by the department shall be allowed for clothing and personal and incidental expense, and the balance applied to the cost of care.

(3) The contractor shall accept the ((~~reimbursement~~)) payment rates established by the department as full compensation for all services

provided under the contract, certification as specified by Title XIX, and licensure under chapter 18.51 RCW. The contractor shall not seek or accept additional compensation from or on behalf of a recipient for any or all such services.

Sec. 34. RCW 74.46.640 and 1995 1st sp.s. c 18 s 112 are each amended to read as follows:

(1) Payments to a contractor may be withheld by the department in each of the following circumstances:

(a) A required report is not properly completed and filed by the contractor within the appropriate time period, including any approved extension. Payments will be released as soon as a properly completed report is received;

(b) State auditors, department auditors, or authorized personnel in the course of their duties are refused access to a nursing facility or are not provided with existing appropriate records. Payments will be released as soon as such access or records are provided;

(c) A refund in connection with a ((~~preliminary or final~~)) settlement or rate adjustment is not paid by the contractor when due. The amount withheld will be limited to the unpaid amount of the refund and any accumulated interest owed to the department as authorized by this chapter;

(d) Payment for the final sixty days of service under a contract will be held in the absence of adequate alternate security acceptable to the department pending ((~~final~~)) settlement <u>of all periods</u> when the contract is terminated; and

(e) Payment for services at any time during the contract period in the absence of adequate alternate security acceptable to the department, if a contractor's net medicaid overpayment liability for one or more nursing facilities or other debt to the department, as determined by ((~~preliminary settlement, final~~)) settlement, civil fines imposed by the department, third-party liabilities or other source, reaches or exceeds fifty thousand dollars, whether subject to good faith dispute or not, and for each subsequent increase in liability reaching or exceeding twenty-five thousand dollars. Payments will be released as soon as practicable after acceptable security is provided or refund to the department is made.

(2) No payment will be withheld until written notification of the suspension is provided to the contractor, stating the reason for the

withholding, except that neither a timely filed request to pursue ((~~the~~)) any administrative appeals or exception procedure that the department may establish((~~ed~~)) by ((~~the department in~~)) rule nor commencement of judicial review, as may be available to the contractor in law, shall delay suspension of payment.

Sec. 35. RCW 74.46.650 and 1980 c 177 s 65 are each amended to read as follows:

All payments to a contractor will end no later than sixty days after any of the following occurs:

(1) A contract ((~~expires,~~)) is terminated ((~~or is not renewed~~));

(2) A facility license is revoked; or

(3) A facility is decertified as a Title XIX facility; except that, in situations where the ((~~secretary~~)) department determines that residents must remain in such facility for a longer period because of the resident's health or safety, payments for such residents shall continue.

Sec. 36. RCW 74.46.660 and 1992 c 215 s 1 are each amended to read as follows:

In order to participate in the ((~~prospective cost-related reimbursement~~)) nursing facility medicaid payment system established by this chapter, the person or legal ((~~organization~~)) entity responsible for operation of a facility shall:

(1) Obtain a state certificate of need and/or federal capital expenditure review (section 1122) approval pursuant to chapter 70.38 RCW and Part 100, Title 42 CFR where required;

(2) Hold the appropriate current license;

(3) Hold current Title XIX certification;

(4) Hold a current contract to provide services under this chapter;

(5) Comply with all provisions of the contract and all ((~~application~~)) applicable regulations, including but not limited to the provisions of this chapter; and

(6) Obtain and maintain medicare certification, under Title XVIII of the social security act, 42 U.S.C. Sec. 1395, as amended, for a portion of the facility's licensed beds. ((~~Until June 1, 1993, the department may grant exemptions from the medicare certification requirements of this subsection to nursing facilities that are making good faith efforts to obtain medicare certification.~~))

Sec. 37. RCW 74.46.680 and 1985 c 361 s 2 are each amended to read as follows:

(1) On the effective date of a change of ownership the department's contract with the old owner shall be terminated. The old owner shall give the department sixty days' written notice of such termination. When certificate of need and/or section 1122 approval is required pursuant to chapter 70.38 RCW and Part 100, Title 42 CFR, for the new owner to acquire the facility, and the new owner wishes to continue to provide service to recipients without interruption, certificate of need and/or section 1122 approval shall be obtained before the old owner submits a notice of termination.

(2) If the new owner desires to participate in the ((~~cost-related reimbursement~~)) nursing facility medicaid payment system, it shall meet the conditions specified in RCW 74.46.660 ((~~and shall submit a projected budget in accordance with RCW 74.46.670 no later than sixty days before the date of the change of ownership~~)). The facility contract with the new owner shall be effective as of the date of the change of ownership.

Sec. 38. RCW 74.46.690 and 1995 1st sp.s. c 18 s 113 are each amended to read as follows:

(1) When a facility contract is terminated for any reason, ((~~the old contractor shall submit~~)) final reports shall be submitted as required by RCW 74.46.040.

(2) Upon notification of a contract termination, the department shall determine by ((~~preliminary or final settlement calculations~~)) settlement or reconciliation the amount of any overpayments made to the contractor, including overpayments disputed by the contractor. If ((~~preliminary or final~~)) settlements are unavailable for any period up to the date of contract termination, the department shall make a reasonable estimate of any overpayment or underpayments for such periods. The reasonable estimate shall be based upon prior period settlements, available audit findings, the projected impact of prospective rates, and other information available to the department. The department shall also determine and add in the total of all other debts and potential debts owed to the department regardless of source, including, but not limited to, interest owed to the department as authorized by this chapter, civil fines imposed by the department, or third-party liabilities.

(3) The old contractor shall provide security, in a form deemed adequate by the department, equal to the total amount of determined and estimated overpayments and all ((~~other~~)) debts and potential debts from any source, whether or not the overpayments are the subject of good faith dispute including but not limited to, interest owed to the department, civil fines imposed by the department, and third-party liabilities. Security shall consist of one or more of the following:

(a) Withheld payments due the old contractor under the contract being terminated; ((~~or~~))

(b) ((~~A surety bond issued by a bonding company acceptable to the department; or~~

~~(c)~~)) An assignment of funds to the department; ((~~or~~

~~(d) Collateral acceptable to the department; or~~

~~(e) A purchaser's~~)) (c) The new contractor's assumption of liability for the prior contractor's ((~~overpayment~~)) debt or potential debt;

(d) An authorization to withhold payments from one or more medicaid nursing facilities that continue to be operated by the old contractor;

((~~(f)~~)) (e) A promissory note secured by a deed of trust; or

((~~(g) Any combination of (a), (b), (c), (d), (e), or (f) of this subsection~~)) (f) Other collateral or security acceptable to the department.

(4) ((~~A surety bond or~~)) An assignment of funds shall:

(a) Be at least equal ((~~in~~)) to the amount ((~~to~~)) of determined or estimated ((~~overpayments, whether or not the subject of good faith dispute,~~)) debt or potential debt minus withheld payments or other security provided; and

(b) ((~~Be issued or accepted by a bonding company or financial institution licensed to transact business in Washington state;~~

~~(c) Be for a term, as determined by the department, sufficient to ensure effectiveness after final settlement and the exhaustion of any administrative appeals or exception procedure and judicial remedies, as may be available to and sought by the contractor, regarding payment, settlement, civil fine, interest assessment, or other debt issues: PROVIDED, That the bond or assignment shall initially be for a term of at least five years, and shall be forfeited if not renewed thereafter in an amount equal to any remaining combined overpayment and debt liability as determined by the department;~~

~~(d) Provide that the full amount of the bond or assignment, or both, shall be paid to the department if a properly completed final cost report is not filed in accordance with this chapter, or if financial records supporting this report are not preserved and made available to the auditor; and~~

~~(e)~~)) Provide that an amount equal to any recovery the department determines is due from the contractor from settlement or from any ((~~other~~)) source of debt to the department, but not exceeding the amount of the ((~~bond and~~)) assignment, shall be paid to the department if the contractor does not pay the ((~~refund and~~)) debt within sixty days following receipt of written demand for payment from the department to the contractor.

(5) The department shall release any payment withheld as security if alternate security is provided under subsection (3) of this section in an amount equivalent to the determined and estimated ((~~overpayments~~)) debt.

(6) If the total of withheld payments((~~, bonds,~~)) and assignments is less than the total of determined and estimated overpayments and debts, the unsecured amount of ((~~such~~)) the overpayments and the debt shall be a debt due the state and shall become a lien against the real and personal property of the contractor from the time of filing by the department with the county auditor of the county where the contractor resides or owns property, and the lien claim has preference over the claims of all unsecured creditors.

(7) ((~~The contractor shall file~~)) A properly completed final cost report shall be filed in accordance with the requirements of ((~~this chapter~~)) RCW 74.46.040, which shall be ((~~audited~~)) examined by the department in accordance with the requirements of RCW 74.46.100. ((~~A final settlement shall be determined within ninety days following completion of the audit process, including completion of any administrative appeals or exception procedure review of the audit requested by the contractor, but not including completion of any judicial review available to and commenced by the contractor.~~))

(8) ((~~Following determination of settlement for all periods,~~)) Security held pursuant to this section shall be released to the contractor after all ((~~overpayments, erroneous payments, and~~)) debts ((~~determined in connection with final settlement, or otherwise~~)), including accumulated interest owed the department, have been paid by the old contractor.

(9) If, after calculation of settlements for any periods, it is determined that overpayments exist in excess of the value of security held by the state, the department may seek recovery of these additional overpayments as provided by law.

(10) Regardless of whether a contractor intends to terminate its medicaid contracts, if a contractor's net medicaid overpayments and erroneous payments for one or more settlement periods, and for one or more nursing facilities, combined with debts due the department, reaches or exceeds a total of fifty thousand dollars, as determined by ((~~preliminary settlement, final~~)) settlement, civil fines imposed by the department, third-party liabilities or by any other source, whether such amounts are subject to good faith dispute or not, the department shall demand and obtain security equivalent to the total of such overpayments, erroneous payments, and debts and shall obtain security for each subsequent increase in liability reaching or exceeding twenty-five thousand dollars. Such security shall meet the criteria in subsections (3) and (4) of this section, except that the department shall not accept an assumption of liability. The department shall withhold all or portions of a contractor's current contract payments or impose liens, or both, if security acceptable to the department is not forthcoming. The department shall release a contractor's withheld payments or lift liens, or both, if the contractor subsequently provides security acceptable to the department. ((~~This subsection shall apply to all overpayments and erroneous payments determined by preliminary or final settlements issued on or after July 1, 1995, regardless of what payment periods the settlements may cover and shall apply to all debts owed the department from any source, including interest debts, which become due on or after July 1, 1995.~~))

Sec. 39. RCW 74.46.770 and 1995 1st sp.s. c 18 s 114 are each amended to read as follows:

(1) ((~~For all nursing facility medicaid payment rates effective on or after July 1, 1995, and for all settlements and audits issued on or after July 1, 1995, regardless of what periods the settlements or audits may cover,~~)) If a contractor wishes to contest the way in which a rule relating to the medicaid payment ((~~rate~~)) system was applied to the contractor by the department, it shall pursue ((~~the~~)) any appeals or exception procedure ((~~established by~~)) that the department may establish in rule authorized by RCW 74.46.780.

(2) If a contractor wishes to challenge the legal validity of a statute, rule, or contract provision or wishes to bring a challenge based in whole or in part on federal law, ((~~including but not limited to issues of procedural or substantive compliance with the federal medicaid minimum payment standard for long-term care facility services, the~~)) any appeals or exception procedure ((~~established by~~)) that the department may establish in rule may not be used for these purposes. This prohibition shall apply regardless of whether the contractor wishes to obtain a decision or ruling on an issue of validity or federal compliance or wishes only to make a record for the purpose of subsequent judicial review.

(3) If a contractor wishes to challenge the legal validity of a statute, rule, or contract provision relating to the medicaid payment rate system, or wishes to bring a challenge based in whole or in part on federal law, it must bring such action de novo in a court of proper jurisdiction as may be provided by law.

Sec. 40. RCW 74.46.780 and 1995 1st sp.s. c 18 s 115 are each amended to read as follows:

((~~For all nursing facility medicaid payment rates effective on or after July 1, 1995, and for all audits completed and settlements issued on or after July 1, 1995, regardless of what periods the payment rates, audits, or settlements may cover,~~)) The department shall establish in rule, consistent with federal requirements for nursing facilities participating in the medicaid program, an appeals or exception procedure that allows individual nursing care providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as the department deems appropriate.

Sec. 41. RCW 74.46.800 and 1980 c 177 s 80 are each amended to read as follows:

(1) The department shall have authority to adopt, ((~~promulgate,~~)) amend, and rescind such administrative rules and definitions as ((~~are~~)) it deems necessary to carry out the policies and purposes of this chapter and to resolve issues and develop procedures that it deems necessary to implement, update, and improve the case mix elements of the nursing facility medicaid payment system. ((~~In addition, at least annually the department shall review changes to generally accepted~~

~~accounting principles and generally accepted auditing standards as approved by the financial accounting standards board, and the American institute of certified public accountants, respectively. The department shall adopt by administrative rule those approved changes which it finds to be consistent with the policies and purposes of this chapter.~~))

(2) Nothing in this chapter shall be construed to require the department to adopt or employ any calculations, steps, tests, methodologies, alternate methodologies, indexes, formulas, mathematical or statistical models, concepts, or procedures for medicaid rate setting or payment that are not expressly called for in this chapter.

Sec. 42. RCW 74.46.820 and 1985 c 361 s 14 are each amended to read as follows:

(1) ((~~Cost reports and their final audit~~)) Financial reports filed by the contractor shall be subject to public disclosure pursuant to the requirements of chapter 42.17 RCW. Notwithstanding any other provision of law, ((~~cost~~)) reports ((~~schedules~~)) showing information on rental or lease of assets, the facility or corporate balance sheet, schedule of changes in financial position, statement of changes in equity-fund balances, notes to financial statements, and any ((~~accompanying~~)) schedules summarizing ((~~the~~)) adjustments to a contractor's financial records, reports on review of internal control and accounting procedures, and letters of comments or recommendations relating to suggested improvements in internal control or accounting procedures which are prepared pursuant to the requirements of this chapter shall be exempt from public disclosure.

((~~This~~)) (2) Subsection (1) of this section does not prevent a contractor from having access to its own records or from authorizing an agent or designee to have access to the contractor's records.

((~~(2)~~)) (3) Regardless of whether any document or report submitted to the secretary pursuant to this chapter is subject to public disclosure, copies of such documents or reports shall be provided by the secretary, upon written request, to the legislature and to state agencies or state or local law enforcement officials who have an official interest in the contents thereof.

Sec. 43. RCW 74.46.840 and 1983 1st ex.s. c 67 s 42 are each amended to read as follows:

If any part of this chapter ((~~and~~)) or RCW 18.51.145 ((~~and~~)) or 74.09.120 is found by an agency of the federal government to be in conflict with federal requirements ((~~which~~)) that are a prescribed condition to the receipts of federal funds to the state, the conflicting part of this chapter ((~~and~~)) or RCW 18.51.145 ((~~and~~)) or 74.09.120 is ((~~hereby~~)) declared inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and such finding or determination shall not affect the operation of the remainder of this chapter ((~~and~~)) or RCW 18.51.145 ((~~and~~)) or 74.09.120 in its application to the agencies concerned. In the event that any portion of this chapter ((~~and~~)) or RCW 18.51.145 ((~~and~~)) or 74.09.120 is found to be in conflict with federal requirements ((~~which~~)) that are a prescribed condition to the receipt of federal funds, the secretary, to the extent that the secretary finds it to be consistent with the general policies and intent of chapters 18.51, 74.09, and 74.46 RCW, may adopt such rules as to resolve a specific conflict and ((~~which~~)) that do meet minimum federal requirements. In addition, the secretary shall submit to the next regular session of the legislature a summary of the specific rule changes made and recommendations for statutory resolution of the conflict.

Sec. 44. RCW 74.09.120 and 1993 sp.s. c 3 s 8 are each amended to read as follows:

The department shall purchase necessary physician and dentist services by contract or "fee for service." The department shall purchase nursing home care by contract and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the department under the authority of RCW 74.46.800. ((~~The department shall establish regulations for reasonable nursing home accounting and reimbursement systems which shall provide that~~)) No payment shall be made to a nursing home which does not permit inspection by the department of social and health services of every part of its premises and an examination of all records, including financial records, methods of administration, general and special dietary programs, the disbursement of drugs and methods of supply, and any other records the department deems relevant to the ((~~establishment of such a system~~)) regulation of nursing home operations, enforcement of standards for resident care, and payment for nursing home services.

The department may purchase nursing home care by contract in veterans' homes operated by the state department of veterans affairs((~~. The department shall establish rules for reasonable accounting and reimbursement systems for such care~~)) and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the department under the authority of RCW 74.46.800.

The department may purchase care in institutions for the mentally retarded, also known as intermediate care facilities for the mentally retarded. The department shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for the mentally retarded include licensed nursing homes, public institutions, licensed boarding homes with fifteen beds or less, and hospital facilities certified as intermediate care facilities for the mentally retarded under the federal medicaid program to provide health, habilitative, or rehabilitative services and twenty-four hour supervision for mentally retarded individuals or persons with related conditions and includes in the program "active treatment" as federally defined.

The department may purchase care in institutions for mental diseases by contract. The department shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for mental diseases are certified under the federal medicaid program and primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases, including medical attention, nursing care, and related services.

The department may purchase all other services provided under this chapter by contract or at rates established by the department.

NEW SECTION. **Sec. 45.** (1) Payment for direct care at the pilot nursing facility in King county designed to meet the service needs of residents living with AIDS, as defined in RCW 70.24.017, and as specifically authorized for this purpose under chapter 9, Laws of 1989 1st ex. sess., shall be exempt from case mix methods of rate determination set forth in this chapter and shall be exempt from the direct care metropolitan statistical area peer group cost limitation set forth in this chapter.

(2) Direct care component rates at the AIDS pilot facility shall be based on direct care reported costs at the pilot facility, utilizing the same three-year, rate-setting cycle prescribed for other nursing

facilities, and as supported by a staffing benchmark based upon a department-approved acuity measurement system.

(3) All other rate-setting principles, cost lids, and limits, including settlement at the lower of cost or rate in direct care, therapy care, and support services, shall apply to the AIDS pilot facility.

(4) This section applies only to the AIDS pilot nursing facility.

NEW SECTION. **Sec. 46.** For nursing facilities located in King county that commenced operations in February 1995, the department shall use each such facility's 1996 allowable costs to retroactively adjust and reset the July 1, 1997, nursing services, food, administrative, and operational rate components. In determining 1996 allowable costs for the affected King county facilities, the department shall use 1994 cost limits adjusted to 1996. The 1996 cost report shall be the basis for rates subsequent to July 1, 1997, until such time as the nursing facility payment methodology recognizes a new cost report for all facilities. The 1996 allowable costs used to revise the July 1, 1997, rate components shall be adjusted using an inflation factor of 3.79 percent.

NEW SECTION. **Sec. 47.** (1) The department of social and health services shall study and provide recommendations, by December 12, 1998, to the chairs of the house of representatives health care committee and the senate health and long-term care committee on the appropriateness of extending the case mix principles, described in chapter . . ., Laws of 1998 (this act), to home and community service providers, as defined in chapter 74.39A RCW. The department shall invite stakeholders to participate in this study.

(2) By December 12, 1999, the department of social and health services shall study and provide recommendations to the chairs of the house of representatives appropriations and health care committees, and the senate ways and means and health and long-term care committees, concerning options for changing the method for paying facilities for capital and property related expenses.

(3) The department of social and health services shall contract with an independent and recognized organization to study and evaluate the impacts of chapter . . ., Laws of 1998 (this act) implementation on access, quality of care, quality of life for nursing facility

residents, and the wage and benefit levels of all nursing facility employees. The department shall require, and the contractor shall submit, a report with the results of this study and evaluation, including their findings, to the governor and legislature by December 1, 2001.

(4) The department of social and health services shall study and, as needed, specify additional case mix groups and appropriate case mix weights to reflect the resource utilization of residents whose care needs are not adequately identified or reflected in the resource utilization group III grouper version 5.10. At a minimum, the department shall study the adequacy of the resource utilization group III grouper version 5.10, including the minimum data set, for capturing the care and resource utilization needs of residents with AIDS, residents with traumatic brain injury, and residents who are behaviorally challenged. The department shall report its findings to the chairs of the house of representatives health care committee and the senate health and long-term care committee by December 12, 2002.

(5) By December 12, 2002, the department of social and health services shall report to the legislature and provide an evaluation of the fiscal impact of rebasing future payments at different intervals, including the impact of averaging two years' cost data as the basis for rebasing. This report shall include the fiscal impact to the state and the fiscal impact to nursing facility providers.

NEW SECTION. **Sec. 48.** The department shall not deem tax expenses that have never been incurred by a nursing facility to be a medicaid allowable cost to that facility for the purposes of payment for services, as described in chapter . . ., Laws of 1998 (this act).

Sec. 49. RCW 72.36.030 and 1993 sp.s. c 3 s 5 are each amended to read as follows:

All of the following persons who have been actual bona fide residents of this state at the time of their application, and who are indigent and unable to support themselves and their families may be admitted to a state veterans' home under rules as may be adopted by the director of the department, unless sufficient facilities and resources are not available to accommodate these people:

(1)(a) All honorably discharged veterans of a branch of the armed forces of the United States or merchant marines; (b) members of the

state militia disabled while in the line of duty; ((~~and~~)) (c) Filipino World War II veterans who swore an oath to American authority and who participated in military engagements with American soldiers; and (d) the spouses of these veterans, merchant marines, and members of the state militia. However, it is required that the spouse was married to and living with the veteran three years prior to the date of application for admittance, or, if married to him or her since that date, was also a resident of a state veterans' home in this state or entitled to admission thereto;

(2)(a) The spouses of: (i) All honorably discharged veterans of the United States armed forces; (ii) merchant marines; and (iii) members of the state militia who were disabled while in the line of duty and who were residents of a state veterans' home in this state or were entitled to admission to one of this state's state veteran homes at the time of death; (b) the spouses of: (i) All honorably discharged veterans of a branch of the United States armed forces; (ii) merchant marines; and (iii) members of the state militia who would have been entitled to admission to one of this state's state veterans' homes at the time of death, but for the fact that the spouse was not indigent, but has since become indigent and unable to support himself or herself and his or her family. However, the included spouse shall be at least fifty years old and have been married to and living with their husband or wife for three years prior to the date of their application. The included spouse shall not have been married since the death of his or her husband or wife to a person who is not a resident of one of this state's state veterans' homes or entitled to admission to one of this state's state veterans' homes; and

(3) All applicants for admission to a state veterans' home shall apply for all federal and state benefits for which they may be eligible, including medical assistance under chapter 74.09 RCW.

NEW SECTION. **Sec. 50.** The following acts or parts of acts are each repealed:

(1) RCW 74.46.105 and 1995 1st sp.s. c 18 s 91, 1985 c 361 s 10, & 1983 1st ex.s. c 67 s 5;

(2) RCW 74.46.115 and 1995 1st sp.s. c 18 s 92 & 1983 1st ex.s. c 67 s 6;

(3) RCW 74.46.130 and 1985 c 361 s 11, 1983 1st ex.s. c 67 s 7, & 1980 c 177 s 13;

(4) RCW 74.46.150 and 1983 1st ex.s. c 67 s 8 & 1980 c 177 s 15;

(5) RCW 74.46.160 and 1995 1st sp.s. c 18 s 93, 1985 c 361 s 12, 1983 1st ex.s. c 67 s 9, & 1980 c 177 s 16;

(6) RCW 74.46.170 and 1995 1st sp.s. c 18 s 94, 1983 1st ex.s. c 67 s 10, & 1980 c 177 s 17;

(7) RCW 74.46.180 and 1995 1st sp.s. c 18 s 95 & 1993 sp.s. c 13 s 2;

(8) RCW 74.46.210 and 1991 sp.s. c 8 s 14 & 1980 c 177 s 21; and

(9) RCW 74.46.670 and 1983 1st ex.s. c 67 s 35 & 1980 c 177 s 67.

NEW SECTION. **Sec. 51.** RCW 74.46.595 and 1995 1st sp.s. c 18 s 98 are each repealed effective July 2, 1998.

NEW SECTION. **Sec. 52.** Sections 1 through 46 and 48 through 54 of this act take effect July 1, 1998.

NEW SECTION. **Sec. 53.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 54.** Sections 9, 10, 18, 19, 21 through 30, 45, 46, and 48 of this act are each added to chapter 74.46 RCW.

NEW SECTION. **Sec. 55.** Section 47 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

--- END ---