H-4415.1

HOUSE BILL 2935

State of Washington 55th Legislature 1998 Regular Session

By Representatives Dyer, Cody, Huff and Backlund

Read first time 01/22/98. Referred to Committee on Health Care.

AN ACT Relating to nursing home payment rates; amending RCW 74.46.010, 74.46.020, 74.46.060, 74.46.090, 74.46.100, 74.46.190, 74.46.210, 74.46.220, 74.46.230, 74.46.360, 74.46.475, 74.46.610, 74.46.620, 74.46.630, 74.46.640, 74.46.660, 74.46.680, 74.46.690, 74.46.770, 74.46.780, 74.46.800, and 74.46.820; 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, 74.46.670, and 74.46.595; and providing effective dates.

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 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)~~)) "Base price" means the per day amount that the department shall determine by arraying from high to low, using two peer groups as

described in this chapter, each facility's allowable medicaid cost per case mix unit, finding the median cost per case mix unit and adding ten percent.

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

(10) "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.

(11) "Case mix index" means a numerical value score that describes the relative resource used for each resident within the groups under the resource utilization group classification system.

(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 past due for the resident under state or 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 rate provided to each nursing facility medicaid recipient. Therapy care shall not be considered part of direct care. The direct care rate component shall be resident specific and not an averaging of the nursing care and related care provided to all medicaid recipients.

(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) "Facility case mix index" means the case mix index for each resident calculated on a facility average and time weighted for all resident days.

(22) "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)~~)) (23) "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)~~)) (24) "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)~~)) (25) "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)~~)) (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) "Imprest fund" means a fund which is regularly replenished in exactly the amount expended from it.~~

~~(24)~~)) (27) "Joint facility costs" means any costs which represent resources which benefit more than one nursing facility, or one nursing facility and any other business or entity.

((~~(25)~~)) (28) "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)~~)) (29) "Medicaid day" or "recipient day" means a calendar day of care provided to a 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.

(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 core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of licensed nursing homes certified to participate in

the medicaid program. The items in the minimum data set standardize communication about the resident problems, strengths, and conditions within facilities, between facilities and between facilities and outside agencies.

(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" or "recipient day" means a calendar day of care provided to a medical care 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) "Pharmacy service" or "pharmaceutical" means over the counter drugs and supplies and includes consultant services but excludes legend drugs and either other drugs or supplies, or both, covered and administered by the department's medical assistance administration.

(41) "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~~)); and

(g) A music therapist who has graduated from an accredited music therapy program, is board certified, and possesses credentials as a registered music therapist or certified music therapist.

((~~(37) "Rebased rate" or "cost-rebased rate" means a facility-specific 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.~~

~~(38)~~)) (42) "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)~~)) (43) "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 exercised.

((~~(40)~~)) (44) "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, audiologist services, rehabilitative, restorative, or maintenance therapy services provided by licensed nurses or nursing assistants-certified, and social services.

(45) "Resident assessment instrument" means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols, including federally approved modifications, revisions, or additions.

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

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

(48) "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)~~)) (49) "Secretary" means the secretary of the department of social and health services.

((~~(42)~~)) (50) "Therapy care" means mental health, mental retardation therapy, physical therapy, respiratory therapy, speech therapy, occupational therapy, or music therapy services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists or by qualified therapists' assistants who are under their supervision.

(51) "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)~~)) (52) "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 74.46.060 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.

(2) The records shall be maintained on the accrual method of accounting and agree with or be reconcilable to the cost report.

Sec. 4. RCW 74.46.090 and 1985 c 361 s 8 are each amended to read as follows:

(1) The process of reconciliation and settlement shall be applied for the following purposes:

(a) To identify and recover overpayments or reimburse underpayments from inaccurate billing of medicaid patient days;

(b) To identify and adjust for overpayments or underpayments based on falsified or inaccurate cost report data;

(c) To identify and adjust for overpayments or underpayments based on inaccurate resident assessment data; and

(d) To identify and recover overpayments in support services.

(2) 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 clinical records shall be retained by the department as provided elsewhere in statute or by department rule.

Sec. 5. 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 assets 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. A schedule of proposed adjustments, including dollar amounts and explanations, shall be provided to the contractor prior to the department making any adjustments to the reported information. After receipt of the schedule of proposed adjustments, the contractor shall have a reasonable period of time, but no less than thirty days, to provide to the department either any additional information to or an explanation of, or both, the reported information. A final schedule of the adjustments shall then be provided to the contractor, including dollar amount and explanations for the adjustments. Final adjustments shall be subject to further 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 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; and

(b) 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 for a recent cost reporting, receivable, or trust fund period 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 material 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 at least ten days prior 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 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. 6.** (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 or settlement, 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 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 the department's administrative appeals or exception procedure established 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. 7.** (1) Contractors shall not receive any additional payment for any overexpenditure amounts in the direct care, operations, property, support services, or return on investment components, except as provided in this chapter. The payment rate, as calculated under this chapter, shall represent full compensation for care and services covered by this chapter.

(2) RCW 74.46.150 through 74.46.180, and rules adopted by the department pursuant thereto prior to January 1, 1998, 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 July 1, 1998, as if these statutes and rules remained in full force and effect.

Sec. 8. 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, are to be allowable. ((~~Costs of providing ancillary 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. 9. RCW 74.46.210 and 1991 sp.s. c 8 s 14 are each amended to read as follows:

All documented costs that are ordinary, necessary, and related to the care of medical care recipients and are not expressly unallowable will be allowable costs. These expenses include:

(1) Meeting licensing and certification standards;

(2) Meeting standards of providing regular room, ((~~nursing, ancillary, and dietary services~~)) direct care, operations, and support services, as established by department rule ((~~and regulation pursuant to chapter 211, Laws of 1979 ex. sess.~~)); and

(3) Fulfilling accounting and reporting requirements imposed by this chapter.

Sec. 10. 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. 11. 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. 12. RCW 74.46.360 and 1997 c 277 s 1 are each amended to read as follows:

(1) For all partial or whole rate periods after December 31, 1984, the cost basis of land and depreciation base of depreciable assets shall be the historical cost of the contractor or lessor, when the assets are leased by the contractor, in acquiring the asset in an arm's-length transaction and preparing it for use, less goodwill, and less accumulated depreciation, if applicable, which has been incurred during periods that the assets have been used in or as a facility by any contractor, such accumulated depreciation to be measured in accordance with subsections (4), (5), and (6) of this section and RCW 74.46.350 and 74.46.370. If the department challenges the historical cost of an asset, or if the contractor cannot or will not provide the historical costs, the department will have the department of general administration, through an appraisal procedure, determine the fair market value of the assets at the time of purchase. The cost basis of land and depreciation base of depreciable assets will not exceed such fair market value.

(2) For new or replacement building construction or for substantial building additions requiring the acquisition of land and which commenced to operate on or after July 1, 1997, the department shall

determine allowable land costs of the additional land acquired for the replacement construction or building additions to be the lesser of:

(a) The contractor's or lessor's actual cost per square foot; or

(b) The square foot land value as established by an appraisal that meets the latest publication of the Uniform Standards of Professional Appraisal Practice (USPAP) and the financial institutions reform, recovery, and enhancement act (FIRREA).

(3) Subject to the provisions of subsection (2) of this section, if, in the course of financing a project, an arm's-length lender has ordered a Uniform Standards of Professional Appraisal Practice appraisal on the land that meets financial institutions reform, recovery, and enhancement act standards and the arm's-length lender has accepted the ordered appraisal, the department shall accept the appraisal value as allowable land costs for calculation of payment.

If the contractor or lessor is unable or unwilling to provide or cause to be provided to the department, or the department is unable to obtain from the arm's-length lender, a lender-approved appraisal that meets the standards of the Uniform Standards of Professional Appraisal Practice and financial institutions reform, recovery, and enhancement act, the department shall order such an appraisal and accept the appraisal as the allowable land costs. If the department orders the Uniform Standards of Professional Appraisal Practice and financial institutions reform, recovery, and enhancement act appraisal, the contractor shall immediately reimburse the department for the costs incurred.

(4) The historical cost of depreciable and nondepreciable donated assets, or of depreciable and nondepreciable assets received through testate or intestate distribution, shall be the lesser of:

(a) Fair market value at the date of donation or death; or

(b) The historical cost base of the owner last contracting with the department, if any.

(5) Estimated salvage value of acquired, donated, or inherited assets shall be deducted from historical cost where the straight-line or sum-of-the-years' digits method of depreciation is used.

(6)(a) For facilities, other than those described under subsection (2) of this section, operating prior to July 1, 1997, where land or depreciable assets are acquired that were used in the medical care program subsequent to January 1, 1980, the cost basis or depreciation base of the assets will not exceed the net book value which did exist

or would have existed had the assets continued in use under the previous contract with the department; except that depreciation shall not be assumed to accumulate during periods when the assets were not in use in or as a facility.

(b) The provisions of (a) of this subsection shall not apply to the most recent arm's-length acquisition if it occurs at least ten years after the ownership of the assets has been previously transferred in an arm's-length transaction nor to the first arm's-length acquisition that occurs after January 1, 1980, for facilities participating in the medical care program prior to January 1, 1980. The new cost basis or depreciation base for such acquisitions shall not exceed the fair market value of the assets as determined by the department of general administration through an appraisal procedure. A determination by the department of general administration of fair market value shall be final unless the procedure used to make such determination is shown to be arbitrary and capricious. For all partial or whole rate periods after July 17, 1984, this subsection is inoperative for any transfer of ownership of any asset, depreciable or nondepreciable, occurring on or after July 18, 1984, leaving (a) of this subsection to apply alone to such transfers: PROVIDED, HOWEVER, That this subsection shall apply to transfers of ownership of assets occurring prior to January 1, 1985, if the costs of such assets have never been reimbursed under medicaid cost reimbursement on an owner-operated basis or as a related-party lease: PROVIDED FURTHER, That for any contractor that can document in writing an enforceable agreement for the purchase of a nursing home dated prior to July 18, 1984, and submitted to the department prior to January 1, 1988, the cost basis of allowable land and the depreciation base of the nursing home, for rates established after July 18, 1984, shall not exceed the fair market value of the assets at the date of purchase as determined by the department of general administration through an appraisal procedure. For medicaid cost reimbursement purposes, an agreement to purchase a nursing home dated prior to July 18, 1984, is enforceable, even though such agreement contains no legal description of the real property involved, notwithstanding the statute of frauds or any other provision of law.

(c) In the case of land or depreciable assets leased by the same contractor since January 1, 1980, in an arm's-length lease, and purchased by the lessee/contractor, the lessee/contractor shall have the option:

(i) To have the provisions of subsection (b) of this section apply to the purchase; or

(ii) To have the reimbursement for property and return on investment continue to be calculated pursuant to the provisions contained in ((~~RCW 74.46.530(1) (e) and (f)~~)) section 23 of this act based upon the provisions of the lease in existence on the date of the purchase, but only if the purchase date meets one of the following criteria:

(A) The purchase date is after the lessor has declared bankruptcy or has defaulted in any loan or mortgage held against the leased property;

(B) The purchase date is within one year of the lease expiration or renewal date contained in the lease;

(C) The purchase date is after a rate setting for the facility in which the reimbursement rate set pursuant to this chapter no longer is equal to or greater than the actual cost of the lease; or

(D) The purchase date is within one year of any purchase option in existence on January 1, 1988.

(d) For all rate periods past or future where land or depreciable assets are acquired from a related organization, the contractor's cost basis and depreciation base shall not exceed the base the related organization had or would have had under a contract with the department.

(e) Where the land or depreciable asset is a donation or distribution between related organizations, the cost basis or depreciation base shall be the lesser of (i) fair market value, less salvage value, or (ii) the cost basis or depreciation base the related organization had or would have had for the asset under a contract with the department.

NEW SECTION. **Sec. 13.** (1) Effective July 1, 1998, nursing facility medicaid payment rates shall have five components: Direct care, operations, support services, property, and return on investment. 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) The operations, property, and return on investment rates shall be based upon a minimum facility occupancy of eighty percent of licensed beds, regardless of how many beds are set up or in use. The

department shall not apply the minimum facility occupancy requirement in the reconciliation or settlement processes.

(3) Adjustments to direct care, operations, and support services 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 appropriate alternate indexes as selected by the department if any index specified in this section ceases to be published or is determined, after consultation with industry representatives, to inadequately predict change in nursing facility costs. The department shall, by rule, adopt an appropriate alternate index as necessary.

(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 by rule be substituted or altered as appropriate.

(5)(a) Direct care, operations, and support services component rates shall be established annually using adjusted cost report data covering at least six months, using an annual cycle beginning with January 1, 1996, through December 31, 1996, adjusted cost report data to establish the July 1, 1998, component rates and thereafter using the immediately preceding January 1st through December 31st adjusted cost report data to establish each subsequent July 1st direct care, operations, and support services component rates.

(b) The July 1, 1998, direct care, operations, and support services rates, based on the January 1, 1996, through December 31, 1996, adjusted cost report data, shall be adjusted for economic trends and conditions using the change in the HCFA index between July 1, 1996, and July 1, 1997, and multiplying by a factor of one and one-half percent.

(c) The July 1, 1999, and all subsequent July 1st direct care, operations, and support services component rates, based on the preceding year’s adjusted cost report data, shall be adjusted for economic trends and conditions using the midpoint of the base period cost report to the midpoint of the rate period and determining the actual change in the HCFA index and projected inflation as of the end of the first calendar quarter preceding the rate period, and so forth.

(d) Direct care component rates shall be updated as assessments are completed and submitted, or otherwise become due, in accordance with section 19 of this act.

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

(7) For new contractors, as defined by the department in rule, the department shall assign the facility to an appropriate peer group using the metropolitan statistical area and nonmetropolitan statistical area criteria described in section 18 of this act. The peer group prices and rates of payment for the direct care, operations, and support services components shall be determined in accordance with sections 18, 19, 21, and 22 of this act. Payment for therapy care shall be made in accordance with section 20 of this act. The property and return on investment rate components shall be determined in accordance with sections 23 and 24 of this act.

(8) Using the principles of payment established in this chapter, 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, existing facilities with expanded new bed capacity, and other circumstances.

NEW SECTION. **Sec. 14.** (1) In addition to meeting the rule-making requirements of chapter 34.05 RCW, the department shall provide to contractors, beneficiaries, their representatives, and other concerned members of the public a reasonable opportunity to review and comment on its nursing facility medicaid payment system, including its rate setting methodologies and justifications.

(2) The department shall periodically, and at least quarterly, convene stakeholder meetings particularly during the initial years following implementation of the new payment system.

Sec. 15. 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. 16.** (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 approval.

(2) A default case mix group shall be established for ungroupable cases. The case mix weight assigned to this group shall be set at 1.000, equivalent to the lowest case mix group weight. Cases in which there is an untimely assessment for the resident shall be grouped into this default case mix group.

NEW SECTION. **Sec. 17.** (1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility 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 wages by dividing the certified nurse aide wage into the registered nurse wage or licensed practical nurse 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. In such a case, the department shall use the most recent adjusted cost report year for the wages, salaries, and benefits data.

NEW SECTION. **Sec. 18.** (1) From individual case mix weights, the department shall determine the facility average case mix index for each medicaid nursing facility.

(2)(a) In calculating the average case mix index for each facility, the department shall include all residents who were physically in the facility at any time during the time period corresponding to the period covered by cost reports included in the rate base under section 13(5)(a) of this act, except that for purposes of establishing the July 1, 1998, direct care component rate, the department shall include only

those residents who were physically in the facility, at any time, during the July 1, 1997, through December 31, 1997, time period.

(b) The facility average case mix index shall exclude all default cases.

(3) The facility average case mix index shall be determined by multiplying the case mix weight of each resident by the number of days, as defined in this section and as applicable, the resident was at each particular case mix classification, 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 completed and transmitted to the department by the cutoff date 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 completed and transmitted to the department by the cutoff date 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 completed and transmitted to the department by the cutoff date 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 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 the facility average case mix index, shall be one month and one day after the end of the quarter for which the resident assessment data is transmitted.

(6) The facility average case mix index shall be calculated once per year in combination with cost report data as specified and as adjusted in section 13(5) of this act to establish a facility's allowable cost per case mix unit.

(7) Each facility's allowable cost per case mix unit shall be arrayed from high to low using two peer groups: (a) A metropolitan statistical area determined and defined by the United States bureau of labor statistics or other appropriate agency or office of the federal government; and (b) those facilities not located in a metropolitan statistical area. The department shall identify the median facility allowable cost per case mix unit, plus ten percent, for the metropolitan statistical area and nonmetropolitan statistical area, which shall represent the base price.

(8) For July 1, 1998, and July 1, 1999, direct care component rate setting only, the department shall establish ceilings and floors above and below each of the base prices.

(a) Beginning on July 1, 1998, the ceiling shall be set at one hundred ten percent of the base price metropolitan statistical area and base price nonmetropolitan statistical area and the floor shall be set at eighty-five percent of the base price metropolitan statistical area and nonmetropolitan statistical area.

(b) Beginning on July 1, 1999, the ceiling shall be set at one hundred five percent of the base price metropolitan statistical area and nonmetropolitan statistical area and the floor shall be set at ninety two and one-half percent of the base price metropolitan statistical area and nonmetropolitan statistical area.

(c) The ceilings and floors established under this subsection represent the ceiling prices and floor prices by which each resident's rate of payment shall be established in accordance with subsection (9), (10), or (11) of this section and in accordance with section 19 of this act.

(9) Facilities having allowable costs per case mix unit above the ceiling, as established in subsection (8) of this section, shall have each of their resident's rate of payment determined using the ceiling price.

(10) Facilities having allowable costs per case mix unit below the floor, as established in subsection (8) of this section, shall have each of their resident's rate of payment determined using the floor price.

(11) Facilities having allowable costs per case mix unit between the floor and ceiling as established in subsection (8) of this section, shall have each of their resident's rate of payment determined using that facility's allowable cost per case mix unit as the price.

NEW SECTION. **Sec. 19.** (1) The direct care component rate relates to the provision of nursing care and related care for one resident of a nursing facility for one day, including direct care supplies. Therapy services and supplies, which are paid under section 20 of this act, shall be excluded from the direct care component rate. 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 the direct care component rate as either the required resident assessments become due or are submitted to the department. If a required resident assessment becomes due and has not been timely submitted to the department as required under federal or state requirements, the resident shall be assigned to the default case mix group until the facility transmits the necessary resident assessment data. Once the resident assessment data is transmitted, the department shall retroactively adjust the facility's direct care component rate. 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. The effective date of the change to the direct care component rate shall be the date on which the resident assessment was completed.

(3) The medicaid resident assessment data shall be classified into a resource utilization group and shall be assigned corresponding case mix indexes. Each medicaid resident's assigned case mix index value shall be multiplied by either the ceiling price, the floor price, the facilities allowable cost per case mix unit price, or the base price as

determined in section 18 of this act, to derive the payment rate for each medicaid resident.

(a) For July 1, 1998, and July 1, 1999, direct care component rates, the department shall use the following prices to derive the payment rate for each resident: (i) The ceiling price shall be used for those facilities having allowable costs per case mix unit at or above the ceiling; (ii) the floor price shall be used for those facilities having allowable costs per case mix unit at or below the floor; and (iii) each facility's allowable cost per case mix unit shall be used for those facilities having allowable costs per case mix unit between the ceiling and the floor.

(b) For July 1, 2000, and all subsequent July 1st direct care component rates, the department shall use the base price as established under section 18 of this act, to derive the payment rate for each resident.

(4) The payment rate derived for each medicaid resident shall be in effect until the resident's next required assessment or until the resident is discharged.

(5) The department may question the accuracy of assessment data for any resident and utilize corrected information in determining direct care component rates. The contractor shall, under the provisions of this chapter, be provided an opportunity to contest any determination made by the department as to the accuracy of the assessment data submitted for any resident under section 26 of this act or RCW 74.46.780.

(6) A contractor may request the department to adjust its direct care component rate under section 25 or 26 of this act, or RCW 74.46.780.

NEW SECTION. **Sec. 20.** (1)(a) Therapy care payment shall relate to the provision of one-on-one therapy provided to medicaid residents by a qualified therapist, as defined in this chapter, or by a qualified therapists' assistant, and shall include copayment or deductible amounts under the medicare program.

(b) Costs associated with the provisions of therapy care that are paid privately, by commercial insurance, or the federal medicare program, except for copayment or deductible amounts, shall be excluded from payment under this chapter.

(c) Consultation services shall be included in the direct care component rate.

(2) Beginning July 1, 1998, the department shall pay for therapy care based on claims submitted. Only claims submitted by an eligible nursing facility therapy services provider, using the UB-92 claim form for physical, speech, or occupational therapy services, shall be paid. An eligible nursing facility therapy provider shall be the individual or entity licensed to provide therapy services or certified to participate in the medicare program. Payment shall be limited to medically necessary or therapeutically appropriate services.

(a) Payment for physical, speech, or occupational therapy, by therapy type, shall be based on units of therapy provided and shall be paid using the same fee amounts established by the department's medical assistance administration for outpatient hospital services. Each unit of therapy shall be based on fifteen minute increments of one-on-one therapy time.

(b) Payment for mental health, mental retardation, respiratory, and music therapy, by therapy type, shall be based on a fee schedule. The fee schedule shall be developed by the department in consultation with provider representatives. The fee schedule shall be in an amount or amounts sufficient to encourage the appropriate use of such therapy care.

(3)(a) The department may, by rule, establish a utilization threshold, expressed either as dates of service per resident or in dollars per resident, or both, which if exceeded will result in a case management review of the medical necessity for the therapy care. In establishing the case management utilization threshold or thresholds, the department shall consult with provider representatives.

(b) The department shall complete its case management utilization review, if required, promptly and shall notify the contractor of its decision no later than ten days following the date on which the necessary documentation demonstrating medical necessity or therapeutic appropriateness for the therapy was submitted.

(4) The department shall by rule establish procedures for billing for therapy care, including the copayment or deductible amounts under the medicare program. Claims for payment shall be submitted to the department's medical assistance administration at least quarterly.

(5) The department shall reimburse a contractor for all allowable therapy care within twenty days following the submission of claims.

NEW SECTION. **Sec. 21.** (1) The operations component rate relates 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 activities and services, exclusive of direct care, therapy care, property, support services, and return on investment.

(2) Beginning July 1, 1998, the department shall determine each nursing facility's operations component rate using cost report data specified by section 13(5)(a) of this act and adjusted by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on eighty percent facility occupancy.

(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 adjusted median per resident day general operations cost for that facility's peer group, metropolitan statistical area or nonmetropolitan statistical area, plus ten percent;

(c) Use the facility's anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity if a contractor elects to bank licensed beds or to convert banked beds to active service under chapter 70.38 RCW, however, in no case shall the department use less than eighty percent occupancy of the facility's licensed bed capacity after banking or conversion; and

(d) Adjust each facility's operations component rate for economic trends and conditions as provided in section 13(5)(b) or (c) of this act.

NEW SECTION. **Sec. 22.** (1) The support services component rate relates to the provision of food, food preparation, dietary, housekeeping, and laundry services for one resident day.

(2) Beginning July 1, 1998, the department shall determine each nursing facility's support services component rate using cost report data specified by section 13(5)(a) of this act.

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

(a) Array facilities' adjusted support services costs per resident day for each facility from facilities' costs reports from the applicable report year, for facilities located within a metropolitan statistical area and for those located in a nonmetropolitan statistical area and determine the median adjusted cost for each peer group;

(b) Set each facility's support services component rate at the adjusted median per resident day support services cost for that facility's peer group, metropolitan statistical area, and nonmetropolitan statistical area, plus fifteen percent; and

(c) Adjust each facility's support services component rate for economic trends and conditions as provided in section 13(5)(b) or (c) of this act.

(4) The facility will return to the department any overpayment amount that the department identifies following the audit and settlement procedures as described in this act.

NEW SECTION. **Sec. 23.** (1) The property component rate shall be determined in accordance with this section, RCW 74.46.310 through 74.46.380, and in accordance with the property rate component rules in effect as of December 1, 1997; except that the minimum occupancy requirement shall be eighty percent as specified in this section.

(2) The property component 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, if any, from such component rate, by the greater of a facility's total resident days for the facility in the prior period or resident days as calculated on eighty percent facility occupancy. 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 component rate shall be adjusted to anticipated resident day level.

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

(4) 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 department.

(5) 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 eighty percent occupancy of the facility's licensed bed capacity after banking or conversion.

NEW SECTION. **Sec. 24.** (1) The return on investment component rate shall be determined in accordance with this section and in accordance with the return on investment component rate rules in effect as of December 1, 1997; except that the minimum occupancy requirement shall be eighty percent as specified in this section.

(2) The department shall establish for each medicaid nursing facility a return on investment (ROI) component rate that shall be composed of two parts: A financing allowance and a variable return allowance. The financing allowance part of a facility's return on investment subcomponent 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 .10, 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 eighty percent facility occupancy. 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 other contiguous land that 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 department has 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 July 1, 1998, rate setting and for all subsequent July 1st rate setting periods, 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 allowable costs for direct care, operations, and support services combined for the 1996, 1998, and subsequent calendar year cost report periods.

(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 direct care, operations, and support services rate components. The percentage amounts will be based on groupings of facilities according to the rankings prescribed in (i) of this subsection (2)(c). 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 component rate for each facility and shall be added to the component rates of each contractor as determined in sections 19, 21, 22, and 23 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 component rate determined according to section 23 of this act, is more than the return on investment component 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 component rate determined according to section 23 of this act. The lesser of the two amounts shall be called the alternate return on investment component rate.

(iii) The return on investment component rate determined according to (d) of this subsection or the alternate return on investment component rate, whichever is greater, shall be the return on investment component rate for the facility.

(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.

(3) 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 eighty percent occupancy of the facility's licensed bed capacity after banking or conversion.

(4) Each biennium, beginning in 1999, the department shall review the adequacy of return on investment component rates in relation to anticipated requirements for maintaining, reducing, or expanding nursing care capacity. The department shall report the results of such a review to the legislature and make recommendations for adjustments in the return on investment component rates utilized in this section, if appropriate.

NEW SECTION. **Sec. 25.** (1) The department, in consultation with interested parties, shall adopt rules to establish criteria the department will use in reviewing any request by a contractor for a prospective rate adjustment for a physical plant capital improvement. The rules shall also specify the time periods for submission and review of proposed physical plant capital improvements. In establishing the criteria, the department may consider, but is not limited to, the following:

(a) The remaining functional life of the facility and the length of time since the facility's last significant improvement;

(b) The amount and scope of renovation or remodel to the facility and whether the facility will be able to serve better the needs of its residents;

(c) Whether the proposed improvement improves the quality of the living conditions of the residents;

(d) Whether the proposed improvement might eliminate life safety, building code, or construction standard waivers;

(e) The percentage of public-pay residents in the facility.

(2) The department shall prospectively adjust a contractor's relevant component rate or rates to address program changes, changes in staffing, or changes in minimum wage levels as may be required by the department.

(3) Rate adjustments under this section may be provided only if funds are appropriated for this purpose.

NEW SECTION. **Sec. 26.** (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 under paid 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;

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

(c) An error made by the contractor in completing a resident assessment or an alleged error made by the department in determining that the contractor erred under section 19 of this act.

(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. 27. 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~~)) an applicant for medicaid until an award letter of eligibility of such ((~~recipient~~)) applicant, 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~~)) medicaid applicants 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~~)) medicaid days of care.

Sec. 28. 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. 29. 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. 30. 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; and

(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 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 request to pursue the administrative appeals or exception procedure established 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. 31. 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. 32. 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. 33. 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) For all cost reports after December 31, 1997, 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. 34. 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,~~)) I<u></u>f 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 appeals or exception procedure established by the department 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 appeals or exception procedure established by the department 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. 35. 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,~~)) T<u></u>he 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 <u>resident assessment accuracy and other</u> such issues as the department deems appropriate.

Sec. 36. RCW 74.46.800 and 1980 c 177 s 80 are each amended to read as follows:

The department shall adopt, ((~~promulgate,~~)) amend, and rescind such administrative rules <u>and definitions</u> as are necessary to carry out the policies and purposes of this chapter <u>and to resolve issues and develop procedures needed to implement, update, and improve the case mix elements of the nursing facility medicaid payment system</u>. ((~~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.~~))

Sec. 37. 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.

NEW SECTION. **Sec. 38.** (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) 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 uniformity of wages for all long-term care 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, 2000.

NEW SECTION. **Sec. 39.** 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; and

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

NEW SECTION. **Sec. 40.** RCW 74.46.595 and 1995 1st sp.s. c 18 s 98 are each repealed effective July 2, 1998.

NEW SECTION. **Sec. 41.** Sections 6, 7, 13, 14, and 16 through 26 of this act are each added to chapter 74.46 RCW.

NEW SECTION. **Sec. 42.** Sections 23 through 26 of this act take effect July 1, 1998.

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