

CERTIFICATION OF ENROLLMENT
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2935

55th Legislature
1998 Regular Session

Passed by the House March 12, 1998
Yeas 98 Nays 0

**Speaker of the
House of Representatives**

Passed by the Senate March 11, 1998
Yeas 47 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Timothy A. Martin, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2935** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2935

AS AMENDED BY THE SENATE

Passed Legislature - 1998 Regular Session

State of Washington 55th Legislature 1998 Regular Session

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

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

1 AN ACT Relating to nursing home payment rates; amending RCW
2 74.46.010, 74.46.020, 74.46.040, 74.46.050, 74.46.060, 74.46.080,
3 74.46.090, 74.46.100, 74.46.190, 74.46.220, 74.46.230, 74.46.270,
4 74.46.280, 74.46.300, 74.46.410, 74.46.475, 74.46.610, 74.46.620,
5 74.46.630, 74.46.640, 74.46.650, 74.46.660, 74.46.680, 74.46.690,
6 74.46.770, 74.46.780, 74.46.800, 74.46.820, 74.46.840, 74.09.120, and
7 72.36.030; adding new sections to chapter 74.46 RCW; adding a new
8 section to chapter 70.38 RCW; creating new sections; repealing RCW
9 74.46.105, 74.46.115, 74.46.130, 74.46.150, 74.46.160, 74.46.170,
10 74.46.180, 74.46.210, 74.46.670, and 74.46.595; prescribing penalties;
11 providing effective dates; and providing an expiration date.

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

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

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

18 The purposes of this chapter are to specify the manner by which
19 legislative appropriations for medicaid nursing facility services are

1 to be allocated as payment rates among nursing facilities, and to set
2 forth auditing, billing, and other administrative standards associated
3 with payments to nursing home facilities.

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

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

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

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

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

22 ~~((4))~~ (3) "Arm's-length transaction" means a transaction
23 resulting from good-faith bargaining between a buyer and seller who are
24 not related organizations and have adverse positions in the market
25 place. Sales or exchanges of nursing home facilities among two or more
26 parties in which all parties subsequently continue to own one or more
27 of the facilities involved in the transactions shall not be considered
28 as arm's-length transactions for purposes of this chapter. Sale of a
29 nursing home facility which is subsequently leased back to the seller
30 within five years of the date of sale shall not be considered as an
31 arm's-length transaction for purposes of this chapter.

32 ~~((5))~~ (4) "Assets" means economic resources of the contractor,
33 recognized and measured in conformity with generally accepted
34 accounting principles.

35 ~~((6))~~ (5) "Audit or department audit" means an examination of
36 the records of a nursing facility participating in the medicaid payment
37 system, including but not limited to: The contractor's financial and
38 statistical records, cost reports and all supporting documentation and

1 schedules, receivables, and resident trust funds, to be performed as
2 deemed necessary by the department and according to department rule.

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

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

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

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

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

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

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

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

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

26 (ii) Through the conversion of an ownership interest;

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

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

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

1 (d) Any person who in the ordinary course of business is a pledgee
2 of ownership interest under a written pledge agreement shall not be
3 deemed to be the beneficial owner of such pledged ownership interest
4 until the pledgee has taken all formal steps necessary which are
5 required to declare a default and determines that the power to vote or
6 to direct the vote or to dispose or to direct the disposition of such
7 pledged ownership interest will be exercised; except that:

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

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

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

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

21 ~~((+9))~~ (8) "Capitalization" means the recording of an expenditure
22 as an asset.

23 ~~((+10))~~ (9) "Case mix" means a measure of the intensity of care
24 and services needed by the residents of a nursing facility or a group
25 of residents in the facility.

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

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

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

37 ~~((+11))~~ (13) "Default case" means no initial assessment has been
38 completed for a resident and transmitted to the department by the

1 cut-off date, or an assessment is otherwise past due for the resident,
2 under state and federal requirements.

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

5 ~~((12))~~ (15) "Depreciation" means the systematic distribution of
6 the cost or other basis of tangible assets, less salvage, over the
7 estimated useful life of the assets.

8 ~~((13))~~ (16) "Direct care" means nursing care and related care
9 provided to nursing facility residents. Therapy care shall not be
10 considered part of direct care.

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

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

17 ~~((15))~~ (19) "Equity" means the net book value of all tangible and
18 intangible assets less the recorded value of all liabilities, as
19 recognized and measured in conformity with generally accepted
20 accounting principles.

21 ~~((16))~~ (20) "Facility" or "nursing facility" means a nursing home
22 licensed in accordance with chapter 18.51 RCW, excepting nursing homes
23 certified as institutions for mental diseases, or that portion of a
24 multiservice facility licensed as a nursing home, or that portion of a
25 hospital licensed in accordance with chapter 70.41 RCW which operates
26 as a nursing home.

27 ~~((17))~~ (21) "Fair market value" means the replacement cost of an
28 asset less observed physical depreciation on the date for which the
29 market value is being determined.

30 ~~((18))~~ (22) "Financial statements" means statements prepared and
31 presented in conformity with generally accepted accounting principles
32 including, but not limited to, balance sheet, statement of operations,
33 statement of changes in financial position, and related notes.

34 ~~((19))~~ (23) "Generally accepted accounting principles" means
35 accounting principles approved by the financial accounting standards
36 board (FASB).

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

1 ~~(21))~~ (24) "Goodwill" means the excess of the price paid for a
2 nursing facility business over the fair market value of all ~~((other))~~
3 net identifiable~~((7))~~ tangible~~((7))~~ and intangible assets acquired, as
4 measured in accordance with generally accepted accounting principles.

5 ~~((22))~~ (25) "Grouper" means a computer software product that
6 groups individual nursing facility residents into case mix
7 classification groups based on specific resident assessment data and
8 computer logic.

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

12 ~~((23))~~ (27) "Imprest fund" means a fund which is regularly
13 replenished in exactly the amount expended from it.

14 ~~((24))~~ (28) "Joint facility costs" means any costs which
15 represent resources which benefit more than one facility, or one
16 facility and any other entity.

17 ~~((25))~~ (29) "Lease agreement" means a contract between two
18 parties for the possession and use of real or personal property or
19 assets for a specified period of time in exchange for specified
20 periodic payments. Elimination (due to any cause other than death or
21 divorce) or addition of any party to the contract, expiration, or
22 modification of any lease term in effect on January 1, 1980, or
23 termination of the lease by either party by any means shall constitute
24 a termination of the lease agreement. An extension or renewal of a
25 lease agreement, whether or not pursuant to a renewal provision in the
26 lease agreement, shall be considered a new lease agreement. A strictly
27 formal change in the lease agreement which modifies the method,
28 frequency, or manner in which the lease payments are made, but does not
29 increase the total lease payment obligation of the lessee, shall not be
30 considered modification of a lease term.

31 ~~((26))~~ (30) "Medical care program" or "medicaid program" means
32 medical assistance, including nursing care, provided under RCW
33 74.09.500 or authorized state medical care services.

34 ~~((27))~~ (31) "Medical care recipient," "medicaid recipient," or
35 "recipient" means an individual determined eligible by the department
36 for the services provided ~~((in))~~ under chapter 74.09 RCW.

37 ~~((28))~~ (32) "Minimum data set" means the overall data component
38 of the resident assessment instrument, indicating the strengths, needs,
39 and preferences of an individual nursing facility resident.

1 ~~(33)~~ (33) "Net book value" means the historical cost of an asset less
2 accumulated depreciation.

3 ~~((+29))~~ (34) "Net invested funds" means the net book value of
4 tangible fixed assets employed by a contractor to provide services
5 under the medical care program, including land, buildings, and
6 equipment as recognized and measured in conformity with generally
7 accepted accounting principles, plus an allowance for working capital
8 which shall be five percent of the product of the per patient day rate
9 multiplied by the prior calendar year reported total patient days of
10 each contractor.

11 ~~((+30))~~ (35) "Operating lease" means a lease under which rental or
12 lease expenses are included in current expenses in accordance with
13 generally accepted accounting principles.

14 ~~((+31))~~ (36) "Owner" means a sole proprietor, general or limited
15 partners, members of a limited liability company, and beneficial
16 interest holders of five percent or more of a corporation's outstanding
17 stock.

18 ~~((+32))~~ (37) "Ownership interest" means all interests beneficially
19 owned by a person, calculated in the aggregate, regardless of the form
20 which such beneficial ownership takes.

21 ~~((+33))~~ (38) "Patient day" or "resident day" means a calendar day
22 of care provided to a nursing facility resident, regardless of payment
23 source, which will include the day of admission and exclude the day of
24 discharge; except that, when admission and discharge occur on the same
25 day, one day of care shall be deemed to exist. A "~~(client day)~~
26 medicaid day" or "recipient day" means a calendar day of care provided
27 to a ~~((medical care))~~ medicaid recipient determined eligible by the
28 department for services provided under chapter 74.09 RCW, subject to
29 the same conditions regarding admission and discharge applicable to a
30 patient day or resident day of care.

31 ~~((+34))~~ (39) "Professionally designated real estate appraiser"
32 means an individual who is regularly engaged in the business of
33 providing real estate valuation services for a fee, and who is deemed
34 qualified by a nationally recognized real estate appraisal educational
35 organization on the basis of extensive practical appraisal experience,
36 including the writing of real estate valuation reports as well as the
37 passing of written examinations on valuation practice and theory, and
38 who by virtue of membership in such organization is required to

1 subscribe and adhere to certain standards of professional practice as
2 such organization prescribes.

3 ~~((35))~~ (40) "Qualified therapist" means:

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

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

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

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

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

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

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

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

22 ~~((i))~~ (f) A respiratory care practitioner certified under chapter
23 18.89 RCW.

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

29 ~~(37))~~ (41) "Rate" or "rate allocation" means the medicaid per-
30 patient-day payment amount for medicaid patients calculated in
31 accordance with the allocation methodology set forth in part E of this
32 chapter.

33 (42) "Real property," whether leased or owned by the contractor,
34 means the building, allowable land, land improvements, and building
35 improvements associated with a nursing facility.

36 (43) "Rebased rate" or "cost-rebased rate" means a facility-
37 specific component rate assigned to a nursing facility for a particular
38 rate period established on desk-reviewed, adjusted costs reported for
39 that facility covering at least six months of a prior calendar year

1 designated as a year to be used for cost rebasing payment rate
2 allocations under the provisions of this chapter.

3 ~~((+38+))~~ (44) "Records" means those data supporting all financial
4 statements and cost reports including, but not limited to, all general
5 and subsidiary ledgers, books of original entry, and transaction
6 documentation, however such data are maintained.

7 ~~((+39+))~~ (45) "Related organization" means an entity which is under
8 common ownership and/or control with, or has control of, or is
9 controlled by, the contractor.

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

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

17 ~~((+40+))~~ (46) "Related care" means only those services that are
18 directly related to providing direct care to nursing facility
19 residents. These services include, but are not limited to, nursing
20 direction and supervision, medical direction, medical records, pharmacy
21 services, activities, and social services.

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

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

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

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

36 ~~((+41+))~~ (51) "Secretary" means the secretary of the department of
37 social and health services.

1 (~~(42)~~) (52) "Support services" means food, food preparation,
2 dietary, housekeeping, and laundry services provided to nursing
3 facility residents.

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

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

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

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

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

19 (2) Not later than one hundred twenty days following the
20 termination or assignment of a contract, the terminating or assigning
21 contractor shall submit to the department a cost report for the period
22 from January 1st through the date the contract was terminated or
23 assigned.

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

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

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

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

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

9 (1) Cost reports shall be prepared in a standard manner and form,
10 as determined by the department(~~(, which shall provide for an itemized~~
11 ~~list of allowable costs and a preliminary settlement report))~~). Costs
12 reported shall be determined in accordance with generally accepted
13 accounting principles, the provisions of this chapter, and such
14 additional rules (~~(and regulations as are)~~) established by the
15 (~~(secretary)~~) department. In the event of conflict, rules adopted and
16 instructions issued by the department take precedence over generally
17 accepted accounting principles.

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

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

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

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

6 (~~((2))~~) (3) When a contract is terminated or assigned, all payments
7 due the terminating or assigning contractor will be withheld until
8 accessibility and preservation of the records within the state of
9 Washington are assured.

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

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

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

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

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

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

34 (~~((3) To ascertain, through department audit that compliance with~~
35 ~~the accounting and auditing provisions of this chapter and the rules~~
36 ~~and regulations of the department as they pertain to these accounting~~
37 ~~and auditing provisions is proper and consistent))~~ (c) The contractor's

1 revenues, expenditures, and costs of the building, land, land
2 improvements, building improvements, and movable and fixed equipment
3 are recorded in compliance with department requirements, instructions,
4 and generally accepted accounting principles; and

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

8 (2) The department shall examine the submitted cost report, or a
9 portion thereof, of each contractor for each nursing facility for each
10 report period to determine if the information is correct, complete,
11 reported in conformance with department instructions and generally
12 accepted accounting principles, the requirements of this chapter, and
13 rules as the department may adopt. The department shall determine the
14 scope of the examination.

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

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

28 (5) The contractor shall:

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

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

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

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

12 (7) Any assets, liabilities, revenues, or expenses reported as
13 allowable that are not supported by adequate documentation in the
14 contractor's records shall be disallowed. Documentation must show both
15 that costs reported were incurred during the period covered by the
16 report and were related to resident care, and that assets reported were
17 used in the provision of resident care.

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

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

26 (10) Part B of this chapter, and rules adopted by the department
27 pursuant thereto prior to January 1, 1998, shall continue to govern the
28 medicaid nursing facility audit process for periods prior to January 1,
29 1997, as if these statutes and rules remained in full force and effect.

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

34 (2) The contractor shall make any payment owed the department,
35 determined by the process of reconciliation, by the process of
36 settlement at the lower of cost or rate in direct care, therapy care,
37 and support services component rate allocations, as authorized in this

1 chapter, within sixty days after notification and demand for payment is
2 sent to the contractor.

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

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

12 (5) The department is authorized to withhold funds from the
13 contractor's payment for services, and to take all other actions
14 authorized by law, to recover amounts due and payable from the
15 contractor, including any accrued interest. Neither a timely filed
16 request to pursue any administrative appeals or exception procedure
17 that the department may establish in rule, nor commencement of judicial
18 review as may be available to the contractor in law, to contest a
19 payment obligation determination shall delay recovery from the
20 contractor or payment to the contractor.

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

28 (2) Contractors shall not be required to refund payments made in
29 the operations, property, and return on investment component rates in
30 excess of the adjusted costs of providing services corresponding to
31 these components.

32 (3) The facility will return to the department any overpayment
33 amounts in each of the direct care, therapy care, and support services
34 rate components that the department identifies following the audit and
35 settlement procedures as described in this chapter, provided that the
36 contractor may retain any overpayment that does not exceed 1.0% of the
37 facility's direct care, therapy care, and support services component
38 rate. However, no overpayments may be retained in a cost center to

1 which savings have been shifted to cover a deficit, as provided in
2 subsection (4) of this section. Facilities that are not in substantial
3 compliance for more than ninety days, and facilities that provide
4 substandard quality of care at any time, during the period for which
5 settlement is being calculated, will not be allowed to retain any
6 amount of overpayment in the facility's direct care, therapy care, and
7 support services component rate. The terms "not in substantial
8 compliance" and "substandard quality of care" shall be defined by
9 federal survey regulations.

10 (4) Determination of unused rate funds, including the amounts of
11 direct care, therapy care, and support services to be recovered, shall
12 be done separately for each component rate, and neither costs nor rate
13 payments shall be shifted from one component rate or corresponding
14 service area to another in determining the degree of underspending or
15 recovery, if any. However, in computing a preliminary or final
16 settlement, savings in the support services cost center may be shifted
17 to cover a deficit in the direct care or therapy cost centers up to the
18 amount of any savings. Not more than twenty percent of the rate in a
19 cost center may be shifted.

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

27 (6) RCW 74.46.150 through 74.46.180, and rules adopted by the
28 department prior to the effective date of this section, shall continue
29 to govern the medicaid settlement process for periods prior to October
30 1, 1998, as if these statutes and rules remained in full force and
31 effect.

32 (7) For calendar year 1998, the department shall calculate split
33 settlements covering January 1, 1998, through September 30, 1998, and
34 October 1, 1998, through December 31, 1998. For the period beginning
35 October 1, 1998, rules specified in this chapter shall apply. The
36 department shall, by rule, determine the division of calendar year 1998
37 adjusted costs for settlement purposes.

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

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

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

13 (3) ~~((Costs applicable to services, facilities, and supplies~~
14 ~~furnished to the provider by related organizations are allowable but at~~
15 ~~the cost to the related organization, provided they do not exceed the~~
16 ~~price of comparable services, facilities, or supplies that could be~~
17 ~~purchased elsewhere.~~

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

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

25 (5) Any costs deemed allowable under this chapter are subject to
26 the provisions of section 18 of this act. The allowability of a cost
27 shall not be construed as creating a legal right or entitlement to
28 reimbursement of the cost.

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

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

36 (2) Documentation of costs to the related organization shall be
37 made available to the ~~((auditor at the time and place the records~~
38 ~~relating to the entity are audited))~~ department. Payments to or for

1 the benefit of the related organization will be disallowed where the
2 cost to the related organization cannot be documented.

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

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

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

17 (3) Organizational costs are those necessary, ordinary, and
18 directly incident to the creation of a corporation or other form of
19 business of the contractor including, but not limited to, legal fees
20 incurred in establishing the corporation or other organization and fees
21 paid to states for incorporation; except, that they do not include
22 costs relating to the issuance and sale of shares of capital stock or
23 other securities. Such organizational costs will be allowable in the
24 ((administrative)) operations cost center if they are amortized over a
25 period of not less than sixty months beginning with the month in which
26 the first patient is admitted for care.

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

29 (1) The contractor shall disclose to the department:

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

32 (b) The methodology of the allocation utilized.

33 (2) Such disclosure shall demonstrate that:

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

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

1 (3) Such disclosure shall be made not later than September (~~30,~~
2 ~~1980,~~) 30th for the following calendar year (~~(and not later than~~
3 ~~September 30th for each year thereafter)~~); except that a new contractor
4 shall submit the first year's disclosure (~~(together with the~~
5 ~~submissions required by RCW 74.46.670. Where a contractor will make~~
6 ~~neither a change in the joint costs to be incurred nor in the~~
7 ~~allocation methodology, the contractor may certify that no change will~~
8 ~~be made in lieu of the disclosure required in subsection (1) of this~~
9 ~~section)~~) at least sixty days prior to the date the new contract
10 becomes effective.

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

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

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

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

26 (1) Management fees will be allowed only if:

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

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

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

34 (3) A management fee paid to or for the benefit of a related
35 organization will be allowable to the extent it does not exceed the
36 lower of the actual cost to the related organization of providing
37 necessary services related to patient care under the agreement or the
38 cost of comparable services purchased elsewhere. Where costs to the

1 related organization represent joint facility costs, the measurement of
2 such costs shall comply with RCW 74.46.270.

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

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

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

17 Rental or lease costs under arm's-length operating leases of office
18 equipment shall be allowable to the extent the cost is necessary and
19 ordinary. The department may adopt rules to limit the allowability of
20 office equipment leasing expenses.

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

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

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

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

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

36 (c) Costs associated with a capital expenditure subject to section
37 1122 approval (part 100, Title 42 C.F.R.) if the department found it

1 was not consistent with applicable standards, criteria, or plans. If
2 the department was not given timely notice of a proposed capital
3 expenditure, all associated costs will be unallowable up to the date
4 they are determined to be reimbursable under applicable federal
5 regulations;

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

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

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

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

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

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

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

34 (k) Charity and courtesy allowances;

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

39 (m) Vending machine expenses;

- 1 (n) Expenses for barber or beautician services not included in
2 routine care;
- 3 (o) Funeral and burial expenses;
- 4 (p) Costs of gift shop operations and inventory;
- 5 (q) Personal items such as cosmetics, smoking materials, newspapers
6 and magazines, and clothing, except those used in patient activity
7 programs;
- 8 (r) Fund-raising expenses, except those directly related to the
9 patient activity program;
- 10 (s) Penalties and fines;
- 11 (t) Expenses related to telephones, televisions, radios, and
12 similar appliances in patients' private accommodations;
- 13 (u) Federal, state, and other income taxes;
- 14 (v) Costs of special care services except where authorized by the
15 department;
- 16 (w) Expenses of an employee benefit not in fact made available to
17 all employees on an equal or fair basis, for example, key-man insurance
18 and other insurance or retirement plans ((not made available to all
19 employees));
- 20 (x) Expenses of profit-sharing plans;
- 21 (y) Expenses related to the purchase and/or use of private or
22 commercial airplanes which are in excess of what a prudent contractor
23 would expend for the ordinary and economic provision of such a
24 transportation need related to patient care;
- 25 (z) Personal expenses and allowances of owners or relatives;
- 26 (aa) All expenses of maintaining professional licenses or
27 membership in professional organizations;
- 28 (bb) Costs related to agreements not to compete;
- 29 (cc) Amortization of goodwill, lease acquisition, or any other
30 intangible asset, whether related to resident care or not, and whether
31 recognized under generally accepted accounting principles or not;
- 32 (dd) Expenses related to vehicles which are in excess of what a
33 prudent contractor would expend for the ordinary and economic provision
34 of transportation needs related to patient care;
- 35 (ee) Legal and consultant fees in connection with a fair hearing
36 against the department where a decision is rendered in favor of the
37 department or where otherwise the determination of the department
38 stands;

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

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

6 (hh) All rental or lease costs other than those provided in RCW
7 74.46.300 on and after January 1, 1985;

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

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

19 (kk) For all partial or whole rate periods after July 17, 1984,
20 costs of land and depreciable assets that cannot be reimbursed under
21 the Deficit Reduction Act of 1984 and implementing state statutory and
22 regulatory provisions;

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

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

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

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

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

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

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

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

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

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

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

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

19 (xx) Tax expenses that a nursing facility has never incurred.

20 NEW SECTION. Sec. 18. A new section, to be codified as RCW
21 74.46.421, is added to chapter 74.46 RCW to read as follows:

22 (1) The purpose of part E of this chapter is to determine nursing
23 facility medicaid payment rates that, in the aggregate for all
24 participating nursing facilities, are in accordance with the biennial
25 appropriations act.

26 (2)(a) The department shall use the nursing facility medicaid
27 payment rate methodologies described in this chapter to determine
28 initial component rate allocations for each medicaid nursing facility.

29 (b) The initial component rate allocations shall be subject to
30 adjustment as provided in this section in order to assure that the
31 state-wide average payment rate to nursing facilities is less than or
32 equal to the state-wide average payment rate specified in the biennial
33 appropriations act.

34 (3) Nothing in this chapter shall be construed as creating a legal
35 right or entitlement to any payment that (a) has not been adjusted
36 under this section or (b) would cause the state-wide average payment
37 rate to exceed the state-wide average payment rate specified in the
38 biennial appropriations act.

1 (4)(a) The state-wide average payment rate for any state fiscal
2 year under the nursing facility medicaid payment system, weighted by
3 patient days, shall not exceed the annual state-wide weighted average
4 nursing facility payment rate identified for that fiscal year in the
5 biennial appropriations act.

6 (b) If the department determines that the weighted average nursing
7 facility payment rate calculated in accordance with this chapter is
8 likely to exceed the weighted average nursing facility payment rate
9 identified in the biennial appropriations act, then the department
10 shall adjust all nursing facility payment rates proportional to the
11 amount by which the weighted average rate allocations would otherwise
12 exceed the budgeted rate amount. Any such adjustments shall only be
13 made prospectively, not retrospectively, and shall be applied
14 proportionately to each component rate allocation for each facility.

15 NEW SECTION. **Sec. 19.** (1) Effective October 1, 1998, nursing
16 facility medicaid payment rate allocations shall be facility-specific
17 and shall have six components: Direct care, therapy care, support
18 services, operations, property, and return on investment. The
19 department shall establish and adjust each of these components, as
20 provided in this section and elsewhere in this chapter, for each
21 medicaid nursing facility in this state.

22 (2) All component rate allocations shall be based upon a minimum
23 facility occupancy of eighty-five percent of licensed beds, regardless
24 of how many beds are set up or in use.

25 (3) Information and data sources used in determining medicaid
26 payment rate allocations, including formulas, procedures, cost report
27 periods, resident assessment instrument formats, resident assessment
28 methodologies, and resident classification and case mix weighting
29 methodologies, may be substituted or altered from time to time as
30 determined by the department.

31 (4)(a) Direct care component rate allocations shall be established
32 using adjusted cost report data covering at least six months. Adjusted
33 cost report data from 1996 will be used for October 1, 1998, through
34 June 30, 2001, direct care component rate allocations; adjusted cost
35 report data from 1999 will be used for July 1, 2001, through June 30,
36 2004, direct care component rate allocations.

37 (b) Direct care component rate allocations based on 1996 cost
38 report data shall be adjusted annually for economic trends and

1 conditions by a factor or factors defined in the biennial
2 appropriations act. A different economic trends and conditions
3 adjustment factor or factors may be defined in the biennial
4 appropriations act for facilities whose direct care component rate is
5 set equal to their adjusted June 30, 1998, rate, as provided in section
6 25(5)(k) of this act.

7 (c) Direct care component rate allocations based on 1999 cost
8 report data shall be adjusted annually for economic trends and
9 conditions by a factor or factors defined in the biennial
10 appropriations act. A different economic trends and conditions
11 adjustment factor or factors may be defined in the biennial
12 appropriations act for facilities whose direct care component rate is
13 set equal to their adjusted June 30, 1998, rate, as provided in section
14 25(5)(k) of this act.

15 (5)(a) Therapy care component rate allocations shall be established
16 using adjusted cost report data covering at least six months. Adjusted
17 cost report data from 1996 will be used for October 1, 1998, through
18 June 30, 2001, therapy care component rate allocations; adjusted cost
19 report data from 1999 will be used for July 1, 2001, through June 30,
20 2004, therapy care component rate allocations.

21 (b) Therapy care component rate allocations shall be adjusted
22 annually for economic trends and conditions by a factor or factors
23 defined in the biennial appropriations act.

24 (6)(a) Support services component rate allocations shall be
25 established using adjusted cost report data covering at least six
26 months. Adjusted cost report data from 1996 shall be used for October
27 1, 1998, through June 30, 2001, support services component rate
28 allocations; adjusted cost report data from 1999 shall be used for July
29 1, 2001, through June 30, 2004, support services component rate
30 allocations.

31 (b) Support services component rate allocations shall be adjusted
32 annually for economic trends and conditions by a factor or factors
33 defined in the biennial appropriations act.

34 (7)(a) Operations component rate allocations shall be established
35 using adjusted cost report data covering at least six months. Adjusted
36 cost report data from 1996 shall be used for October 1, 1998, through
37 June 30, 2001, operations component rate allocations; adjusted cost
38 report data from 1999 shall be used for July 1, 2001, through June 30,
39 2004, operations component rate allocations.

1 (b) Operations component rate allocations shall be adjusted
2 annually for economic trends and conditions by a factor or factors
3 defined in the biennial appropriations act.

4 (8) For July 1, 1998, through September 30, 1998, a facility's
5 property and return on investment component rates shall be the
6 facility's June 30, 1998, property and return on investment component
7 rates, without increase. For October 1, 1998, through June 30, 1999,
8 a facility's property and return on investment component rates shall be
9 rebased utilizing 1997 adjusted cost report data covering at least six
10 months of data.

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

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

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

29 (12) The department shall establish in rule procedures, principles,
30 and conditions, including necessary threshold costs, for adjusting
31 rates to reflect capital improvements or new requirements imposed by
32 the department or the federal government. Any such rate adjustments
33 are subject to the provisions of section 18 of this act.

34 NEW SECTION. **Sec. 20.** The department shall disclose to any member
35 of the public all rate-setting information consistent with requirements
36 of state and federal laws.

1 **Sec. 21.** RCW 74.46.475 and 1985 c 361 s 13 are each amended to
2 read as follows:

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

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

- 19 (a) Exception profiling; and
- 20 (b) Establishing rates.

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

23 NEW SECTION. **Sec. 22.** (1) The department shall employ the
24 resource utilization group III case mix classification methodology.
25 The department shall use the forty-four group index maximizing model
26 for the resource utilization group III grouper version 5.10, but the
27 department may revise or update the classification methodology to
28 reflect advances or refinements in resident assessment or
29 classification, subject to federal requirements.

30 (2) A default case mix group shall be established for cases in
31 which the resident dies or is discharged for any purpose prior to
32 completion of the resident's initial assessment. The default case mix
33 group and case mix weight for these cases shall be designated by the
34 department.

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

NEW SECTION.

Sec. 23.

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

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

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

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

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

(c) Assign a case mix weight of 1.000 to the resource utilization group III classification group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. The case mix weights shall be revised, but only when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st

1 effective date of each cost-rebased direct care component rate.
2 However, the department may revise case mix weights more frequently if,
3 and only if, significant variances in wage ratios occur among direct
4 care staff in the different caregiver classifications identified in
5 this section.

6 (5) Case mix weights shall be revised when direct care component
7 rates are cost-rebased every three years as provided in section
8 19(4)(a) of this act.

9 NEW SECTION. **Sec. 24.** (1) From individual case mix weights for
10 the applicable quarter, the department shall determine two average case
11 mix indexes for each medicaid nursing facility, one for all residents
12 in the facility, known as the facility average case mix index, and one
13 for medicaid residents, known as the medicaid average case mix index.

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

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

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

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

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

37 (ii) If a resident's significant change, quarterly, or annual
38 assessment is timely completed and transmitted to the department by the

1 cutoff date under state and federal requirements and as described in
2 subsection (5) of this section, the start date shall be the date the
3 assessment is completed;

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

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

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

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

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

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

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

31 (6) A threshold of ninety percent, as described and calculated in
32 this subsection, shall be used to determine the case mix index each
33 quarter. The threshold shall also be used to determine which
34 facilities' costs per case mix unit are included in determining the
35 ceiling, floor, and price. If the facility does not meet the ninety
36 percent threshold, the department may use an alternate case mix index
37 to determine the facility average and medicaid average case mix indexes
38 for the quarter. The threshold is a count of unique minimum data set
39 assessments, and it shall include resident assessment instrument

1 tracking forms for residents discharged prior to completing an initial
2 assessment. The threshold is calculated by dividing the count of
3 unique minimum data set assessments by the average census for each
4 facility. A daily census shall be reported by each nursing facility as
5 it transmits assessment data to the department. The department shall
6 compute a quarterly average census based on the daily census. If no
7 census has been reported by a facility during a specified quarter, then
8 the department shall use the facility's licensed beds as the
9 denominator in computing the threshold.

10 (7)(a) Although the facility average and the medicaid average case
11 mix indexes shall both be calculated quarterly, the facility average
12 case mix index will be used only every three years in combination with
13 cost report data as specified by sections 19 and 25 of this act, to
14 establish a facility's allowable cost per case mix unit. A facility's
15 medicaid average case mix index shall be used to update a nursing
16 facility's direct care component rate quarterly.

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

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

24 (ii) For July 1, 2001, direct care component rates, the department
25 shall use an average of facility average case mix indexes from the four
26 calendar quarters of 1999.

27 (c) The medicaid average case mix index used to update or
28 recalibrate a nursing facility's direct care component rate quarterly
29 shall be from the calendar quarter commencing six months prior to the
30 effective date of the quarterly rate. For example, October 1, 1998,
31 through December 31, 1998, direct care component rates shall utilize
32 case mix averages from the April 1, 1998, through June 30, 1998,
33 calendar quarter, and so forth.

34 NEW SECTION. **Sec. 25.** (1) The direct care component rate
35 allocation corresponds to the provision of nursing care for one
36 resident of a nursing facility for one day, including direct care
37 supplies. Therapy services and supplies, which correspond to the
38 therapy care component rate, shall be excluded. The direct care

1 component rate includes elements of case mix determined consistent with
2 the principles of this section and other applicable provisions of this
3 chapter.

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

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

21 (4) Cost report data used in setting direct care component rate
22 allocations shall be 1996 and 1999, for rate periods as specified in
23 section 19(4)(a) of this act.

24 (5) Beginning October 1, 1998, the department shall rebase each
25 nursing facility's direct care component rate allocation as described
26 in section 19 of this act, adjust its direct care component rate
27 allocation for economic trends and conditions as described in section
28 19 of this act, and update its medicaid average case mix index,
29 consistent with the following:

30 (a) Reduce total direct care costs reported by each nursing
31 facility for the applicable cost report period specified in section
32 19(4)(a) of this act to reflect any department adjustments, and to
33 eliminate reported resident therapy costs and adjustments, in order to
34 derive the facility's total allowable direct care cost;

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

1 licensed beds, to derive the facility's allowable direct care cost per
2 resident day;

3 (c) Adjust the facility's per resident day direct care cost by the
4 applicable factor specified in section 19(4) (b) and (c) of this act to
5 derive its adjusted allowable direct care cost per resident day;

6 (d) Divide each facility's adjusted allowable direct care cost per
7 resident day by the facility average case mix index for the applicable
8 quarters specified by section 24(7)(b) of this act to derive the
9 facility's allowable direct care cost per case mix unit;

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

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

19 (g) Except as provided in (k) of this subsection, from October 1,
20 1998, through June 30, 2000, determine each facility's quarterly direct
21 care component rate as follows:

22 (i) Any facility whose allowable cost per case mix unit is less
23 than eighty-five percent of the facility's peer group median
24 established under (f) of this subsection shall be assigned a cost per
25 case mix unit equal to eighty-five percent of the facility's peer group
26 median, and shall have a direct care component rate allocation equal to
27 the facility's assigned cost per case mix unit multiplied by that
28 facility's medicaid average case mix index from the applicable quarter
29 specified in section 24(7)(c) of this act;

30 (ii) Any facility whose allowable cost per case mix unit is greater
31 than one hundred fifteen percent of the peer group median established
32 under (f) of this subsection shall be assigned a cost per case mix unit
33 equal to one hundred fifteen percent of the peer group median, and
34 shall have a direct care component rate allocation equal to the
35 facility's assigned cost per case mix unit multiplied by that
36 facility's medicaid average case mix index from the applicable quarter
37 specified in section 24(7)(c) of this act;

38 (iii) Any facility whose allowable cost per case mix unit is
39 between eighty-five and one hundred fifteen percent of the peer group

1 median established under (f) of this subsection shall have a direct
2 care component rate allocation equal to the facility's allowable cost
3 per case mix unit multiplied by that facility's medicaid average case
4 mix index from the applicable quarter specified in section 24(7)(c) of
5 this act;

6 (h) Except as provided in (k) of this subsection, from July 1,
7 2000, through June 30, 2002, determine each facility's quarterly direct
8 care component rate as follows:

9 (i) Any facility whose allowable cost per case mix unit is less
10 than ninety percent of the facility's peer group median established
11 under (f) of this subsection shall be assigned a cost per case mix unit
12 equal to ninety percent of the facility's peer group median, and shall
13 have a direct care component rate allocation equal to the facility's
14 assigned cost per case mix unit multiplied by that facility's medicaid
15 average case mix index from the applicable quarter specified in section
16 24(7)(c) of this act;

17 (ii) Any facility whose allowable cost per case mix unit is greater
18 than one hundred ten percent of the peer group median established under
19 (f) of this subsection shall be assigned a cost per case mix unit equal
20 to one hundred ten percent of the peer group median, and shall have a
21 direct care component rate allocation equal to the facility's assigned
22 cost per case mix unit multiplied by that facility's medicaid average
23 case mix index from the applicable quarter specified in section
24 24(7)(c) of this act;

25 (iii) Any facility whose allowable cost per case mix unit is
26 between ninety and one hundred ten percent of the peer group median
27 established under (f) of this subsection shall have a direct care
28 component rate allocation equal to the facility's allowable cost per
29 case mix unit multiplied by that facility's medicaid average case mix
30 index from the applicable quarter specified in section 24(7)(c) of this
31 act;

32 (i) From July 1, 2002, through June 30, 2004, determine each
33 facility's quarterly direct care component rate as follows:

34 (i) Any facility whose allowable cost per case mix unit is less
35 than ninety-five percent of the facility's peer group median
36 established under (f) of this subsection shall be assigned a cost per
37 case mix unit equal to ninety-five percent of the facility's peer group
38 median, and shall have a direct care component rate allocation equal to
39 the facility's assigned cost per case mix unit multiplied by that

1 facility's medicaid average case mix index from the applicable quarter
2 specified in section 24(7)(c) of this act;

3 (ii) Any facility whose allowable cost per case mix unit is greater
4 than one hundred five percent of the peer group median established
5 under (f) of this subsection shall be assigned a cost per case mix unit
6 equal to one hundred five percent of the peer group median, and shall
7 have a direct care component rate allocation equal to the facility's
8 assigned cost per case mix unit multiplied by that facility's medicaid
9 average case mix index from the applicable quarter specified in section
10 24(7)(c) of this act;

11 (iii) Any facility whose allowable cost per case mix unit is
12 between ninety-five and one hundred five percent of the peer group
13 median established under (f) of this subsection shall have a direct
14 care component rate allocation equal to the facility's allowable cost
15 per case mix unit multiplied by that facility's medicaid average case
16 mix index from the applicable quarter specified in section 24(7)(c) of
17 this act;

18 (j) Beginning July 1, 2004, determine each facility's quarterly
19 direct care component rate by multiplying the facility's peer group
20 median allowable direct care cost per case mix unit by that facility's
21 medicaid average case mix index from the applicable quarter as
22 specified in section 24(7)(c) of this act.

23 (k)(i) Between October 1, 1998, and June 30, 2000, the department
24 shall compare each facility's direct care component rate allocation
25 calculated under (g) of this subsection with the facility's nursing
26 services component rate in effect on June 30, 1998, less therapy costs,
27 plus any exceptional care offsets as reported on the cost report,
28 adjusted for economic trends and conditions as provided in section 19
29 of this act. A facility shall receive the higher of the two rates;

30 (ii) Between July 1, 2000, and June 30, 2002, the department shall
31 compare each facility's direct care component rate allocation
32 calculated under (h) of this subsection with the facility's direct care
33 component rate in effect on June 30, 2000. A facility shall receive
34 the higher of the two rates.

35 (6) The direct care component rate allocations calculated in
36 accordance with this section shall be adjusted to the extent necessary
37 to comply with section 18 of this act. If the department determines
38 that the weighted average rate allocations for all rate components for
39 all facilities is likely to exceed the weighted average total rate

1 specified in the state biennial appropriations act, the department
2 shall adjust the rate allocations calculated in this section
3 proportional to the amount by which the total weighted average rate
4 allocations would otherwise exceed the budgeted level. Such
5 adjustments shall only be made prospectively, not retrospectively.

6 NEW SECTION. **Sec. 26.** (1) The therapy care component rate
7 allocation corresponds to the provision of medicaid one-on-one therapy
8 provided by a qualified therapist as defined in this chapter, including
9 therapy supplies and therapy consultation, for one day for one medicaid
10 resident of a nursing facility. The therapy care component rate
11 allocation for October 1, 1998, through June 30, 2001, shall be based
12 on adjusted therapy costs and days from calendar year 1996. The
13 therapy component rate allocation for July 1, 2001, through June 30,
14 2004, shall be based on adjusted therapy costs and days from calendar
15 year 1999. The therapy care component rate shall be adjusted for
16 economic trends and conditions as specified in section 19(5)(b) of this
17 act, and shall be determined in accordance with this section.

18 (2) In rebasing, as provided in section 19(5)(a) of this act, the
19 department shall take from the cost reports of facilities the following
20 reported information:

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

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

27 (c) Therapy consulting expenses for all residents.

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

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

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

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

37 Metropolitan statistical areas and nonmetropolitan statistical
38 areas shall be as determined by the United States office of management

1 and budget or other applicable federal office. The department shall
2 array the facilities in each peer group from highest to lowest based on
3 their total cost per unit of therapy for each therapy type. The
4 department shall determine the median total cost per unit of therapy
5 for each therapy type and add ten percent of median total cost per unit
6 of therapy. The cost per unit of therapy for each therapy type at a
7 nursing facility shall be the lesser of its cost per unit of therapy
8 for each therapy type or the median total cost per unit plus ten
9 percent for each therapy type for its peer group.

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

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

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

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

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

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

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

1 (6) The therapy care component rate allocations calculated in
2 accordance with this section shall be adjusted to the extent necessary
3 to comply with section 18 of this act. If the department determines
4 that the weighted average rate allocations for all rate components for
5 all facilities is likely to exceed the weighted average total rate
6 specified in the state biennial appropriations act, the department
7 shall adjust the rate allocations calculated in this section
8 proportional to the amount by which the total weighted average rate
9 allocations would otherwise exceed the budgeted level. Such
10 adjustments shall only be made prospectively, not retrospectively.

11 NEW SECTION. **Sec. 27.** (1) The support services component rate
12 allocation corresponds to the provision of food, food preparation,
13 dietary, housekeeping, and laundry services for one resident for one
14 day.

15 (2) Beginning October 1, 1998, the department shall determine each
16 medicaid nursing facility's support services component rate allocation
17 using cost report data specified by section 19(6) of this act.

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

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

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

32 (c) Adjust each facility's support services component rate for
33 economic trends and conditions as provided in section 19(6) of this
34 act.

35 (4) The support services component rate allocations calculated in
36 accordance with this section shall be adjusted to the extent necessary
37 to comply with section 18 of this act. If the department determines
38 that the weighted average rate allocations for all rate components for

1 all facilities is likely to exceed the weighted average total rate
2 specified in the state biennial appropriations act, the department
3 shall adjust the rate allocations calculated in this section
4 proportional to the amount by which the total weighted average rate
5 allocations would otherwise exceed the budgeted level. Such
6 adjustments shall only be made prospectively, not retrospectively.

7 NEW SECTION. **Sec. 28.** (1) The operations component rate
8 allocation corresponds to the general operation of a nursing facility
9 for one resident for one day, including but not limited to management,
10 administration, utilities, office supplies, accounting and bookkeeping,
11 minor building maintenance, minor equipment repairs and replacements,
12 and other supplies and services, exclusive of direct care, therapy
13 care, support services, property, and return on investment.

14 (2) Beginning October 1, 1998, the department shall determine each
15 medicaid nursing facility's operations component rate allocation using
16 cost report data specified by section 19(7)(a) of this act.

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

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

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

30 (c) Adjust each facility's operations component rate for economic
31 trends and conditions as provided in section 19(7)(b) of this act.

32 (4) The operations component rate allocations calculated in
33 accordance with this section shall be adjusted to the extent necessary
34 to comply with section 18 of this act. If the department determines
35 that the weighted average rate allocations for all rate components for
36 all facilities is likely to exceed the weighted average total rate
37 specified in the state biennial appropriations act, the department
38 shall adjust the rate allocations calculated in this section

1 proportional to the amount by which the total weighted average rate
2 allocations would otherwise exceed the budgeted level. Such
3 adjustments shall only be made prospectively, not retrospectively.

4 NEW SECTION. **Sec. 29.** (1) The property component rate allocation
5 for each facility shall be determined by dividing the sum of the
6 reported allowable prior period actual depreciation, subject to RCW
7 74.46.310 through 74.46.380, adjusted for any capitalized additions or
8 replacements approved by the department, and the retained savings from
9 such cost center, by the greater of a facility's total resident days
10 for the facility in the prior period or resident days as calculated on
11 eighty-five percent facility occupancy. If a capitalized addition or
12 retirement of an asset will result in a different licensed bed capacity
13 during the ensuing period, the prior period total resident days used in
14 computing the property component rate shall be adjusted to anticipated
15 resident day level.

16 (2) A nursing facility's property component rate allocation shall
17 be rebased annually, effective July 1st or October 1st as applicable,
18 in accordance with this section and this chapter.

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

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

31 (5) The property component rate allocations calculated in
32 accordance with this section shall be adjusted to the extent necessary
33 to comply with section 18 of this act. If the department determines
34 that the weighted average rate allocations for all rate components for
35 all facilities is likely to exceed the weighted average total rate
36 specified in the state biennial appropriations act, the department
37 shall adjust the rate allocations calculated in this section
38 proportional to the amount by which the total weighted average rate

1 allocations would otherwise exceed the budgeted level. Such
2 adjustments shall only be made prospectively, not retrospectively.

3 NEW SECTION. **Sec. 30.** (1) The department shall establish for each
4 medicaid nursing facility a return on investment component rate
5 allocation composed of two parts: A financing allowance and a variable
6 return allowance. The financing allowance part of a facility's return
7 on investment component rate shall be rebased annually, effective July
8 1st, in accordance with the provisions of this section and this
9 chapter.

10 (a) The financing allowance shall be determined by multiplying the
11 net invested funds of each facility by .10, and dividing by the greater
12 of a nursing facility's total resident days from the most recent cost
13 report period or resident days calculated on eighty-five percent
14 facility occupancy. If a capitalized addition or retirement of an
15 asset will result in a different licensed bed capacity during the
16 ensuing period, the prior period total resident days used in computing
17 the financing and variable return allowances shall be adjusted to the
18 anticipated resident day level.

19 (b) In computing the portion of net invested funds representing the
20 net book value of tangible fixed assets, the same assets, depreciation
21 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,
22 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,
23 shall be utilized, except that the capitalized cost of land upon which
24 the facility is located and such other contiguous land which is
25 reasonable and necessary for use in the regular course of providing
26 resident care shall also be included. Subject to provisions and
27 limitations contained in this chapter, for land purchased by owners or
28 lessors before July 18, 1984, capitalized cost of land shall be the
29 buyer's capitalized cost. For all partial or whole rate periods after
30 July 17, 1984, if the land is purchased after July 17, 1984,
31 capitalized cost shall be that of the owner of record on July 17, 1984,
32 or buyer's capitalized cost, whichever is lower. In the case of leased
33 facilities where the net invested funds are unknown or the contractor
34 is unable to provide necessary information to determine net invested
35 funds, the secretary shall have the authority to determine an amount
36 for net invested funds based on an appraisal conducted according to RCW
37 74.46.360(1).

38 (c) In determining the variable return allowance:

1 (i) For the October 1, 1998, rate setting, the department, without
2 utilizing peer groups, shall first rank all facilities in numerical
3 order from highest to lowest according to their per resident day
4 adjusted or audited, or both, allowable costs for nursing services,
5 food, administration, and operational costs combined for the 1996
6 calendar year cost report period.

7 (ii) The department shall then compute the variable return
8 allowance by multiplying the appropriate percentage amounts, which
9 shall not be less than one percent and not greater than four percent,
10 by the sum of the facility's nursing services, food, administrative,
11 and operational rate components. The percentage amounts will be based
12 on groupings of facilities according to the rankings prescribed in
13 (c)(i) of this subsection. Those groups of facilities with lower per
14 diem costs shall receive higher percentage amounts than those with
15 higher per diem costs.

16 (d) The sum of the financing allowance and the variable return
17 allowance shall be the return on investment rate for each facility, and
18 shall be added to the prospective rates of each contractor as
19 determined in sections 19 through 29 of this act.

20 (e) In the case of a facility that was leased by the contractor as
21 of January 1, 1980, in an arm's-length agreement, which continues to be
22 leased under the same lease agreement, and for which the annualized
23 lease payment, plus any interest and depreciation expenses associated
24 with contractor-owned assets, for the period covered by the prospective
25 rates, divided by the contractor's total resident days, minus the
26 property component rate allocation determined according to section 29
27 of this act, is more than the return on investment rate determined
28 according to (d) of this subsection, the following shall apply:

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

38 (ii) The sum of the financing allowance computed under (e)(i) of
39 this subsection and the variable allowance shall be compared to the

1 annualized lease payment, plus any interest and depreciation associated
2 with contractor-owned assets, for the period covered by the prospective
3 rates, divided by the contractor's total resident days, minus the
4 property component rate determined according to section 29 of this act.
5 The lesser of the two amounts shall be called the alternate return on
6 investment rate.

7 (iii) The return on investment rate determined according to (d) of
8 this subsection or the alternate return on investment rate, whichever
9 is greater, shall be the return on investment rate for the facility and
10 shall be added to the prospective rates of the contractor as determined
11 in sections 19 through 29 of this act.

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

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

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

34 (4) The return or investment component rate allocations calculated
35 in accordance with this section shall be adjusted to the extent
36 necessary to comply with section 18 of this act. If the department
37 determines that the weighted average rate allocations for all rate
38 components for all facilities is likely to exceed the weighted average
39 total rate specified in the state biennial appropriations act, the

1 department shall adjust the rate allocations calculated in this section
2 proportional to the amount by which the total weighted average rate
3 allocations would otherwise exceed the budgeted level. Such
4 adjustments shall only be made prospectively, not retrospectively.

5 NEW SECTION. **Sec. 31.** (1) The department may adjust component
6 rates for errors or omissions made in establishing component rates and
7 determine amounts either overpaid to the contractor or underpaid by the
8 department.

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

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

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

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

20 (4) The department shall review a contractor's request for a rate
21 adjustment because of an alleged error or omission, even if the time
22 period has expired in which the contractor must appeal the rate when
23 initially issued, pursuant to rules adopted by the department under RCW
24 74.46.780. If the request is received after this time period, the
25 department has the authority to correct the rate if it agrees an error
26 or omission was committed. However, if the request is denied, the
27 contractor shall not be entitled to any appeals or exception review
28 procedure that the department may adopt under RCW 74.46.780.

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

37 (6) Component rate adjustments approved in accordance with this
38 section are subject to the provisions of section 18 of this act.

1 **Sec. 32.** RCW 74.46.610 and 1983 1st ex.s. c 67 s 33 are each
2 amended to read as follows:

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

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

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

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

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

11 (2) A facility shall not bill the department for service provided
12 to a recipient until an award letter of eligibility of such recipient
13 under rules established under chapter 74.09 RCW has been received by
14 the facility. However a facility may bill and shall be reimbursed for
15 all medical care recipients referred to the facility by the department
16 prior to the receipt of the award letter of eligibility or the denial
17 of such eligibility.

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

19 **Sec. 33.** RCW 74.46.620 and 1980 c 177 s 62 are each amended to
20 read as follows:

21 (1) The department will (~~reimburse~~) pay a contractor for service
22 rendered under the facility contract and billed in accordance with RCW
23 74.46.610.

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

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

30 **Sec. 34.** RCW 74.46.630 and 1980 c 177 s 63 are each amended to
31 read as follows:

32 (1) The department will notify a contractor of the amount each
33 medical care recipient is required to pay for care provided under the
34 contract and the effective date of such required contribution. It is
35 the contractor's responsibility to collect that portion of the cost of
36 care from the patient, and to account for any authorized reduction from

1 his or her contribution in accordance with rules (~~and regulations~~)
2 established by the (~~secretary~~) department.

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

14 (3) The contractor shall accept the (~~reimbursement~~) payment rates
15 established by the department as full compensation for all services
16 provided under the contract, certification as specified by Title XIX,
17 and licensure under chapter 18.51 RCW. The contractor shall not seek
18 or accept additional compensation from or on behalf of a recipient for
19 any or all such services.

20 **Sec. 35.** RCW 74.46.640 and 1995 1st sp.s. c 18 s 112 are each
21 amended to read as follows:

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

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

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

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

37 (d) Payment for the final sixty days of service (~~under~~) prior to
38 termination or assignment of a contract will be held in the absence of

1 adequate alternate security acceptable to the department pending
2 (~~final~~) settlement of all periods when the contract is terminated or
3 assigned; and

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

15 (2) No payment will be withheld until written notification of the
16 suspension is provided to the contractor, stating the reason for the
17 withholding, except that neither a timely filed request to pursue
18 (~~the~~) any administrative appeals or exception procedure that the
19 department may establish(~~ed~~) by (~~the department in~~) rule nor
20 commencement of judicial review, as may be available to the contractor
21 in law, shall delay suspension of payment.

22 **Sec. 36.** RCW 74.46.650 and 1980 c 177 s 65 are each amended to
23 read as follows:

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

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

28 (2) A facility license is revoked; or

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

34 **Sec. 37.** RCW 74.46.660 and 1992 c 215 s 1 are each amended to read
35 as follows:

36 In order to participate in the (~~prospective cost related~~
37 ~~reimbursement~~) nursing facility medicaid payment system established by

1 this chapter, the person or legal ((organization)) entity responsible
2 for operation of a facility shall:

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

6 (2) Hold the appropriate current license;

7 (3) Hold current Title XIX certification;

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

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

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

18 **Sec. 38.** RCW 74.46.680 and 1985 c 361 s 2 are each amended to read
19 as follows:

20 (1) On the effective date of a change of ownership the department's
21 contract with the old owner shall be ((terminated)) automatically
22 assigned to the new owner, unless: (a) The new owner does not desire
23 to participate in medicaid as a nursing facility provider; (b) the
24 department elects not to continue the contract with the new owner for
25 good cause; or (c) the new owner elects not to accept assignment and
26 requests certification and a new contract. The old owner shall give
27 the department sixty days' written notice of such ((termination))
28 intent to change ownership and assign. When certificate of need and/or
29 section 1122 approval is required pursuant to chapter 70.38 RCW and
30 Part 100, Title 42 CFR, for the new owner to acquire the facility, and
31 the new owner wishes to continue to provide service to recipients
32 without interruption, certificate of need and/or section 1122 approval
33 shall be obtained before the old owner submits a notice of
34 ((termination)) intent to change ownership and assign.

35 (2) If the new owner desires to participate in the ((cost-related
36 reimbursement)) nursing facility medicaid payment system, it shall meet
37 the conditions specified in RCW 74.46.660 ((and shall submit a
38 projected budget in accordance with RCW 74.46.670 no later than sixty

1 ~~days before the date of the change of ownership~~). The facility
2 contract with the new owner shall be effective as of the date of the
3 change of ownership.

4 **Sec. 39.** RCW 74.46.690 and 1995 1st sp.s. c 18 s 113 are each
5 amended to read as follows:

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

9 (2) Upon a notification of ~~((a contract termination))~~ intent to
10 change ownership, the department shall determine by ~~((preliminary or~~
11 ~~final settlement calculations))~~ settlement or reconciliation the amount
12 of any overpayments made to the assigning or terminating contractor,
13 including overpayments disputed by the assigning or terminating
14 contractor. If ~~((preliminary or final))~~ settlements are unavailable
15 for any period up to the date of ~~((contract termination))~~ assignment or
16 termination, the department shall make a reasonable estimate of any
17 overpayment or underpayments for such periods. The reasonable estimate
18 shall be based upon prior period settlements, available audit findings,
19 the projected impact of prospective rates, and other information
20 available to the department. The department shall also determine and
21 add in the total of all other debts and potential debts owed to the
22 department regardless of source, including, but not limited to,
23 interest owed to the department as authorized by this chapter, civil
24 fines imposed by the department, or third-party liabilities.

25 (3) ~~((The old))~~ For all cost reports filed after December 31, 1997,
26 the assigning or terminating contractor shall provide security, in a
27 form deemed adequate by the department, equal to the total amount of
28 determined and estimated overpayments and all ~~((other))~~ debts and
29 potential debts from any source, whether or not the overpayments are
30 the subject of good faith dispute including but not limited to,
31 interest owed to the department, civil fines imposed by the department,
32 and third-party liabilities. Security shall consist of one or more of
33 the following:

34 (a) Withheld payments due the assigning or terminating contractor
35 under the contract being assigned or terminated; ~~((or))~~

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

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

1 ~~(d) Collateral acceptable to the department; or~~
2 ~~(e) A purchaser's)) (c) The new contractor's assumption of~~
3 ~~liability for the prior contractor's ((overpayment)) debt or potential~~
4 ~~debt;~~

5 ~~(d) An authorization to withhold payments from one or more medicaid~~
6 ~~nursing facilities that continue to be operated by the assigning or~~
7 ~~terminating contractor;~~

8 ~~((f)) (e) A promissory note secured by a deed of trust; or~~
9 ~~((g) Any combination of (a), (b), (c), (d), (e), or (f) of this~~
10 ~~subsection)) (f) Other collateral or security acceptable to the~~
11 ~~department.~~

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

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

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

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

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

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

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

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

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

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

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

32 (10) Regardless of whether a contractor intends to ~~((terminate its~~
33 ~~medicaid contracts))~~ change ownership, if a contractor's net medicaid
34 overpayments and erroneous payments for one or more settlement periods,
35 and for one or more nursing facilities, combined with debts due the
36 department, reaches or exceeds a total of fifty thousand dollars, as
37 determined by ~~((preliminary settlement, final))~~ settlement, civil fines
38 imposed by the department, third-party liabilities or by any other
39 source, whether such amounts are subject to good faith dispute or not,

1 the department shall demand and obtain security equivalent to the total
2 of such overpayments, erroneous payments, and debts and shall obtain
3 security for each subsequent increase in liability reaching or
4 exceeding twenty-five thousand dollars. Such security shall meet the
5 criteria in subsections (3) and (4) of this section, except that the
6 department shall not accept an assumption of liability. The department
7 shall withhold all or portions of a contractor's current contract
8 payments or impose liens, or both, if security acceptable to the
9 department is not forthcoming. The department shall release a
10 contractor's withheld payments or lift liens, or both, if the
11 contractor subsequently provides security acceptable to the department.
12 (~~This subsection shall apply to all overpayments and erroneous
13 payments determined by preliminary or final settlements issued on or
14 after July 1, 1995, regardless of what payment periods the settlements
15 may cover and shall apply to all debts owed the department from any
16 source, including interest debts, which become due on or after July 1,
17 1995.~~)

18 (11) Notwithstanding the application of security measures
19 authorized by this section, if the department determines that any
20 remaining debt of the old owner is uncollectible from the old owner,
21 the new owner is liable for the unsatisfied debt in all respects. If
22 the new owner does not accept assignment of the contract and the
23 contingent liability for all debt of the prior owner, a new
24 certification survey shall be done and no payments shall be made to the
25 new owner until the department determines the facility is in
26 substantial compliance for the purposes of certification.

27 (12) Medicaid provider contracts shall only be assigned if there is
28 a change of ownership, and with approval by the department.

29 **Sec. 40.** RCW 74.46.770 and 1995 1st sp.s. c 18 s 114 are each
30 amended to read as follows:

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

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

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

17 **Sec. 41.** RCW 74.46.780 and 1995 1st sp.s. c 18 s 115 are each
18 amended to read as follows:

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

29 **Sec. 42.** RCW 74.46.800 and 1980 c 177 s 80 are each amended to
30 read as follows:

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

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

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

12 **Sec. 43.** RCW 74.46.820 and 1985 c 361 s 14 are each amended to
13 read as follows:

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

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

30 ~~((2))~~ (3) Regardless of whether any document or report submitted
31 to the secretary pursuant to this chapter is subject to public
32 disclosure, copies of such documents or reports shall be provided by
33 the secretary, upon written request, to the legislature and to state
34 agencies or state or local law enforcement officials who have an
35 official interest in the contents thereof.

36 **Sec. 44.** RCW 74.46.840 and 1983 1st ex.s. c 67 s 42 are each
37 amended to read as follows:

1 If any part of this chapter ((and)) or RCW 18.51.145 ((and)) or
2 74.09.120 is found by an agency of the federal government to be in
3 conflict with federal requirements ((which)) that are a prescribed
4 condition to the receipts of federal funds to the state, the
5 conflicting part of this chapter ((and)) or RCW 18.51.145 ((and)) or
6 74.09.120 is ((hereby)) declared inoperative solely to the extent of
7 the conflict and with respect to the agencies directly affected, and
8 such finding or determination shall not affect the operation of the
9 remainder of this chapter ((and)) or RCW 18.51.145 ((and)) or 74.09.120
10 in its application to the agencies concerned. In the event that any
11 portion of this chapter ((and)) or RCW 18.51.145 ((and)) or 74.09.120
12 is found to be in conflict with federal requirements ((which)) that are
13 a prescribed condition to the receipt of federal funds, the secretary,
14 to the extent that the secretary finds it to be consistent with the
15 general policies and intent of chapters 18.51, 74.09, and 74.46 RCW,
16 may adopt such rules as to resolve a specific conflict and ((which))
17 that do meet minimum federal requirements. In addition, the secretary
18 shall submit to the next regular session of the legislature a summary
19 of the specific rule changes made and recommendations for statutory
20 resolution of the conflict.

21 **Sec. 45.** RCW 74.09.120 and 1993 sp.s. c 3 s 8 are each amended to
22 read as follows:

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

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

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

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

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

28 NEW SECTION. Sec. 46. (1) Payment for direct care at the pilot
29 nursing facility in King county designed to meet the service needs of
30 residents living with AIDS, as defined in RCW 70.24.017, and as
31 specifically authorized for this purpose under chapter 9, Laws of 1989
32 1st ex. sess., shall be exempt from case mix methods of rate
33 determination set forth in this chapter and shall be exempt from the
34 direct care metropolitan statistical area peer group cost limitation
35 set forth in this chapter.

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

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

3 (3) The provisions of section 18 of this act and all other rate-
4 setting principles, cost lids, and limits, including settlement as
5 provided in section 10 of this act shall apply to the AIDS pilot
6 facility.

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

8 NEW SECTION. **Sec. 47.** (1) By December 1, 1998, the department of
9 social and health services shall study and provide recommendations to
10 the chairs of the house of representatives appropriations and health
11 care committees, and the senate ways and means and health and long-term
12 care committees, concerning options for changing the method for paying
13 facilities for capital and property related expenses.

14 (2) The department of social and health services shall contract
15 with an independent and recognized organization to study and evaluate
16 the impacts of chapter 74.46 RCW implementation on access, quality of
17 care, quality of life for nursing facility residents, and the wage and
18 benefit levels of all nursing facility employees. The department shall
19 require, and the contractor shall submit, a report with the results of
20 this study and evaluation, including their findings, to the governor
21 and legislature by December 1, 2001.

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

34 (4) By December 12, 2002, the department of social and health
35 services shall report to the legislature and provide an evaluation of
36 the fiscal impact of rebasing future payments at different intervals,
37 including the impact of averaging two years' cost data as the basis for

1 rebasing. This report shall include the fiscal impact to the state and
2 the fiscal impact to nursing facility providers.

3 NEW SECTION. **Sec. 48.** By December 12, 1998, the department of
4 social and health services shall study and provide recommendation to
5 appropriate committees of the legislature on the appropriateness of
6 extending case-mix reimbursement to home and community services
7 providers, as defined in chapter 74.39A RCW. The department shall
8 invite stakeholders to participate in this study.

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

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

17 (1)(a) All honorably discharged veterans of a branch of the armed
18 forces of the United States or merchant marines; (b) members of the
19 state militia disabled while in the line of duty; (~~and~~) (c) Filipino
20 World War II veterans who swore an oath to American authority and who
21 participated in military engagements with American soldiers; and (d)
22 the spouses of these veterans, merchant marines, and members of the
23 state militia. However, it is required that the spouse was married to
24 and living with the veteran three years prior to the date of
25 application for admittance, or, if married to him or her since that
26 date, was also a resident of a state veterans' home in this state or
27 entitled to admission thereto;

28 (2)(a) The spouses of: (i) All honorably discharged veterans of
29 the United States armed forces; (ii) merchant marines; and (iii)
30 members of the state militia who were disabled while in the line of
31 duty and who were residents of a state veterans' home in this state or
32 were entitled to admission to one of this state's state veteran homes
33 at the time of death; (b) the spouses of: (i) All honorably discharged
34 veterans of a branch of the United States armed forces; (ii) merchant
35 marines; and (iii) members of the state militia who would have been
36 entitled to admission to one of this state's state veterans' homes at
37 the time of death, but for the fact that the spouse was not indigent,

1 but has since become indigent and unable to support himself or herself
2 and his or her family. However, the included spouse shall be at least
3 fifty years old and have been married to and living with their husband
4 or wife for three years prior to the date of their application. The
5 included spouse shall not have been married since the death of his or
6 her husband or wife to a person who is not a resident of one of this
7 state's state veterans' homes or entitled to admission to one of this
8 state's state veterans' homes; and

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

12 NEW SECTION. Sec. 50. A new section is added to chapter 70.38 RCW
13 to read as follows:

14 (1) A change in bed capacity at a residential hospice care center
15 shall not be subject to certificate of need review under this chapter
16 if the department determined prior to June 1994 that the construction,
17 development, or other establishment of the residential hospice care
18 center was not subject to certificate of need review under this
19 chapter.

20 (2) For purposes of this section, a "residential hospice care
21 center" means any building, facility, place, or equivalent that opened
22 in December 1996 and is organized, maintained, and operated
23 specifically to provide beds, accommodations, facilities, and services
24 over a continuous period of twenty-four hours or more for palliative
25 care of two or more individuals, not related to the operator, who are
26 diagnosed as being in the latter stages of an advanced disease that is
27 expected to lead to death.

28 NEW SECTION. Sec. 51. (1) A facility's nursing services, food,
29 administrative, and operational component rates, existing on June 30,
30 1998, weighted by medicaid resident days, and adjusted by a factor
31 specified in the biennial appropriations act, shall be the facility's
32 nursing services, food, administrative, and operational component rates
33 for the period July 1, 1998, through September 30, 1998.

34 (2) A facility's return on investment and property component rates
35 existing on June 30, 1998, or as subsequently adjusted or revised,
36 shall be the facility's return on investment and property component

1 rates for the period July 1, 1998, through September 30, 1998, with no
2 increase for the period July 1, 1998, through September 30, 1998.

3 NEW SECTION. **Sec. 52.** The following acts or parts of acts are
4 each repealed:

5 (1) RCW 74.46.105 and 1995 1st sp.s. c 18 s 91, 1985 c 361 s 10, &
6 1983 1st ex.s. c 67 s 5;

7 (2) RCW 74.46.115 and 1995 1st sp.s. c 18 s 92 & 1983 1st ex.s. c
8 67 s 6;

9 (3) RCW 74.46.130 and 1985 c 361 s 11, 1983 1st ex.s. c 67 s 7, &
10 1980 c 177 s 13;

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

12 (5) RCW 74.46.160 and 1995 1st sp.s. c 18 s 93, 1985 c 361 s 12,
13 1983 1st ex.s. c 67 s 9, & 1980 c 177 s 16;

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

16 (7) RCW 74.46.180 and 1995 1st sp.s. c 18 s 95 & 1993 sp.s. c 13 s
17 2;

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

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

20 NEW SECTION. **Sec. 53.** RCW 74.46.595 and 1995 1st sp.s. c 18 s 98
21 are each repealed effective July 2, 1998.

22 NEW SECTION. **Sec. 54.** The following acts or parts of acts are
23 each repealed, effective June 30, 1999:

24 (1) 1998 c . . . s 29 (section 29 of this act) (uncodified); and

25 (2) 1998 c . . . s 30 (section 30 of this act) (uncodified).

26 NEW SECTION. **Sec. 55.** Sections 1 through 37, 40 through 49, and
27 52 through 54 of this act take effect July 1, 1998.

28 NEW SECTION. **Sec. 56.** If any provision of this act or its
29 application to any person or circumstance is held invalid, the
30 remainder of the act or the application of the provision to other
31 persons or circumstances is not affected.

32 NEW SECTION. **Sec. 57.** (1) Sections 9, 10, 19, 20, 22 through 28,
33 31, and 46 of this act are each added to chapter 74.46 RCW.

1 (2) Sections 19, 20, 22 through 28, and 31 of this act shall be
2 codified in part E of chapter 74.46 RCW.

3 NEW SECTION. **Sec. 58.** Section 51 of this act takes effect July 1,
4 1998, and expires October 1, 1998.

5 NEW SECTION. **Sec. 59.** Sections 38 and 39 of this act take effect
6 October 1, 1998.

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