H-2684.1

SUBSTITUTE HOUSE BILL 2242

State of Washington 57th Legislature 2001 First Special Session

By House Committee on Appropriations (originally sponsored by Representatives Cody, Lisk, Ruderman, Alexander and Eickmeyer)

Read first time 05/03/2001. Referred to Committee on .

AN ACT Relating to medicaid nursing home rates; amending RCW 74.46.020, 74.46.165, 74.46.410, 74.46.421, 74.46.431, 74.46.433, 74.46.435, 74.46.437, 74.46.501, and 74.46.711; amending 1998 c 322 s 47 (uncodified); reenacting and amending RCW 74.46.506; adding new sections to chapter 74.46 RCW; creating new sections; repealing RCW 74.46.908 and 74.46.506; providing effective dates; providing an expiration date; and declaring an emergency.

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

Sec. 1. RCW 74.46.020 and 1999 c 353 s 1 are each amended to read as follows:

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

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

(2) "Appraisal" means the process of estimating the fair market value or reconstructing the historical cost of an asset acquired in a past period as performed by a professionally designated real estate

appraiser with no pecuniary interest in the property to be appraised. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

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

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

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

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

(7) "Beneficial owner" means:

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

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

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

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

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

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

(ii) Through the conversion of an ownership interest;

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

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

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

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

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

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

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

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

(8) "Capital portion of the rate" means the sum of the property and financing allowance rate allocations, as established in part E of this chapter.

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

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

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

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

(13) "Certificate of capital authorization" means a certification from the department for an allocation from the biennial capital financing authorization for all new or replacement building construction, or for major renovation projects, receiving a certificate of need or a certificate of need exemption under chapter 70.38 RCW after July 1, 2001.

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

((~~(14)~~)) (15) "Default case" means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

((~~(15)~~)) (16) "Department" means the department of social and health services (DSHS) and its employees.

((~~(16)~~)) (17) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

((~~(17)~~)) (18) "Direct care" means nursing care and related care provided to nursing facility residents. Therapy care shall not be considered part of direct care.

((~~(18)~~)) (19) "Direct care supplies" means medical, pharmaceutical, and other supplies required for the direct care of a nursing facility's residents.

((~~(19)~~)) (20) "Entity" means an individual, partnership, corporation, limited liability company, or any other association of individuals capable of entering enforceable contracts.

((~~(20)~~)) (21) "Equity" means the net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

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

((~~(22)~~)) (23) "Fair market value" means the replacement cost of an asset less observed physical depreciation on the date for which the market value is being determined.

((~~(23)~~)) (24) "Financial statements" means statements prepared and presented in conformity with generally accepted accounting principles including, but not limited to, balance sheet, statement of operations, statement of changes in financial position, and related notes.

((~~(24)~~)) (25) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB).

((~~(25)~~)) (26) "Goodwill" means the excess of the price paid for a nursing facility business over the fair market value of all net identifiable tangible and intangible assets acquired, as measured in accordance with generally accepted accounting principles.

((~~(26)~~)) (27) "Grouper" means a computer software product that groups individual nursing facility residents into case mix classification groups based on specific resident assessment data and computer logic.

((~~(27)~~)) (28) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect’s fees, and engineering studies.

((~~(28)~~)) (29) "Home and central office costs" means costs that are incurred in the support and operation of a home or central office. Home and central office costs include centralized services that are done in support of a nursing facility. The department may exclude costs that are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients.

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

((~~(29)~~)) (31) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(30)~~)) (32) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

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

((~~(32)~~)) (34) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

((~~(33)~~)) (35) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

((~~(34)~~)) (36) "Net book value" means the historical cost of an asset less accumulated depreciation.

((~~(35)~~)) (37) "Net invested funds" means the net book value of tangible fixed assets employed by a contractor to provide services under the medical care program, including land, buildings, and equipment as recognized and measured in conformity with generally accepted accounting principles.

((~~(36)~~)) (38) "Noncapital portion of the rate" means the sum of the direct care, therapy care, operations, support services, and variable return rate allocations, as established in part E of this chapter.

((~~(37)~~)) (39) "Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with generally accepted accounting principles.

((~~(38)~~)) (40) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

((~~(39)~~)) (41) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form which such beneficial ownership takes.

((~~(40)~~)) (42) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A "medicaid day" or "recipient day" means a calendar day of care provided to a medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

((~~(41)~~)) (43) "Professionally designated real estate appraiser" means an individual who is regularly engaged in the business of providing real estate valuation services for a fee, and who is deemed qualified by a nationally recognized real estate appraisal educational organization on the basis of extensive practical appraisal experience, including the writing of real estate valuation reports as well as the passing of written examinations on valuation practice and theory, and who by virtue of membership in such organization is required to subscribe and adhere to certain standards of professional practice as such organization prescribes.

((~~(42)~~)) (44) "Qualified therapist" means:

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

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

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

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

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

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

((~~(43)~~)) (45) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in part E of this chapter.

((~~(44)~~)) (46) "Real property," whether leased or owned by the contractor, means the building, allowable land, land improvements, and building improvements associated with a nursing facility.

((~~(45)~~)) (47) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost-rebasing payment rate allocations under the provisions of this chapter.

((~~(46)~~)) (48) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(47)~~)) (49) "Related organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by, the contractor.

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

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

((~~(48)~~)) (50) "Related care" means only those services that are directly related to providing direct care to nursing facility residents. These services include, but are not limited to, nursing direction and supervision, medical direction, medical records, pharmacy services, activities, and social services.

((~~(49)~~)) (51) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally

mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

((~~(50)~~)) (52) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident's potential problems and risk areas.

((~~(51)~~)) (53) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(52)~~)) (54) "Restricted fund" means those funds the principal and/or income of which is limited by agreement with or direction of the donor to a specific purpose.

((~~(53)~~)) (55) "Secretary" means the secretary of the department of social and health services.

((~~(54)~~)) (56) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.

((~~(55)~~)) (57) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under their supervision, including related costs as designated by the department.

((~~(56)~~)) (58) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

Sec. 2. RCW 74.46.165 and 1998 c 322 s 10 are each amended to read as follows:

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

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

(3) The facility will return to the department any overpayment amounts in each of the direct care, therapy care, and support services rate components that the department identifies following the audit and settlement procedures as described in this chapter, provided that the contractor may retain any overpayment that does not exceed 1.0% of the facility's direct care, therapy care, and support services component rate. However, no overpayments may be retained in a cost center to which savings have been shifted to cover a deficit, as provided in subsection (4) of this section. Facilities that are not in substantial compliance for more than ninety days, and facilities that provide substandard quality of care at any time, during the period for which settlement is being calculated, will not be allowed to retain any amount of overpayment in the facility's direct care, therapy care, and support services component rate. The terms "not in substantial compliance" and "substandard quality of care" shall be defined by federal survey regulations.

(4) Determination of unused rate funds, including the amounts of direct care, therapy care, and support services to be recovered, shall be done separately for each component rate, and, except as otherwise provided in this subsection, neither costs nor rate payments shall be shifted from one component rate or corresponding service area to another in determining the degree of underspending or recovery, if any. ((~~However,~~)) In computing a preliminary or final settlement, savings in the support services cost center ((~~may~~)) shall be shifted to cover a deficit in the direct care or therapy cost centers up to the amount of any savings((~~. Not more than twenty percent of the rate in a cost center may be shifted~~)), but no more than twenty percent of the support services component rate may be shifted. In computing a preliminary or final settlement, savings in direct care and therapy care may be shifted to cover a deficit in these two cost centers up to the amount of savings in each, regardless of the percentage of either component rate shifted. Contractor-retained overpayments up to one percent of direct care, therapy care, and support services rate components, as authorized in subsection (3) of this section, shall be calculated and applied after all shifting is completed.

(5) Total and component payment rates assigned to a nursing facility, as calculated and revised, if needed, under the provisions of this chapter and those rules as the department may adopt, shall represent the maximum payment for nursing facility services rendered to

medicaid recipients for the period the rates are in effect. No increase in payment to a contractor shall result from spending above the total payment rate or in any rate component.

(6) RCW 74.46.150 through 74.46.180, and rules adopted by the department prior to July 1, 1998, shall continue to govern the medicaid settlement process for periods prior to October 1, 1998, as if these statutes and rules remained in full force and effect.

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

Sec. 3. RCW 74.46.410 and 1998 c 322 s 17 are each amended to read as follows:

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

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

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

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

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

(d) Costs associated with a construction or acquisition project requiring certificate of need approval, or exemption from the requirements for certificate of need for the replacement of existing

nursing home beds, pursuant to chapter 70.38 RCW if such approval or exemption was not obtained;

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

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

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

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

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

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

(k) Charity and courtesy allowances;

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

(m) Vending machine expenses;

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

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

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

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

(s) Penalties and fines;

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

(u) Televisions acquired prior to July 1, 2001;

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

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

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

((~~(x)~~)) (y) Expenses of profit-sharing plans;

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

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

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

((~~(bb)~~)) (cc) Costs related to agreements not to compete;

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

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

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

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

((~~(gg)~~)) (hh) Lease acquisition costs, goodwill, the cost of bed rights, or any other intangible assets;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. RCW 74.46.421 and 1999 c 353 s 3 are each amended to read as follows:

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

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

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

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

(4)((~~(a) The statewide average payment rate for the capital portion of the rate for any state fiscal year under the nursing facility medicaid payment system, weighted by patient days, shall not exceed the~~

~~annual statewide weighted average nursing facility payment rate for the capital portion of the rate identified for that fiscal year in the biennial appropriations act.~~

~~(b) If the department determines that the weighted average nursing facility payment rate for the capital portion of the rate calculated in accordance with this chapter is likely to exceed the weighted average nursing facility payment rate for the capital portion of the rate identified in the biennial appropriations act, then the department shall adjust all nursing facility property and financing allowance payment rates proportional to the amount by which the weighted average rate allocations would otherwise exceed the budgeted capital portion of the rate amount. Any such adjustments shall only be made prospectively, not retrospectively, and shall be applied proportionately to each component rate allocation for each facility.~~

~~(5)~~))(a) The statewide average payment rate for the noncapital portion of the rate for any state fiscal year under the nursing facility payment system, weighted by patient days, shall not exceed the annual statewide weighted average nursing facility payment rate for the noncapital portion of the rate identified for that fiscal year in the biennial appropriations act.

(b) If the department determines that the weighted average nursing facility payment rate for the noncapital portion of the rate calculated in accordance with this chapter is likely to exceed the weighted average nursing facility payment rate for the noncapital portion of the rate identified in the biennial appropriations act, then the department shall adjust all nursing facility direct care, therapy care, support services, operations, and variable return payment rates proportional to the amount by which the weighted average rate allocations would otherwise exceed the budgeted noncapital portion of the rate amount. Any such adjustments shall only be made prospectively, not retrospectively, and shall be applied proportionately to each direct care, therapy care, support services, operations, and variable return rate allocation for each facility.

Sec. 5. RCW 74.46.431 and 1999 c 353 s 4 are each amended to read as follows:

(1) Effective July 1, 1999, nursing facility medicaid payment rate allocations shall be facility-specific and shall have seven components: Direct care, therapy care, support services, operations, property,

financing allowance, and variable return. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

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

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

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

(b) Direct care component rate allocations based on 1996 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

(c) Direct care component rate allocations based on 1999 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(k).

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

report data from 1999 will be used for July 1, 2001, through June 30, 2004, therapy care component rate allocations.

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

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

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

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

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

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

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

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

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for

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

(12) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421.

Sec. 6. RCW 74.46.433 and 1999 c 353 s 9 are each amended to read as follows:

(1) The department shall establish for each medicaid nursing facility a variable return component rate allocation. In determining the variable return allowance:

(a) The variable return array and percentage ((~~assigned at the October 1, 1998, rate setting shall remain in effect until June 30, 2001~~)) shall be assigned whenever rebasing of noncapital rate allocations is scheduled under RCW 46.46.431 (4), (5), (6), and (7).

(b) To calculate the array of facilities for the July 1, 2001, rate setting, the department, without using peer groups, shall first rank all facilities in numerical order from highest to lowest according to each facility's examined and documented, but unlidded, combined direct care, therapy care, support services, and operations per resident day cost from the 1999 cost report period. However, before being combined with other per resident day costs and ranked, a facility's direct care cost per resident day shall be adjusted to reflect its facility average case mix index, to be averaged from the four calendar quarters of 1999, weighted by the facility's resident days from each quarter, under RCW 74.46.501(7)(b)(ii). The array shall then be divided into four quartiles, each containing, as nearly as possible, an equal number of facilities, and four percent shall be assigned to facilities in the lowest quartile, three percent to facilities in the next lowest

quartile, two percent to facilities in the next highest quartile, and one percent to facilities in the highest quartile.

(c) The department shall ((~~then~~)) compute the variable return allowance by multiplying ((~~the appropriate~~)) a facility's assigned percentage ((~~amounts, which shall not be less than one percent and not greater than four percent,~~)) by the sum of the facility's direct care, therapy care, support services, and operations ((~~rate components. The percentage amounts will be based on groupings of facilities according to the rankings prescribed in (a) of this subsection, as applicable. Those groups of facilities with lower per diem costs shall receive higher percentage amounts than those with higher per diem costs~~)) component rates determined in accordance with this chapter and rules adopted by the department.

(2) The variable return rate allocation calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

Sec. 7. RCW 74.46.435 and 1999 c 353 s 10 are each amended to read as follows:

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

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

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

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

((~~(5) The property component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.~~))

Sec. 8. RCW 74.46.437 and 1999 c 353 s 11 are each amended to read as follows:

(1) Beginning July 1, 1999, the department shall establish for each medicaid nursing facility a financing allowance component rate allocation. The financing allowance component rate shall be rebased annually, effective July 1st, in accordance with the provisions of this section and this chapter.

(2) The financing allowance shall be determined by multiplying the net invested funds of each facility by .10, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on eighty-five percent facility occupancy. However, assets acquired on or after May 17, 1999, shall be grouped in a separate financing allowance calculation that shall be multiplied by .085. The financing allowance factor of .085 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings that have been submitted to the department of health for construction review approval, prior to May 17, 1999. If a capitalized addition or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the financing allowance shall be adjusted to the greater of the anticipated resident day level or eighty-five percent of the new licensed bed capacity.

(3) In computing the portion of net invested funds representing the net book value of tangible fixed assets, the same assets, depreciation bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,

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

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

((~~(5) The financing allowance rate allocation calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.~~))

Sec. 9. RCW 74.46.501 and 1998 c 322 s 24 are each amended to read as follows:

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

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

through June 30th, July 1st through September 30th, or October 1st through December 31st).

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

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

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

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

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

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

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

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

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

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

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

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

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

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used only every three years in combination with cost report data as specified by RCW 74.46.431 and 74.46.506, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate quarterly.

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

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

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

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

Sec. 10. RCW 74.46.506 and 1999 c 353 s 5 and 1999 c 181 s 1 are each reenacted and amended to read as follows:

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

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

(3) The department may question the accuracy of assessment data for any resident and utilize corrected or substitute information, however

derived, in determining direct care component rates. The department is authorized to impose civil fines and to take adverse rate actions against a contractor, as specified by the department in rule, in order to obtain compliance with resident assessment and data transmission requirements and to ensure accuracy.

(4) Cost report data used in setting direct care component rate allocations shall be 1996 and 1999, for rate periods as specified in RCW 74.46.431(4)(a).

(5) Beginning October 1, 1998, the department shall rebase each nursing facility's direct care component rate allocation as described in RCW 74.46.431, adjust its direct care component rate allocation for economic trends and conditions as described in RCW 74.46.431, and update its medicaid average case mix index, consistent with the following:

(a) Reduce total direct care costs reported by each nursing facility for the applicable cost report period specified in RCW 74.46.431(4)(a) to reflect any department adjustments, and to eliminate reported resident therapy costs and adjustments, in order to derive the facility's total allowable direct care cost;

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

(c) Adjust the facility's per resident day direct care cost by the applicable factor specified in RCW 74.46.431(4) (b) and (c) to derive its adjusted allowable direct care cost per resident day;

(d) Divide each facility's adjusted allowable direct care cost per resident day by the facility average case mix index for the applicable quarters specified by RCW 74.46.501(7)(b) to derive the facility's allowable direct care cost per case mix unit;

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

(f) Array separately the allowable direct care cost per case mix unit for all metropolitan statistical area and for all nonmetropolitan

statistical area facilities, and determine the median allowable direct care cost per case mix unit for each peer group;

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

(i) Any facility whose allowable cost per case mix unit is less than eighty-five percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to eighty-five percent of the facility's peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred fifteen percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred fifteen percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between eighty-five and one hundred fifteen percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

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

(i) Any facility whose allowable cost per case mix unit is less than ninety percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety percent of the facility's peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred ten percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred ten percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety and one hundred ten percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

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

(i) Any facility whose allowable cost per case mix unit is less than ninety-five percent of the facility's peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to ninety-five percent of the facility's peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(ii) Any facility whose allowable cost per case mix unit is greater than one hundred five percent of the peer group median established under (f) of this subsection shall be assigned a cost per case mix unit equal to one hundred five percent of the peer group median, and shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(iii) Any facility whose allowable cost per case mix unit is between ninety-five and one hundred five percent of the peer group median established under (f) of this subsection shall have a direct care component rate allocation equal to the facility's allowable cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

(j) Beginning July 1, 2004, determine each facility's quarterly direct care component rate by multiplying the facility's peer group median allowable direct care cost per case mix unit by that facility's medicaid average case mix index from the applicable quarter as specified in RCW 74.46.501(7)(c).

(k)(i) Between October 1, 1998, and June 30, 2000, the department shall compare each facility's direct care component rate allocation calculated under (g) of this subsection with the facility's nursing services component rate in effect on September 30, 1998, less therapy costs, plus any exceptional care offsets as reported on the cost report, adjusted for economic trends and conditions as provided in RCW 74.46.431. A facility shall receive the higher of the two rates;

(ii) Between July 1, 2000, and June 30, 2002, the department shall compare each facility's direct care component rate allocation calculated under (h) of this subsection with the facility's direct care component rate in effect on June 30, 2000. A facility shall receive the higher of the two rates. Between July 1, 2001, and June 30, 2002, if during any quarter a facility whose rate paid under (h) of this subsection is greater than the direct care rate in effect on June 30, 2000, the facility shall be paid in that and each subsequent quarter pursuant to (h) of this subsection and shall not be entitled to the greater of the two rates.

(6) The direct care component rate allocations calculated in accordance with this section shall be adjusted to the extent necessary to comply with RCW 74.46.421.

(7) Payments resulting from increases in direct care component rates, granted under authority of RCW 74.46.508(1) for a facility's exceptional care residents, shall be offset against the facility's examined, allowable direct care costs, for each report year or partial period such increases are paid. Such reductions in allowable direct care costs shall be for rate setting, settlement, and other purposes deemed appropriate by the department.

Sec. 11. RCW 74.46.711 and 1995 1st sp.s. c 18 s 69 are each amended to read as follows:

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within ((~~forty-five~~)) thirty days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's

estate; but in the case of a resident who received long-term care services paid in whole or in part by the department, the funds and accounting shall be sent to the state of Washington, department of social and health services, office of financial recovery. The department shall establish a release procedure for use for burial expenses.

NEW SECTION. **Sec. 12.** A new section is added to chapter 74.46 RCW to read as follows:

The total capital authorization available for any biennial period shall be specified in the biennial appropriations act and shall be calculated on an annual basis. When setting the capital authorization level, the legislature shall consider both the need for, and the cost of, new and replacement beds.

NEW SECTION. **Sec. 13.** A new section is added to chapter 74.46 RCW to read as follows:

The department shall establish rules for issuing a certificate of capital authorization. Applications for a certificate of capital authorization shall be submitted and approved on a biennial basis. The rules for a certificate of capital authorization shall be consistent with the following principles:

(1) The certificate of capital authorization shall be approved on a first-come, first-served basis.

(2) Those projects that do not receive approval in one authorization period shall have priority the following biennium should the project be resubmitted.

(3) The department shall have the authority to give priority for a project that is necessitated by an emergency situation even if the project is not submitted in a timely fashion. The department shall establish rules for determining what constitutes an emergency.

(4) The department shall establish deadlines for progress and the department shall have the authority to withdraw the certificate of capital authorization where the holder of the certificate has not complied with those deadlines in a good faith manner.

Sec. 14. 1998 c 322 s 47 (uncodified) is amended to read as follows:

(1) By December 1, 1998, the department of social and health services shall study and provide recommendations to the chairs of the house of representatives appropriations and health care committees, and the senate ways and means and health and long-term care committees, concerning options for changing the method for paying facilities for capital and property related expenses.

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

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

~~(4)~~)) By December 12, 2002, the department of social and health services shall report to the legislature and provide an evaluation of the fiscal impact of rebasing future payments at different intervals, including the impact of averaging two years' cost data as the basis for rebasing. This report shall include the fiscal impact to the state and the fiscal impact to nursing facility providers.

NEW SECTION. **Sec. 15.** (1) It is the intent of the legislature to revise the methodology for setting direct care rates for facilities paid pursuant to chapter 74.46 RCW on or before July 1, 2002. In the process of revising those rates, the legislature recognizes that other rate components including, but not limited to, property, financing allowance, and operations may need revision.

(2) The legislature recognizes and affirms that case mix is an important tool in linking rates to client and care needs and that case mix will continue to be an important part of any new approach. The new system must:

(a) Continue to link client acuity to the direct care rate using case mix;

(b) Consider an approach linking client acuity, as measured by case mix, to the number of hours of services assumed to be provided for each client and then link the hours of service assumed to be provided to the direct care rate by multiplying the hours by an assumed wage and benefit rate;

(c) Account for differences in wage and benefit rates in various areas of the state. The comparison is to be done primarily using settled cost reports for the most recent year for which reliable data, after settlements, is available;

(d) Provide cost controls and incentives at least equal to the rate system currently in place;

(e) Not contain automatic cost increases, automatic indexing, hold harmless provisions, or mandatory future rebasing of costs; and

(f) Cost no more than the rate system in place as assumed in the 2001-2003 omnibus appropriations act adopted during the 2001 legislative session.

NEW SECTION. **Sec. 16.** The joint legislative task force on nursing home rates is hereby created.

(1) Membership of the task force shall consist of eight legislators. The president of the senate shall appoint four members of the senate, including two members of the majority party and two members of the minority party. The co-speakers of the house of representatives shall appoint four members of the house of representatives, including two members from each party. Each body shall select representatives from committees with jurisdiction over health and long-term care and fiscal matters.

(2) The joint legislative task force shall work together with the department of social and health services and with interested parties to develop a proposed rate system that meets the requirements set forth in section 15 of this act.

(3)(a) The department shall identify and present to the joint legislative task force several alternatives; however, it shall identify

the alternative that best meets the goals set forth in section 15 of this act. All alternatives developed by the department must be provided to the joint legislative task force and to interested parties no later than October 31, 2001.

(b) For each alternative, the department shall also calculate a system of shadow rates that shows what the facility rate is for fiscal year 2002, the direct care costs reflected in the 1999 cost reports, what the payments would be in fiscal year 2002 if the alternative were in effect at that time, what the payments would be in fiscal year 2003 under the current system, and what the payments would be in fiscal year 2003 under the alternative. The rate information must be provided to the joint legislative task force and to all interested parties no later than November 15, 2001.

(4) To mitigate potential impacts that the expiration of the current hold harmless system may have on the direct care rate, the joint legislative task force shall:

(a) Consider increasing minimum occupancy standards;

(b) Consider not modifying property, financing allowance, or operations rate components for prospective reductions in licensed bed capacity through bed banking;

(c) Assume that any savings generated by this subsection be applied towards increasing the direct care rate.

(5) The joint legislative task force shall complete its review and submit its recommendations in the form of a report to the appropriate policy and fiscal committees of the legislature by December 1, 2001.

(6) This section expires December 31, 2001.

NEW SECTION. **Sec. 17.** RCW 74.46.908 (Repealer) and 1999 c 353 s 17 are each repealed.

NEW SECTION. **Sec. 18.** RCW 74.46.506 (Direct care component rate allocations--Determination--Quarterly updates--Fines) and 1999 c 353 s 5, 1999 c 181 s 1, & 1998 c 322 s 25 are each repealed.

NEW SECTION. **Sec. 19.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 29, 2001, in the omnibus appropriations act, this act is null and void.

NEW SECTION. **Sec. 20.** (1) Sections 1 through 10 and 12 through 16 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 2001.

(2) Sections 17 and 19 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect June 29, 2001.

(3) Section 18 of this act takes effect June 30, 2002.

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