
HOUSE BILL 2242

State of Washington 57th Legislature 2001 Regular Session

By Representatives Cody, Lisk, Ruderman and Alexander

Read first time . Referred to Committee on .

1 AN ACT Relating to medicaid nursing home rates; amending RCW
2 74.46.020, 74.46.165, 74.46.410, 74.46.421, 74.46.431, 74.46.433,
3 74.46.435, 74.46.437, 74.46.501, and 74.46.711; amending 1998 c 322 s
4 47 (uncodified); reenacting and amending RCW 74.46.506; adding new
5 sections to chapter 74.46 RCW; creating new sections; repealing RCW
6 74.46.908 and 74.46.506; providing effective dates; and declaring an
7 emergency.

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

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

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

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

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

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

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

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

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

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

26 (7) "Beneficial owner" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (14) "Contractor" means a person or entity licensed under chapter
18 18.51 RCW to operate a medicare and medicaid certified nursing
19 facility, responsible for operational decisions, and contracting with
20 the department to provide services to medicaid recipients residing in
21 the facility.

22 ~~((14))~~ (15) "Default case" means no initial assessment has been
23 completed for a resident and transmitted to the department by the
24 cut-off date, or an assessment is otherwise past due for the resident,
25 under state and federal requirements.

26 ~~((15))~~ (16) "Department" means the department of social and
27 health services (DSHS) and its employees.

28 ~~((16))~~ (17) "Depreciation" means the systematic distribution of
29 the cost or other basis of tangible assets, less salvage, over the
30 estimated useful life of the assets.

31 ~~((17))~~ (18) "Direct care" means nursing care and related care
32 provided to nursing facility residents. Therapy care shall not be
33 considered part of direct care.

34 ~~((18))~~ (19) "Direct care supplies" means medical, pharmaceutical,
35 and other supplies required for the direct care of a nursing facility's
36 residents.

37 ~~((19))~~ (20) "Entity" means an individual, partnership,
38 corporation, limited liability company, or any other association of
39 individuals capable of entering enforceable contracts.

1 (~~(20)~~) (21) "Equity" means the net book value of all tangible and
2 intangible assets less the recorded value of all liabilities, as
3 recognized and measured in conformity with generally accepted
4 accounting principles.

5 (~~(21)~~) (22) "Facility" or "nursing facility" means a nursing home
6 licensed in accordance with chapter 18.51 RCW, excepting nursing homes
7 certified as institutions for mental diseases, or that portion of a
8 multiservice facility licensed as a nursing home, or that portion of a
9 hospital licensed in accordance with chapter 70.41 RCW which operates
10 as a nursing home.

11 (~~(22)~~) (23) "Fair market value" means the replacement cost of an
12 asset less observed physical depreciation on the date for which the
13 market value is being determined.

14 (~~(23)~~) (24) "Financial statements" means statements prepared and
15 presented in conformity with generally accepted accounting principles
16 including, but not limited to, balance sheet, statement of operations,
17 statement of changes in financial position, and related notes.

18 (~~(24)~~) (25) "Generally accepted accounting principles" means
19 accounting principles approved by the financial accounting standards
20 board (FASB).

21 (~~(25)~~) (26) "Goodwill" means the excess of the price paid for a
22 nursing facility business over the fair market value of all net
23 identifiable tangible and intangible assets acquired, as measured in
24 accordance with generally accepted accounting principles.

25 (~~(26)~~) (27) "Grouper" means a computer software product that
26 groups individual nursing facility residents into case mix
27 classification groups based on specific resident assessment data and
28 computer logic.

29 (~~(27)~~) (28) "Historical cost" means the actual cost incurred in
30 acquiring and preparing an asset for use, including feasibility
31 studies, architect's fees, and engineering studies.

32 (~~(28)~~) (29) "Imprest fund" means a fund which is regularly
33 replenished in exactly the amount expended from it.

34 (~~(29)~~) (30) "Joint facility costs" means any costs which
35 represent resources which benefit more than one facility, or one
36 facility and any other entity.

37 (~~(30)~~) (31) "Lease agreement" means a contract between two
38 parties for the possession and use of real or personal property or
39 assets for a specified period of time in exchange for specified

1 periodic payments. Elimination (due to any cause other than death or
2 divorce) or addition of any party to the contract, expiration, or
3 modification of any lease term in effect on January 1, 1980, or
4 termination of the lease by either party by any means shall constitute
5 a termination of the lease agreement. An extension or renewal of a
6 lease agreement, whether or not pursuant to a renewal provision in the
7 lease agreement, shall be considered a new lease agreement. A strictly
8 formal change in the lease agreement which modifies the method,
9 frequency, or manner in which the lease payments are made, but does not
10 increase the total lease payment obligation of the lessee, shall not be
11 considered modification of a lease term.

12 ~~((+31+))~~ (32) "Medical care program" or "medicaid program" means
13 medical assistance, including nursing care, provided under RCW
14 74.09.500 or authorized state medical care services.

15 ~~((+32+))~~ (33) "Medical care recipient," "medicaid recipient," or
16 "recipient" means an individual determined eligible by the department
17 for the services provided under chapter 74.09 RCW.

18 ~~((+33+))~~ (34) "Minimum data set" means the overall data component
19 of the resident assessment instrument, indicating the strengths, needs,
20 and preferences of an individual nursing facility resident.

21 ~~((+34+))~~ (35) "Net book value" means the historical cost of an
22 asset less accumulated depreciation.

23 ~~((+35+))~~ (36) "Net invested funds" means the net book value of
24 tangible fixed assets employed by a contractor to provide services
25 under the medical care program, including land, buildings, and
26 equipment as recognized and measured in conformity with generally
27 accepted accounting principles.

28 ~~((+36+))~~ (37) "Noncapital portion of the rate" means the sum of the
29 direct care, therapy care, operations, support services, and variable
30 return rate allocations, as established in part E of this chapter.

31 ~~((+37+))~~ (38) "Operating lease" means a lease under which rental or
32 lease expenses are included in current expenses in accordance with
33 generally accepted accounting principles.

34 ~~((+38+))~~ (39) "Owner" means a sole proprietor, general or limited
35 partners, members of a limited liability company, and beneficial
36 interest holders of five percent or more of a corporation's outstanding
37 stock.

1 (~~(39)~~) (40) "Ownership interest" means all interests beneficially
2 owned by a person, calculated in the aggregate, regardless of the form
3 which such beneficial ownership takes.

4 (~~(40)~~) (41) "Patient day" or "resident day" means a calendar day
5 of care provided to a nursing facility resident, regardless of payment
6 source, which will include the day of admission and exclude the day of
7 discharge; except that, when admission and discharge occur on the same
8 day, one day of care shall be deemed to exist. A "medicaid day" or
9 "recipient day" means a calendar day of care provided to a medicaid
10 recipient determined eligible by the department for services provided
11 under chapter 74.09 RCW, subject to the same conditions regarding
12 admission and discharge applicable to a patient day or resident day of
13 care.

14 (~~(41)~~) (42) "Professionally designated real estate appraiser"
15 means an individual who is regularly engaged in the business of
16 providing real estate valuation services for a fee, and who is deemed
17 qualified by a nationally recognized real estate appraisal educational
18 organization on the basis of extensive practical appraisal experience,
19 including the writing of real estate valuation reports as well as the
20 passing of written examinations on valuation practice and theory, and
21 who by virtue of membership in such organization is required to
22 subscribe and adhere to certain standards of professional practice as
23 such organization prescribes.

24 (~~(42)~~) (43) "Qualified therapist" means:

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

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

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

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

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

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

1 (~~(43)~~) (44) "Rate" or "rate allocation" means the medicaid per-
2 patient-day payment amount for medicaid patients calculated in
3 accordance with the allocation methodology set forth in part E of this
4 chapter.

5 (~~(44)~~) (45) "Real property," whether leased or owned by the
6 contractor, means the building, allowable land, land improvements, and
7 building improvements associated with a nursing facility.

8 (~~(45)~~) (46) "Rebased rate" or "cost-rebased rate" means a
9 facility-specific component rate assigned to a nursing facility for a
10 particular rate period established on desk-reviewed, adjusted costs
11 reported for that facility covering at least six months of a prior
12 calendar year designated as a year to be used for cost-rebasing payment
13 rate allocations under the provisions of this chapter.

14 (~~(46)~~) (47) "Records" means those data supporting all financial
15 statements and cost reports including, but not limited to, all general
16 and subsidiary ledgers, books of original entry, and transaction
17 documentation, however such data are maintained.

18 (~~(47)~~) (48) "Related organization" means an entity which is under
19 common ownership and/or control with, or has control of, or is
20 controlled by, the contractor.

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

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

28 (~~(48)~~) (49) "Related care" means only those services that are
29 directly related to providing direct care to nursing facility
30 residents. These services include, but are not limited to, nursing
31 direction and supervision, medical direction, medical records, pharmacy
32 services, activities, and social services.

33 (~~(49)~~) (50) "Resident assessment instrument," including federally
34 approved modifications for use in this state, means a federally
35 mandated, comprehensive nursing facility resident care planning and
36 assessment tool, consisting of the minimum data set and resident
37 assessment protocols.

38 (~~(50)~~) (51) "Resident assessment protocols" means those
39 components of the resident assessment instrument that use the minimum

1 data set to trigger or flag a resident's potential problems and risk
2 areas.

3 ~~((+51+))~~ (52) "Resource utilization groups" means a case mix
4 classification system that identifies relative resources needed to care
5 for an individual nursing facility resident.

6 ~~((+52+))~~ (53) "Restricted fund" means those funds the principal
7 and/or income of which is limited by agreement with or direction of the
8 donor to a specific purpose.

9 ~~((+53+))~~ (54) "Secretary" means the secretary of the department of
10 social and health services.

11 ~~((+54+))~~ (55) "Support services" means food, food preparation,
12 dietary, housekeeping, and laundry services provided to nursing
13 facility residents.

14 ~~((+55+))~~ (56) "Therapy care" means those services required by a
15 nursing facility resident's comprehensive assessment and plan of care,
16 that are provided by qualified therapists, or support personnel under
17 their supervision, including related costs as designated by the
18 department.

19 ~~((+56+))~~ (57) "Title XIX" or "medicaid" means the 1965 amendments
20 to the social security act, P.L. 89-07, as amended and the medicaid
21 program administered by the department.

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

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

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

34 (3) The facility will return to the department any overpayment
35 amounts in each of the direct care, therapy care, and support services
36 rate components that the department identifies following the audit and
37 settlement procedures as described in this chapter, provided that the
38 contractor may retain any overpayment that does not exceed 1.0% of the

1 facility's direct care, therapy care, and support services component
2 rate. However, no overpayments may be retained in a cost center to
3 which savings have been shifted to cover a deficit, as provided in
4 subsection (4) of this section. Facilities that are not in substantial
5 compliance for more than ninety days, and facilities that provide
6 substandard quality of care at any time, during the period for which
7 settlement is being calculated, will not be allowed to retain any
8 amount of overpayment in the facility's direct care, therapy care, and
9 support services component rate. The terms "not in substantial
10 compliance" and "substandard quality of care" shall be defined by
11 federal survey regulations.

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

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

38 (6) RCW 74.46.150 through 74.46.180, and rules adopted by the
39 department prior to July 1, 1998, shall continue to govern the medicaid

1 settlement process for periods prior to October 1, 1998, as if these
2 statutes and rules remained in full force and effect.

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

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

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

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

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

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

24 (c) Costs associated with a capital expenditure subject to section
25 1122 approval (part 100, Title 42 C.F.R.) if the department found it
26 was not consistent with applicable standards, criteria, or plans. If
27 the department was not given timely notice of a proposed capital
28 expenditure, all associated costs will be unallowable up to the date
29 they are determined to be reimbursable under applicable federal
30 regulations;

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

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

- 1 (f) Salaries or other compensation of owners, officers, directors,
2 stockholders, partners, principals, participants, and others associated
3 with the contractor or its home office, including all board of
4 directors' fees for any purpose, except reasonable compensation paid
5 for service related to patient care;
- 6 (g) Costs in excess of limits or in violation of principles set
7 forth in this chapter;
- 8 (h) Costs resulting from transactions or the application of
9 accounting methods which circumvent the principles of the payment
10 system set forth in this chapter;
- 11 (i) Costs applicable to services, facilities, and supplies
12 furnished by a related organization in excess of the lower of the cost
13 to the related organization or the price of comparable services,
14 facilities, or supplies purchased elsewhere;
- 15 (j) Bad debts of non-Title XIX recipients. Bad debts of Title XIX
16 recipients are allowable if the debt is related to covered services, it
17 arises from the recipient's required contribution toward the cost of
18 care, the provider can establish that reasonable collection efforts
19 were made, the debt was actually uncollectible when claimed as
20 worthless, and sound business judgment established that there was no
21 likelihood of recovery at any time in the future;
- 22 (k) Charity and courtesy allowances;
- 23 (l) Cash, assessments, or other contributions, excluding dues, to
24 charitable organizations, professional organizations, trade
25 associations, or political parties, and costs incurred to improve
26 community or public relations;
- 27 (m) Vending machine expenses;
- 28 (n) Expenses for barber or beautician services not included in
29 routine care;
- 30 (o) Funeral and burial expenses;
- 31 (p) Costs of gift shop operations and inventory;
- 32 (q) Personal items such as cosmetics, smoking materials, newspapers
33 and magazines, and clothing, except those used in patient activity
34 programs;
- 35 (r) Fund-raising expenses, except those directly related to the
36 patient activity program;
- 37 (s) Penalties and fines;
- 38 (t) Expenses related to telephones, (~~televisions~~) radios, and
39 similar appliances in patients' private accommodations;

1 (u) Televisions acquired prior to July 1, 2001;
2 (v) Federal, state, and other income taxes;
3 ~~((v))~~ (w) Costs of special care services except where authorized
4 by the department;
5 ~~((w))~~ (x) Expenses of an employee benefit not in fact made
6 available to all employees on an equal or fair basis, for example, key-
7 man insurance and other insurance or retirement plans;
8 ~~((x))~~ (y) Expenses of profit-sharing plans;
9 ~~((y))~~ (z) Expenses related to the purchase and/or use of private
10 or commercial airplanes which are in excess of what a prudent
11 contractor would expend for the ordinary and economic provision of such
12 a transportation need related to patient care;
13 ~~((z))~~ (aa) Personal expenses and allowances of owners or
14 relatives;
15 ~~((aa))~~ (bb) All expenses of maintaining professional licenses or
16 membership in professional organizations;
17 ~~((bb))~~ (cc) Costs related to agreements not to compete;
18 ~~((ee))~~ (dd) Amortization of goodwill, lease acquisition, or any
19 other intangible asset, whether related to resident care or not, and
20 whether recognized under generally accepted accounting principles or
21 not;
22 ~~((dd))~~ (ee) Expenses related to vehicles which are in excess of
23 what a prudent contractor would expend for the ordinary and economic
24 provision of transportation needs related to patient care;
25 ~~((ee))~~ (ff) Legal and consultant fees in connection with a fair
26 hearing against the department where a decision is rendered in favor of
27 the department or where otherwise the determination of the department
28 stands;
29 ~~((ff))~~ (gg) Legal and consultant fees of a contractor or
30 contractors in connection with a lawsuit against the department;
31 ~~((gg))~~ (hh) Lease acquisition costs, goodwill, the cost of bed
32 rights, or any other intangible assets;
33 ~~((hh))~~ (ii) All rental or lease costs other than those provided
34 in RCW 74.46.300 on and after January 1, 1985;
35 ~~((ii))~~ (jj) Postsurvey charges incurred by the facility as a
36 result of subsequent inspections under RCW 18.51.050 which occur beyond
37 the first postsurvey visit during the certification survey calendar
38 year;

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

9 (~~(kk)~~) (ll) For all partial or whole rate periods after July 17,
10 1984, costs of land and depreciable assets that cannot be reimbursed
11 under the Deficit Reduction Act of 1984 and implementing state
12 statutory and regulatory provisions;

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

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

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

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

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

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

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

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

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

1 (~~(uu)~~) (vv) Outside consultation expenses required to meet
2 department-required minimum data set completion proficiency;
3 (~~(vv)~~) (ww) Interest charges assessed by any department or agency
4 of this state for failure to make a timely refund of overpayments and
5 interest expenses incurred for loans obtained to make the refunds;
6 (~~(ww)~~) (xx) All home office or central office costs, whether on
7 or off the nursing facility premises, and whether allocated or not to
8 specific services, in excess of the median of those adjusted costs for
9 all facilities reporting such costs for the most recent report period;
10 and
11 (~~(xx)~~) (yy) Tax expenses that a nursing facility has never
12 incurred.

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

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

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

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

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

32 (4)(~~(a)~~) ~~The statewide average payment rate for the capital portion~~
33 ~~of the rate for any state fiscal year under the nursing facility~~
34 ~~medicaid payment system, weighted by patient days, shall not exceed the~~
35 ~~annual statewide weighted average nursing facility payment rate for the~~
36 ~~capital portion of the rate identified for that fiscal year in the~~
37 ~~biennial appropriations act.~~

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

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

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

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

33 (1) Effective July 1, 1999, nursing facility medicaid payment rate
34 allocations shall be facility-specific and shall have seven components:
35 Direct care, therapy care, support services, operations, property,
36 financing allowance, and variable return. The department shall
37 establish and adjust each of these components, as provided in this

1 section and elsewhere in this chapter, for each medicaid nursing
2 facility in this state.

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

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

12 (4)(a) Direct care component rate allocations shall be established
13 using adjusted cost report data covering at least six months. Adjusted
14 cost report data from 1996 will be used for October 1, 1998, through
15 June 30, 2001, direct care component rate allocations; adjusted cost
16 report data from 1999 will be used for July 1, 2001, through June 30,
17 2004, direct care component rate allocations.

18 (b) Direct care component rate allocations based on 1996 cost
19 report data shall be adjusted annually for economic trends and
20 conditions by a factor or factors defined in the biennial
21 appropriations act. A different economic trends and conditions
22 adjustment factor or factors may be defined in the biennial
23 appropriations act for facilities whose direct care component rate is
24 set equal to their adjusted June 30, 1998, rate, as provided in RCW
25 74.46.506(5)(k).

26 (c) Direct care component rate allocations based on 1999 cost
27 report data shall be adjusted annually for economic trends and
28 conditions by a factor or factors defined in the biennial
29 appropriations act. A different economic trends and conditions
30 adjustment factor or factors may be defined in the biennial
31 appropriations act for facilities whose direct care component rate is
32 set equal to their adjusted June 30, 1998, rate, as provided in RCW
33 74.46.506(5)(k).

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

1 (b) Therapy care 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 (6)(a) Support services component rate allocations shall be
5 established using adjusted cost report data covering at least six
6 months. Adjusted cost report data from 1996 shall be used for October
7 1, 1998, through June 30, 2001, support services component rate
8 allocations; adjusted cost report data from 1999 shall be used for July
9 1, 2001, through June 30, 2004, support services component rate
10 allocations.

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

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

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

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

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

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

36 (11) The department shall establish in rule procedures, principles,
37 and conditions for determining component rate allocations for
38 facilities in circumstances not directly addressed by this chapter,
39 including but not limited to: The need to prorate inflation for

1 partial-period cost report data, newly constructed facilities, existing
2 facilities entering the medicaid program for the first time or after a
3 period of absence from the program, existing facilities with expanded
4 new bed capacity, existing medicaid facilities following a change of
5 ownership of the nursing facility business, facilities banking beds or
6 converting beds back into service, facilities having less than six
7 months of either resident assessment, cost report data, or both, under
8 the current contractor prior to rate setting, and other circumstances.

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

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

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

19 (a) The variable return array and percentage ((assigned at the
20 October 1, 1998, rate setting shall remain in effect until June 30,
21 2001)) shall be assigned whenever rebasing of noncapital rate
22 allocations is scheduled under RCW 46.46.431 (4), (5), (6), and (7).

23 (b) To calculate the array of facilities for the July 1, 2001, rate
24 setting, the department, without using peer groups, shall first rank
25 all facilities in numerical order from highest to lowest according to
26 each facility's examined and documented, but unlidged, combined direct
27 care, therapy care, support services, and operations per resident day
28 cost from the 1999 cost report period. However, before being combined
29 with other per resident day costs and ranked, a facility's direct care
30 cost per resident day shall be adjusted to reflect its facility average
31 case mix index, to be averaged from the four calendar quarters of 1999,
32 weighted by the facility's resident days from each quarter, under RCW
33 74.46.501(7)(b)(ii). The array shall then be divided into four
34 quartiles, each containing, as nearly as possible, an equal number of
35 facilities, and four percent shall be assigned to facilities in the
36 lowest quartile, three percent to facilities in the next lowest
37 quartile, two percent to facilities in the next highest quartile, and
38 one percent to facilities in the highest quartile.

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

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

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

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

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

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

36 (4) For the purpose of calculating a nursing facility's property
37 component rate, if a contractor elects to bank licensed beds or to
38 convert banked beds to active service, under chapter 70.38 RCW, the

1 department shall use the facility's anticipated resident occupancy
2 level subsequent to the decrease or increase in licensed bed capacity.
3 However, in no case shall the department use less than eighty-five
4 percent occupancy of the facility's licensed bed capacity after banking
5 or conversion.

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

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

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

16 (2) The financing allowance shall be determined by multiplying the
17 net invested funds of each facility by .10, and dividing by the greater
18 of a nursing facility's total resident days from the most recent cost
19 report period or resident days calculated on eighty-five percent
20 facility occupancy. However, assets acquired on or after May 17, 1999,
21 shall be grouped in a separate financing allowance calculation that
22 shall be multiplied by .085. The financing allowance factor of .085
23 shall not be applied to the net invested funds pertaining to new
24 construction or major renovations receiving certificate of need
25 approval or an exemption from certificate of need requirements under
26 chapter 70.38 RCW, or to working drawings that have been submitted to
27 the department of health for construction review approval, prior to May
28 17, 1999. If a capitalized addition or retirement of an asset will
29 result in a different licensed bed capacity during the ensuing period,
30 the prior period total resident days used in computing the financing
31 allowance shall be adjusted to the greater of the anticipated resident
32 day level or eighty-five percent of the new licensed bed capacity.

33 (3) In computing the portion of net invested funds representing the
34 net book value of tangible fixed assets, the same assets, depreciation
35 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,
36 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,
37 shall be utilized, except that the capitalized cost of land upon which
38 the facility is located and such other contiguous land which is

1 reasonable and necessary for use in the regular course of providing
2 resident care shall also be included. Subject to provisions and
3 limitations contained in this chapter, for land purchased by owners or
4 lessors before July 18, 1984, capitalized cost of land shall be the
5 buyer's capitalized cost. For all partial or whole rate periods after
6 July 17, 1984, if the land is purchased after July 17, 1984,
7 capitalized cost shall be that of the owner of record on July 17, 1984,
8 or buyer's capitalized cost, whichever is lower. In the case of leased
9 facilities where the net invested funds are unknown or the contractor
10 is unable to provide necessary information to determine net invested
11 funds, the secretary shall have the authority to determine an amount
12 for net invested funds based on an appraisal conducted according to RCW
13 74.46.360(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (b) The facility average case mix index used to establish each
39 nursing facility's direct care component rate shall be based on an

1 average of calendar quarters of the facility's average case mix
2 indexes.

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

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

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

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

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

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

35 (3) The department may question the accuracy of assessment data for
36 any resident and utilize corrected or substitute information, however
37 derived, in determining direct care component rates. The department is
38 authorized to impose civil fines and to take adverse rate actions

1 against a contractor, as specified by the department in rule, in order
2 to obtain compliance with resident assessment and data transmission
3 requirements and to ensure accuracy.

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

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

13 (a) Reduce total direct care costs reported by each nursing
14 facility for the applicable cost report period specified in RCW
15 74.46.431(4)(a) to reflect any department adjustments, and to eliminate
16 reported resident therapy costs and adjustments, in order to derive the
17 facility's total allowable direct care cost;

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

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

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

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

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

1 (g) Except as provided in (k) of this subsection, from October 1,
2 1998, through June 30, 2000, determine each facility's quarterly direct
3 care component rate as follows:

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

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

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

26 (h) Except as provided in (k) of this subsection, from July 1,
27 2000, through June 30, 2002, determine each facility's quarterly direct
28 care component rate as follows:

29 (i) Any facility whose allowable cost per case mix unit is less
30 than ninety percent of the facility's peer group median established
31 under (f) of this subsection shall be assigned a cost per case mix unit
32 equal to ninety percent of the facility's peer group median, and shall
33 have a direct care component rate allocation equal to the facility's
34 assigned cost per case mix unit multiplied by that facility's medicaid
35 average case mix index from the applicable quarter specified in RCW
36 74.46.501(7)(c);

37 (ii) Any facility whose allowable cost per case mix unit is greater
38 than one hundred ten percent of the peer group median established under
39 (f) of this subsection shall be assigned a cost per case mix unit equal

1 to one hundred ten percent of the peer group median, and shall have a
2 direct care component rate allocation equal to the facility's assigned
3 cost per case mix unit multiplied by that facility's medicaid average
4 case mix index from the applicable quarter specified in RCW
5 74.46.501(7)(c);

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

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

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

22 (ii) Any facility whose allowable cost per case mix unit is greater
23 than one hundred five percent of the peer group median established
24 under (f) of this subsection shall be assigned a cost per case mix unit
25 equal to one hundred five percent of the peer group median, and shall
26 have a direct care component rate allocation equal to the facility's
27 assigned cost per case mix unit multiplied by that facility's medicaid
28 average case mix index from the applicable quarter specified in RCW
29 74.46.501(7)(c);

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

36 (j) Beginning July 1, 2004, determine each facility's quarterly
37 direct care component rate by multiplying the facility's peer group
38 median allowable direct care cost per case mix unit by that facility's

1 medicaid average case mix index from the applicable quarter as
2 specified in RCW 74.46.501(7)(c).

3 (k)(i) Between October 1, 1998, and June 30, 2000, the department
4 shall compare each facility's direct care component rate allocation
5 calculated under (g) of this subsection with the facility's nursing
6 services component rate in effect on September 30, 1998, less therapy
7 costs, plus any exceptional care offsets as reported on the cost
8 report, adjusted for economic trends and conditions as provided in RCW
9 74.46.431. A facility shall receive the higher of the two rates;

10 (ii) Between July 1, 2000, and June 30, 2002, the department shall
11 compare each facility's direct care component rate allocation
12 calculated under (h) of this subsection with the facility's direct care
13 component rate in effect on June 30, 2000. A facility shall receive
14 the higher of the two rates. Between July 1, 2001, and June 30, 2002,
15 if during any quarter a facility whose rate paid under (h) of this
16 subsection is greater than the direct care rate in effect on June 30,
17 2000, the facility shall be paid in that and each subsequent quarter
18 pursuant to (h) of this subsection and shall not be entitled to the
19 greater of the two rates.

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

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

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

32 Upon the death of a resident with a personal fund deposited with
33 the facility, the facility must convey within (~~forty-five~~) thirty
34 days the resident's funds, and a final accounting of those funds, to
35 the individual or probate jurisdiction administering the resident's
36 estate; but in the case of a resident who received long-term care
37 services paid in whole or in part by the department, the funds and
38 accounting shall be sent to the state of Washington, department of

1 social and health services, office of financial recovery. The
2 department shall establish a release procedure for use for burial
3 expenses.

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

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

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

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

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

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

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

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

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

33 (1) By December 1, 1998, the department of social and health
34 services shall study and provide recommendations to the chairs of the
35 house of representatives appropriations and health care committees, and
36 the senate ways and means and health and long-term care committees,

1 concerning options for changing the method for paying facilities for
2 capital and property related expenses.

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

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

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

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

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

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

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

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

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

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

16 (f) Cost no more than the rate system in place as assumed in the
17 2001-2003 omnibus appropriations act adopted during the 2001
18 legislative session.

19 (3) To mitigate potential impacts that the expiration of the
20 current hold harmless system may have on the direct care rate, the
21 study must also:

22 (a) Consider increasing minimum occupancy standards;

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

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

28 NEW SECTION. **Sec. 16.** The department of social and health
29 services shall work together with interested parties, including
30 representatives from the industry and legislators, to develop a
31 proposed rate system that meets the requirements set forth in RCW
32 74.46.165. While the department is encouraged to identify and present
33 to the legislature several alternatives, the department shall identify
34 the alternative that best meets the goals set forth in RCW 74.46.165.
35 All alternatives developed by the department must be made available to
36 the legislature and to interested parties no later than October 31,
37 2001. For each alternative, the department shall also calculate a
38 system of shadow rates that shows what the facility rate is for fiscal

1 year 2002, the direct care costs reflected in the 1999 cost reports,
2 what the payments would be in fiscal year 2002 if the alternative were
3 in effect at that time, what the payments would be in fiscal year 2003
4 under the current system, and what the payments would be in fiscal year
5 2003 under the alternative. The rate information must be made
6 available to the legislature and to all interested parties not later
7 than November 15, 2001.

8 NEW SECTION. **Sec. 17.** RCW 74.46.908 (Repealer) and 1999 c 353 s
9 17 are each repealed.

10 NEW SECTION. **Sec. 18.** RCW 74.46.506 (Direct care component rate
11 allocations--Determination--Quarterly updates--Fines) and 1999 c 353 s
12 5, 1999 c 181 s 1, & 1998 c 322 s 25 are each repealed.

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

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

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

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

--- END ---