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HOUSE BILL 2792

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State of Washington

57th Legislature

2002 Regular Session

By Representatives Edwards, Skinner, Campbell, Casada, Linville, Bush, Conway, Carrell, Clements, Morell, Pflug, Woods and Chase

Read first time 01/28/2002. Referred to Committee on Appropriations.

1 AN ACT Relating to medicaid nursing home rates; and amending RCW  
2 74.46.020, 74.46.410, 74.46.431, 74.46.433, 74.46.435, 74.46.437,  
3 74.46.506, and 74.46.521.

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

5 **Sec. 1.** RCW 74.46.020 and 2001 1st sp.s. c 8 s 1 are each amended  
6 to read as follows:

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

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

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

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

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

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

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

22 (7) "Beneficial owner" means:

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

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

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

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

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

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

1 (ii) Through the conversion of an ownership interest;  
2 (iii) Pursuant to the power to revoke a trust, discretionary  
3 account, or similar arrangement; or  
4 (iv) Pursuant to the automatic termination of a trust,  
5 discretionary account, or similar arrangement;  
6 except that, any person who acquires an ownership interest or power  
7 specified in (c)(i), (ii), or (iii) of this subsection with the purpose  
8 or effect of changing or influencing the control of the contractor, or  
9 in connection with or as a participant in any transaction having such  
10 purpose or effect, immediately upon such acquisition shall be deemed to  
11 be the beneficial owner of the ownership interest which may be acquired  
12 through the exercise or conversion of such ownership interest or power;  
13 (d) Any person who in the ordinary course of business is a pledgee  
14 of ownership interest under a written pledge agreement shall not be  
15 deemed to be the beneficial owner of such pledged ownership interest  
16 until the pledgee has taken all formal steps necessary which are  
17 required to declare a default and determines that the power to vote or  
18 to direct the vote or to dispose or to direct the disposition of such  
19 pledged ownership interest will be exercised; except that:  
20 (i) The pledgee agreement is bona fide and was not entered into  
21 with the purpose nor with the effect of changing or influencing the  
22 control of the contractor, nor in connection with any transaction  
23 having such purpose or effect, including persons meeting the conditions  
24 set forth in (b) of this subsection; and  
25 (ii) The pledgee agreement, prior to default, does not grant to the  
26 pledgee:  
27 (A) The power to vote or to direct the vote of the pledged  
28 ownership interest; or  
29 (B) The power to dispose or direct the disposition of the pledged  
30 ownership interest, other than the grant of such power(s) pursuant to  
31 a pledge agreement under which credit is extended and in which the  
32 pledgee is a broker or dealer.  
33 (8) "Capitalization" means the recording of an expenditure as an  
34 asset.  
35 (9) "Case mix" means a measure of the intensity of care and  
36 services needed by the residents of a nursing facility or a group of  
37 residents in the facility.  
38 (10) "Case mix index" means a number representing the average case  
39 mix of a nursing facility.

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

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

10 (13) "Contractor" means a person or entity licensed under chapter  
11 18.51 RCW to operate a medicare and medicaid certified nursing  
12 facility, responsible for operational decisions, and contracting with  
13 the department to provide services to medicaid recipients residing in  
14 the facility.

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

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

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

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

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

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

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

37 (21) (~~"Essential community provider" means a facility which is the~~  
38 ~~only nursing facility within a commuting distance radius of at least~~  
39 ~~forty minutes duration, traveling by automobile.~~

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

7       ~~((23))~~ (22) "Fair market value" means the replacement cost of an  
8 asset less observed physical depreciation on the date for which the  
9 market value is being determined.

10       ~~((24))~~ (23) "Financial statements" means statements prepared and  
11 presented in conformity with generally accepted accounting principles  
12 including, but not limited to, balance sheet, statement of operations,  
13 statement of changes in financial position, and related notes.

14       ~~((25))~~ (24) "Generally accepted accounting principles" means  
15 accounting principles approved by the financial accounting standards  
16 board (FASB).

17       ~~((26))~~ (25) "Goodwill" means the excess of the price paid for a  
18 nursing facility business over the fair market value of all net  
19 identifiable tangible and intangible assets acquired, as measured in  
20 accordance with generally accepted accounting principles.

21       ~~((27))~~ (26) "Grouper" means a computer software product that  
22 groups individual nursing facility residents into case mix  
23 classification groups based on specific resident assessment data and  
24 computer logic.

25       ~~((28))~~ (27) "High labor-cost county" means an urban county in  
26 which the median allowable facility cost per case mix unit is more than  
27 ten percent higher than the median allowable facility cost per case mix  
28 unit among all other urban counties, excluding that county.

29       ~~((29))~~ (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       ~~((30))~~ (29) "Home and central office costs" means costs that are  
33 incurred in the support and operation of a home and central office.  
34 Home and central office costs include centralized services that are  
35 performed in support of a nursing facility. The department may exclude  
36 from this definition costs that are nonduplicative, documented,  
37 ordinary, necessary, and related to the provision of care services to  
38 authorized patients.

1       (~~(31)~~) (30) "Imprest fund" means a fund which is regularly  
2 replenished in exactly the amount expended from it.

3       (~~(32)~~) (31) "Joint facility costs" means any costs which  
4 represent resources which benefit more than one facility, or one  
5 facility and any other entity.

6       (~~(33)~~) (32) "Lease agreement" means a contract between two  
7 parties for the possession and use of real or personal property or  
8 assets for a specified period of time in exchange for specified  
9 periodic payments. Elimination (due to any cause other than death or  
10 divorce) or addition of any party to the contract, expiration, or  
11 modification of any lease term in effect on January 1, 1980, or  
12 termination of the lease by either party by any means shall constitute  
13 a termination of the lease agreement. An extension or renewal of a  
14 lease agreement, whether or not pursuant to a renewal provision in the  
15 lease agreement, shall be considered a new lease agreement. A strictly  
16 formal change in the lease agreement which modifies the method,  
17 frequency, or manner in which the lease payments are made, but does not  
18 increase the total lease payment obligation of the lessee, shall not be  
19 considered modification of a lease term.

20       (~~(34)~~) (33) "Medical care program" or "medicaid program" means  
21 medical assistance, including nursing care, provided under RCW  
22 74.09.500 or authorized state medical care services.

23       (~~(35)~~) (34) "Medical care recipient," "medicaid recipient," or  
24 "recipient" means an individual determined eligible by the department  
25 for the services provided under chapter 74.09 RCW.

26       (~~(36)~~) (35) "Minimum data set" means the overall data component  
27 of the resident assessment instrument, indicating the strengths, needs,  
28 and preferences of an individual nursing facility resident.

29       (~~(37)~~) (36) "Net book value" means the historical cost of an  
30 asset less accumulated depreciation.

31       (~~(38)~~) (37) "Net invested funds" means the net book value of  
32 tangible fixed assets employed by a contractor to provide services  
33 under the medical care program, including land, buildings, and  
34 equipment as recognized and measured in conformity with generally  
35 accepted accounting principles.

36       (~~(39)~~) (38) "Nonurban county" means a county which is not located  
37 in a metropolitan statistical area as determined and defined by the  
38 United States office of management and budget or other appropriate  
39 agency or office of the federal government.

1       (~~(40)~~) (39) "Operating lease" means a lease under which rental or  
2 lease expenses are included in current expenses in accordance with  
3 generally accepted accounting principles.

4       (~~(41)~~) (40) "Owner" means a sole proprietor, general or limited  
5 partners, members of a limited liability company, and beneficial  
6 interest holders of five percent or more of a corporation's outstanding  
7 stock.

8       (~~(42)~~) (41) "Ownership interest" means all interests beneficially  
9 owned by a person, calculated in the aggregate, regardless of the form  
10 which such beneficial ownership takes.

11       (~~(43)~~) (42) "Patient day" or "resident day" means a calendar day  
12 of care provided to a nursing facility resident, regardless of payment  
13 source, which will include the day of admission and exclude the day of  
14 discharge; except that, when admission and discharge occur on the same  
15 day, one day of care shall be deemed to exist. A "medicaid day" or  
16 "recipient day" means a calendar day of care provided to a medicaid  
17 recipient determined eligible by the department for services provided  
18 under chapter 74.09 RCW, subject to the same conditions regarding  
19 admission and discharge applicable to a patient day or resident day of  
20 care.

21       (~~(44)~~) (43) "Professionally designated real estate appraiser"  
22 means an individual who is regularly engaged in the business of  
23 providing real estate valuation services for a fee, and who is deemed  
24 qualified by a nationally recognized real estate appraisal educational  
25 organization on the basis of extensive practical appraisal experience,  
26 including the writing of real estate valuation reports as well as the  
27 passing of written examinations on valuation practice and theory, and  
28 who by virtue of membership in such organization is required to  
29 subscribe and adhere to certain standards of professional practice as  
30 such organization prescribes.

31       (~~(45)~~) (44) "Qualified therapist" means:

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

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

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

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

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

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

7 (~~(46)~~) (45) "Rate" or "rate allocation" means the medicaid per-  
8 patient-day payment amount for medicaid patients calculated in  
9 accordance with the allocation methodology set forth in part E of this  
10 chapter.

11 (~~(47)~~) (46) "Real property," whether leased or owned by the  
12 contractor, means the building, allowable land, land improvements, and  
13 building improvements associated with a nursing facility.

14 (~~(48)~~) (47) "Rebased rate" or "cost-rebased rate" means a  
15 facility-specific component rate assigned to a nursing facility for a  
16 particular rate period established on desk-reviewed, adjusted costs  
17 reported for that facility covering at least six months of a prior  
18 calendar year designated as a year to be used for cost-rebasing payment  
19 rate allocations under the provisions of this chapter.

20 (~~(49)~~) (48) "Records" means those data supporting all financial  
21 statements and cost reports including, but not limited to, all general  
22 and subsidiary ledgers, books of original entry, and transaction  
23 documentation, however such data are maintained.

24 (~~(50)~~) (49) "Related organization" means an entity which is under  
25 common ownership and/or control with, or has control of, or is  
26 controlled by, the contractor.

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

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

34 (~~(51)~~) (50) "Related care" means only those services that are  
35 directly related to providing direct care to nursing facility  
36 residents. These services include, but are not limited to, nursing  
37 direction and supervision, medical direction, medical records, pharmacy  
38 services, activities, and social services.



1       (~~(52)~~) (51) "Resident assessment instrument," including federally  
2 approved modifications for use in this state, means a federally  
3 mandated, comprehensive nursing facility resident care planning and  
4 assessment tool, consisting of the minimum data set and resident  
5 assessment protocols.

6       (~~(53)~~) (52) "Resident assessment protocols" means those  
7 components of the resident assessment instrument that use the minimum  
8 data set to trigger or flag a resident's potential problems and risk  
9 areas.

10       (~~(54)~~) (53) "Resource utilization groups" means a case mix  
11 classification system that identifies relative resources needed to care  
12 for an individual nursing facility resident.

13       (~~(55)~~) (54) "Restricted fund" means those funds the principal  
14 and/or income of which is limited by agreement with or direction of the  
15 donor to a specific purpose.

16       (~~(56)~~) (55) "Secretary" means the secretary of the department of  
17 social and health services.

18       (~~(57)~~) (56) "Support services" means food, food preparation,  
19 dietary, housekeeping, and laundry services provided to nursing  
20 facility residents.

21       (~~(58)~~) (57) "Therapy care" means those services required by a  
22 nursing facility resident's comprehensive assessment and plan of care,  
23 that are provided by qualified therapists, or support personnel under  
24 their supervision, including related costs as designated by the  
25 department.

26       (~~(59)~~) (58) "Title XIX" or "medicaid" means the 1965 amendments  
27 to the social security act, P.L. 89-07, as amended and the medicaid  
28 program administered by the department.

29       (~~(60)~~) (59) "Urban county" means a county which is located in a  
30 metropolitan statistical area as determined and defined by the United  
31 States office of management and budget or other appropriate agency or  
32 office of the federal government.

33       **Sec. 2.** RCW 74.46.410 and 2001 1st sp.s. c 8 s 3 are each amended  
34 to read as follows:

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

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

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

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

11 (c) Costs associated with a capital expenditure subject to section  
12 1122 approval (part 100, Title 42 C.F.R.) if the department found it  
13 was not consistent with applicable standards, criteria, or plans. If  
14 the department was not given timely notice of a proposed capital  
15 expenditure, all associated costs will be unallowable up to the date  
16 they are determined to be reimbursable under applicable federal  
17 regulations;

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

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

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

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

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

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

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

8 (k) Charity and courtesy allowances;

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

13 (m) Vending machine expenses;

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

16 (o) Funeral and burial expenses;

17 (p) Costs of gift shop operations and inventory;

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

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

23 (s) Penalties and fines;

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

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

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

28 (w) Costs of special care services except where authorized by the  
29 department;

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

33 (y) Expenses of profit-sharing plans;

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

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

1 (bb) All expenses of maintaining professional licenses or  
2 membership in professional organizations;

3 (cc) Costs related to agreements not to compete;

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

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

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

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

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

18 (~~(ii)~~) (~~All rental or lease costs other than those provided in RCW~~  
19 ~~74.46.300 on and after January 1, 1985;~~

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

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

31 (~~(ll)~~) (kk) For all partial or whole rate periods after July 17,  
32 1984, costs of land and depreciable assets that cannot be reimbursed  
33 under the Deficit Reduction Act of 1984 and implementing state  
34 statutory and regulatory provisions;

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

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

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

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

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

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

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

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

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

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

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

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

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

37       **Sec. 3.** RCW 74.46.431 and 2001 1st sp.s. c 8 s 5 are each amended  
38 to read as follows:

1 (1) Effective July 1, 1999, nursing facility medicaid payment rate  
2 allocations shall be facility-specific and shall have seven components:  
3 Direct care, therapy care, support services, operations, property,  
4 financing allowance, and variable return. The department shall  
5 establish and adjust each of these components, as provided in this  
6 section and elsewhere in this chapter, for each medicaid nursing  
7 facility in this state.

8 (2) All component rate allocations (~~((for essential community  
9 providers as defined in this chapter))~~) shall be based upon a minimum  
10 facility occupancy of eighty-five percent of licensed beds, regardless  
11 of how many beds are set up or in use. (~~(For all facilities other than  
12 essential community providers, effective July 1, 2001, component rate  
13 allocations in direct care, therapy care, support services, variable  
14 return, operations, property, and financing allowance shall continue to  
15 be based upon a minimum facility occupancy of eighty five percent of  
16 licensed beds. For all facilities other than essential community  
17 providers, effective July 1, 2002, the component rate allocations in  
18 operations, property, and financing allowance shall be based upon a  
19 minimum facility occupancy of ninety percent of licensed beds,  
20 regardless of how many beds are set up or in use.))~~)

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

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

33 (b) Direct care component rate allocations based on 1996 cost  
34 report data shall be adjusted annually for economic trends and  
35 conditions by a factor or factors defined in the biennial  
36 appropriations act. A different economic trends and conditions  
37 adjustment factor or factors may be defined in the biennial  
38 appropriations act for facilities whose direct care component rate is

1 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
2 74.46.506(5)(i).

3 (c) Direct care component rate allocations based on 1999 cost  
4 report data shall be adjusted annually for economic trends and  
5 conditions by a factor or factors defined in the biennial  
6 appropriations act. A different economic trends and conditions  
7 adjustment factor or factors may be defined in the biennial  
8 appropriations act for facilities whose direct care component rate is  
9 set equal to their adjusted June 30, 1998, rate, as provided in RCW  
10 74.46.506(5)(i).

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

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

20 (6)(a) Support services component rate allocations shall be  
21 established using adjusted cost report data covering at least six  
22 months. Adjusted cost report data from 1996 shall be used for October  
23 1, 1998, through June 30, 2001, support services component rate  
24 allocations; adjusted cost report data from 1999 shall be used for July  
25 1, 2001, through June 30, 2004, support services component rate  
26 allocations.

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

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

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

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

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

11 (10) Medicaid contractors shall pay to all facility staff a minimum  
12 wage of the greater of the state minimum wage or the federal minimum  
13 wage.

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

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

32 (13) (~~Effective July 1, 2001, medicaid rates shall continue to be~~  
33 ~~revised downward in all components, in accordance with department~~  
34 ~~rules, for facilities converting banked beds to active service under~~  
35 ~~chapter 70.38 RCW, by using the facility's increased licensed bed~~  
36 ~~capacity to recalculate minimum occupancy for rate setting. However,~~  
37 ~~for facilities other than essential community providers which bank beds~~  
38 ~~under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be~~  
39 ~~revised upward, in accordance with department rules, in direct care,~~



1 ~~therapy care, support services, and variable return components only, by~~  
2 ~~using the facility's decreased licensed bed capacity to recalculate~~  
3 ~~minimum occupancy for rate setting, but no upward revision shall be~~  
4 ~~made to operations, property, or financing allowance component rates.~~

5 (14)) Facilities obtaining a certificate of need or a certificate  
6 of need exemption under chapter 70.38 RCW after June 30, 2001, must  
7 have a certificate of capital authorization in order for (a) the  
8 depreciation resulting from the capitalized addition to be included in  
9 calculation of the facility's property component rate allocation; and  
10 (b) the net invested funds associated with the capitalized addition to  
11 be included in calculation of the facility's financing allowance rate  
12 allocation.

13 **Sec. 4.** RCW 74.46.433 and 2001 1st sp.s. c 8 s 6 are each amended  
14 to read as follows:

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

18 (a) The variable return array and percentage shall be assigned  
19 whenever rebasing of noncapital rate allocations is scheduled under RCW  
20 (~~46.46.431~~ [74.46.431]) 74.46.431 (4), (5), (6), and (7).

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

37 (c) The department shall(~~, subject to (d) of this subsection,~~)  
38 compute the variable return allowance by multiplying a facility's

1 assigned percentage by the sum of the facility's direct care, therapy  
2 care, support services, and operations component rates determined in  
3 accordance with this chapter and rules adopted by the department.

4 ~~((d) Effective July 1, 2001, if a facility's examined and  
5 documented direct care cost per resident day for the preceding report  
6 year is lower than its average direct care component rate weighted by  
7 medicaid resident days for the same year, the facility's direct care  
8 cost shall be substituted for its July 1, 2001, direct care component  
9 rate, and its variable return component rate shall be determined or  
10 adjusted each July 1st by multiplying the facility's assigned  
11 percentage by the sum of the facility's July 1, 2001, therapy care,  
12 support services, and operations component rates, and its direct care  
13 cost per resident day for the preceding year.))~~

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

17 **Sec. 5.** RCW 74.46.435 and 2001 1st sp.s. c 8 s 7 are each amended  
18 to read as follows:

19 (1) ~~((Effective July 1, 2001,))~~ The property component rate  
20 allocation for each facility shall be determined by dividing the sum of  
21 the reported allowable prior period actual depreciation, subject to RCW  
22 74.46.310 through 74.46.380, adjusted for any capitalized additions or  
23 replacements approved by the department, and the retained savings from  
24 such cost center, by the greater of a facility's total resident days  
25 for the facility in the prior period or resident days as calculated on  
26 eighty-five percent facility occupancy. ~~((Effective July 1, 2002, the  
27 property component rate allocation for all facilities, except essential  
28 community providers, shall be set by using the greater of a facility's  
29 total resident days from the most recent cost report period or resident  
30 days calculated at ninety percent facility occupancy.))~~ If a  
31 capitalized addition or retirement of an asset will result in a  
32 different licensed bed capacity during the ensuing period, the prior  
33 period total resident days used in computing the property component  
34 rate shall be adjusted to anticipated resident day level.

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

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

5 (4) ~~((Effective July 1, 2001,))~~ For the purpose of calculating a  
6 nursing facility's property component rate, if a contractor ~~((has~~  
7 ~~elected))~~ elects to bank licensed beds prior to April 1, 2001, or  
8 elects to convert banked beds to active service at any time, under  
9 chapter 70.38 RCW, the department shall use the facility's ~~((new~~  
10 ~~licensed bed capacity to recalculate minimum occupancy for rate setting~~  
11 ~~and revise the property component rate, as needed, effective as of the~~  
12 ~~date the beds are banked or converted to active service))~~ anticipated  
13 resident occupancy level subsequent to the decrease or increase in  
14 licensed bed capacity. However, in no case shall the department use  
15 less than eighty-five percent occupancy of the facility's licensed bed  
16 capacity after banking or conversion. ~~((Effective July 1, 2002, in no~~  
17 ~~case, other than essential community providers, shall the department~~  
18 ~~use less than ninety percent occupancy of the facility's licensed bed~~  
19 ~~capacity after conversion.))~~

20 (5) The property 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 **Sec. 6.** RCW 74.46.437 and 2001 1st sp.s. c 8 s 8 are each amended  
24 to read as follows:

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

30 (2) ~~((Effective July 1, 2001,))~~ The financing allowance shall be  
31 determined by multiplying the net invested funds of each facility by  
32 .10, and dividing by the greater of a nursing facility's total resident  
33 days from the most recent cost report period or resident days  
34 calculated on eighty-five percent facility occupancy. ~~((Effective July~~  
35 ~~1, 2002, the financing allowance component rate allocation for all~~  
36 ~~facilities, other than essential community providers, shall be set by~~  
37 ~~using the greater of a facility's total resident days from the most~~  
38 ~~recent cost report period or resident days calculated at ninety percent~~

1 ~~facility occupancy.))~~ However, assets acquired on or after May 17,  
2 1999, shall be grouped in a separate financing allowance calculation  
3 that shall be multiplied by .085. The financing allowance factor of  
4 .085 shall not be applied to the net invested funds pertaining to new  
5 construction or major renovations receiving certificate of need  
6 approval or an exemption from certificate of need requirements under  
7 chapter 70.38 RCW, or to working drawings that have been submitted to  
8 the department of health for construction review approval, prior to May  
9 17, 1999. If a capitalized addition, renovation, replacement, or  
10 retirement of an asset will result in a different licensed bed capacity  
11 during the ensuing period, the prior period total resident days used in  
12 computing the financing allowance shall be adjusted to the greater of  
13 the anticipated resident day level or eighty-five percent of the new  
14 licensed bed capacity. ~~((Effective July 1, 2002, for all facilities,  
15 other than essential community providers, the total resident days used  
16 to compute the financing allowance after a capitalized addition,  
17 renovation, replacement, or retirement of an asset shall be set by  
18 using the greater of a facility's total resident days from the most  
19 recent cost report period or resident days calculated at ninety percent  
20 facility occupancy.))~~

21 (3) In computing the portion of net invested funds representing the  
22 net book value of tangible fixed assets, the same assets, depreciation  
23 bases, lives, and methods referred to in RCW 74.46.330, 74.46.350,  
24 74.46.360, 74.46.370, and 74.46.380, including owned and leased assets,  
25 shall be utilized, except that the capitalized cost of land upon which  
26 the facility is located and such other contiguous land which is  
27 reasonable and necessary for use in the regular course of providing  
28 resident care shall also be included. Subject to provisions and  
29 limitations contained in this chapter, for land purchased by owners or  
30 lessors before July 18, 1984, capitalized cost of land shall be the  
31 buyer's capitalized cost. For all partial or whole rate periods after  
32 July 17, 1984, if the land is purchased after July 17, 1984,  
33 capitalized cost shall be that of the owner of record on July 17, 1984,  
34 or buyer's capitalized cost, whichever is lower. In the case of leased  
35 facilities where the net invested funds are unknown or the contractor  
36 is unable to provide necessary information to determine net invested  
37 funds, the secretary shall have the authority to determine an amount  
38 for net invested funds based on an appraisal conducted according to RCW  
39 74.46.360(1).

1       (4) (~~Effective July 1, 2001,~~) For the purpose of calculating a  
2 nursing facility's financing allowance component rate, if a contractor  
3 (~~has elected~~) elects to bank licensed beds (~~prior to May 25, 2001,~~)  
4 or elects to convert banked beds to active service (~~at any time~~),  
5 under chapter 70.38 RCW, the department shall use the facility's (~~new~~  
6 ~~licensed bed capacity to recalculate minimum occupancy for rate setting~~  
7 ~~and revise the financing allowance component rate, as needed, effective~~  
8 ~~as of the date the beds are banked or converted to active service~~)  
9 anticipated resident occupancy level subsequent to the decrease or  
10 increase in licensed bed capacity. However, in no case shall the  
11 department use less than eighty-five percent occupancy of the  
12 facility's licensed bed capacity after banking or conversion.  
13 (~~Effective July 1, 2002, in no case, other than for essential~~  
14 ~~community providers, shall the department use less than ninety percent~~  
15 ~~occupancy of the facility's licensed bed capacity after conversion.~~)

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

19       **Sec. 7.** RCW 74.46.506 and 2001 1st sp.s. c 8 s 10 are each amended  
20 to read as follows:

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

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

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

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

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

17 (a) Reduce total direct care costs reported by each nursing  
18 facility for the applicable cost report period specified in RCW  
19 74.46.431(4)(a) to reflect any department adjustments, and to eliminate  
20 reported resident therapy costs and adjustments, in order to derive the  
21 facility's total allowable direct care cost;

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

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

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

35 (e) Effective for July 1, 2001, rate setting, divide nursing  
36 facilities into at least two and, if applicable, three peer groups:  
37 Those located in nonurban counties; those located in high labor-cost  
38 counties, if any; and those located in other urban counties;

1 (f) Array separately the allowable direct care cost per case mix  
2 unit for all facilities in nonurban counties; for all facilities in  
3 high labor-cost counties, if applicable; and for all facilities in  
4 other urban counties, including the high labor-cost counties, and  
5 determine the median allowable direct care cost per case mix unit for  
6 each peer group;

7 (g) Except as provided in (i) of this subsection, from October 1,  
8 1998, through June 30, 2000, determine each facility's quarterly direct  
9 care component rate as follows:

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

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

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

32 (h) Except as provided in (i) of this subsection, from July 1,  
33 2000, forward, and for all future rate setting, determine each  
34 facility's quarterly direct care component rate as follows:

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

1 assigned cost per case mix unit multiplied by that facility's medicaid  
2 average case mix index from the applicable quarter specified in RCW  
3 74.46.501(7)(c);

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

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

18 (i)(i) Between October 1, 1998, and June 30, 2000, the department  
19 shall compare each facility's direct care component rate allocation  
20 calculated under (g) of this subsection with the facility's nursing  
21 services component rate in effect on September 30, 1998, less therapy  
22 costs, plus any exceptional care offsets as reported on the cost  
23 report, adjusted for economic trends and conditions as provided in RCW  
24 74.46.431. A facility shall receive the higher of the two rates.

25 (ii) Between July 1, 2000, and June 30, 2002, the department shall  
26 compare each facility's direct care component rate allocation  
27 calculated under (h) of this subsection with the facility's direct care  
28 component rate in effect on June 30, 2000. A facility shall receive  
29 the higher of the two rates. Between July 1, 2001, and June 30, 2002,  
30 if during any quarter a facility whose rate paid under (h) of this  
31 subsection is greater than either the direct care rate in effect on  
32 June 30, 2000, or than that facility's allowable direct care cost per  
33 case mix unit calculated in (d) of this subsection multiplied by that  
34 facility's medicaid average case mix index from the applicable quarter  
35 specified in RCW 74.46.501(7)(c), the facility shall be paid in that  
36 and each subsequent quarter pursuant to (h) of this subsection and  
37 shall not be entitled to the greater of the two rates.

38 (iii) Effective July 1, 2002, all direct care component rate  
39 allocations shall be as determined under (h) of this subsection.



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

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

11 **Sec. 8.** RCW 74.46.521 and 2001 1st sp.s. c 8 s 13 are each amended  
12 to read as follows:

13 (1) The operations component rate allocation corresponds to the  
14 general operation of a nursing facility for one resident for one day,  
15 including but not limited to management, administration, utilities,  
16 office supplies, accounting and bookkeeping, minor building  
17 maintenance, minor equipment repairs and replacements, and other  
18 supplies and services, exclusive of direct care, therapy care, support  
19 services, property, financing allowance, and variable return.

20 (2) Beginning October 1, 1998, the department shall determine each  
21 medicaid nursing facility's operations component rate allocation using  
22 cost report data specified by RCW 74.46.431(7)(a). ~~((Effective July 1,  
23 2002, operations component rates for all facilities except essential  
24 community providers shall be based upon a minimum occupancy of ninety  
25 percent of licensed beds, and no operations component rate shall be  
26 revised in response to beds banked on or after May 25, 2001, under  
27 chapter 70.38 RCW.))~~

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

30 (a) Array facilities' adjusted general operations costs per  
31 adjusted resident day for each facility from facilities' cost reports  
32 from the applicable report year, for facilities located within urban  
33 counties and for those located within nonurban counties and determine  
34 the median adjusted cost for each peer group;

35 (b) Set each facility's operations component rate at the lower of:

36 (i) The facility's per resident day adjusted operations costs from  
37 the applicable cost report period adjusted if necessary to a minimum

1 occupancy of eighty-five percent of licensed beds (~~before July 1,~~  
2 ~~2002, and ninety percent effective July 1, 2002~~); or

3 (ii) The adjusted median per resident day general operations cost  
4 for that facility's peer group, urban counties or nonurban counties;  
5 and

6 (c) Adjust each facility's operations component rate for economic  
7 trends and conditions as provided in RCW 74.46.431(7)(b).

8 (4) The operations component rate allocations calculated in  
9 accordance with this section shall be adjusted to the extent necessary  
10 to comply with RCW 74.46.421.

--- END ---