CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 2242

Chapter 8, Laws of 2001

(partial veto)

57th Legislature
2001 First Special Legislative Session

MEDICAID NURSING HOME RATES

EFFECTIVE DATE: 7/1/01 - Except section 20, which becomes effective 6/29/01.

Passed by the House May 24, 2001
Yeas 77 Nays 19

FRANK CHOPP
Speaker of the House of Representatives

CLYDE BALLARD
Speaker of the House of Representatives

Passed by the Senate May 24, 2001
Yeas 33 Nays 11

BRAD OWEN
President of the Senate

Approved June 11, 2001, with the exception of section 19, which is vetoed.

GARY LOCKE
Governor of the State of Washington

CERTIFICATE

We, Timothy A. Martin and Cynthia Zehnder, Co-Chief Clerks of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 2242** as passed by the House of Representatives and the Senate on the dates hereon set forth.

CYNTHIA ZEHNDER
Chief Clerk

TIMOTHY A. MARTIN
Chief Clerk

FILED

June 11, 2001 - 3:08 p.m.

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 2242

AS AMENDED BY THE SENATE

Passed Legislature - 2001 First Special Session

State of Washington 57th Legislature 2001 First Special Session

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

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

AN ACT Relating to medicaid nursing home rates; amending RCW 74.46.020, 74.46.165, 74.46.410, 74.46.421, 74.46.431, 74.46.433, 74.46.435, 74.46.437, 74.46.501, 74.46.515, 74.46.521, 74.46.711, and 70.38.115; amending 1998 c 322 s 47 (uncodified); reenacting and amending RCW 74.46.506 and 74.46.511; adding new sections to chapter 74.46 RCW; creating a new section; repealing RCW 74.46.908; providing effective dates; providing an expiration date; and declaring an emergency.

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

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

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

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

(2) "Appraisal" means the process of estimating the fair market value or reconstructing the historical cost of an asset acquired in a

past period as performed by a professionally designated real estate appraiser with no pecuniary interest in the property to be appraised. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

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

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

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

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

(7) "Beneficial owner" means:

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

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

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

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

of a plan or scheme to evade the reporting requirements of this chapter;

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

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

(ii) Through the conversion of an ownership interest;

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

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

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

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

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

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

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

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

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

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

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

((~~(11)~~)) (10) "Case mix index" means a number representing the average case mix of a nursing facility.

((~~(12)~~)) (11) "Case mix weight" means a numeric score that identifies the relative resources used by a particular group of a nursing facility's residents.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

((~~(28)~~)) (30) "Home and central office costs" means costs that are incurred in the support and operation of a home and central office. Home and central office costs include centralized services that are performed in support of a nursing facility. The department may exclude from this definition costs that are nonduplicative, documented, ordinary, necessary, and related to the provision of care services to authorized patients.

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

((~~(29)~~)) (32) "Joint facility costs" means any costs which represent resources which benefit more than one facility, or one facility and any other entity.

((~~(30)~~)) (33) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination (due to any cause other than death or divorce) or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not pursuant to a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease payments are made, but does not increase the total lease payment obligation of the lessee, shall not be considered modification of a lease term.

((~~(31)~~)) (34) "Medical care program" or "medicaid program" means medical assistance, including nursing care, provided under RCW 74.09.500 or authorized state medical care services.

((~~(32)~~)) (35) "Medical care recipient," "medicaid recipient," or "recipient" means an individual determined eligible by the department for the services provided under chapter 74.09 RCW.

((~~(33)~~)) (36) "Minimum data set" means the overall data component of the resident assessment instrument, indicating the strengths, needs, and preferences of an individual nursing facility resident.

((~~(34)~~)) (37) "Net book value" means the historical cost of an asset less accumulated depreciation.

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

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

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

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

((~~(38)~~)) (41) "Owner" means a sole proprietor, general or limited partners, members of a limited liability company, and beneficial interest holders of five percent or more of a corporation's outstanding stock.

((~~(39)~~)) (42) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form which such beneficial ownership takes.

((~~(40)~~)) (43) "Patient day" or "resident day" means a calendar day of care provided to a nursing facility resident, regardless of payment source, which will include the day of admission and exclude the day of discharge; except that, when admission and discharge occur on the same day, one day of care shall be deemed to exist. A "medicaid day" or "recipient day" means a calendar day of care provided to a medicaid recipient determined eligible by the department for services provided under chapter 74.09 RCW, subject to the same conditions regarding admission and discharge applicable to a patient day or resident day of care.

((~~(41)~~)) (44) "Professionally designated real estate appraiser" means an individual who is regularly engaged in the business of providing real estate valuation services for a fee, and who is deemed qualified by a nationally recognized real estate appraisal educational organization on the basis of extensive practical appraisal experience,

including the writing of real estate valuation reports as well as the passing of written examinations on valuation practice and theory, and who by virtue of membership in such organization is required to subscribe and adhere to certain standards of professional practice as such organization prescribes.

((~~(42)~~)) (45) "Qualified therapist" means:

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

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

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

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

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

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

((~~(43)~~)) (46) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in part E of this chapter.

((~~(44)~~)) (47) "Real property," whether leased or owned by the contractor, means the building, allowable land, land improvements, and building improvements associated with a nursing facility.

((~~(45)~~)) (48) "Rebased rate" or "cost-rebased rate" means a facility-specific component rate assigned to a nursing facility for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of a prior calendar year designated as a year to be used for cost-rebasing payment rate allocations under the provisions of this chapter.

((~~(46)~~)) (49) "Records" means those data supporting all financial statements and cost reports including, but not limited to, all general and subsidiary ledgers, books of original entry, and transaction documentation, however such data are maintained.

((~~(47)~~)) (50) "Related organization" means an entity which is under common ownership and/or control with, or has control of, or is controlled by, the contractor.

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

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

((~~(48)~~)) (51) "Related care" means only those services that are directly related to providing direct care to nursing facility residents. These services include, but are not limited to, nursing direction and supervision, medical direction, medical records, pharmacy services, activities, and social services.

((~~(49)~~)) (52) "Resident assessment instrument," including federally approved modifications for use in this state, means a federally mandated, comprehensive nursing facility resident care planning and assessment tool, consisting of the minimum data set and resident assessment protocols.

((~~(50)~~)) (53) "Resident assessment protocols" means those components of the resident assessment instrument that use the minimum data set to trigger or flag a resident's potential problems and risk areas.

((~~(51)~~)) (54) "Resource utilization groups" means a case mix classification system that identifies relative resources needed to care for an individual nursing facility resident.

((~~(52)~~)) (55) "Restricted fund" means those funds the principal and/or income of which is limited by agreement with or direction of the donor to a specific purpose.

((~~(53)~~)) (56) "Secretary" means the secretary of the department of social and health services.

((~~(54)~~)) (57) "Support services" means food, food preparation, dietary, housekeeping, and laundry services provided to nursing facility residents.

((~~(55)~~)) (58) "Therapy care" means those services required by a nursing facility resident's comprehensive assessment and plan of care, that are provided by qualified therapists, or support personnel under

their supervision, including related costs as designated by the department.

((~~(56)~~)) (59) "Title XIX" or "medicaid" means the 1965 amendments to the social security act, P.L. 89-07, as amended and the medicaid program administered by the department.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of the cost

to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere;

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

(k) Charity and courtesy allowances;

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

(m) Vending machine expenses;

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

(o) Funeral and burial expenses;

(p) Costs of gift shop operations and inventory;

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

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

(s) Penalties and fines;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(5)~~))(a) The statewide average payment rate ((~~for the noncapital portion of the rate~~)) for any state fiscal year under the nursing facility payment system, weighted by patient days, shall not exceed the

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

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

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

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

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

minimum facility occupancy of ninety percent of licensed beds, regardless of how many beds are set up or in use.

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded

new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities temporarily reducing the number of set-up beds during a remodel, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

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

(13) Effective July 1, 2001, medicaid rates shall continue to be revised downward in all components, in accordance with department rules, for facilities converting banked beds to active service under chapter 70.38 RCW, by using the facility's increased licensed bed capacity to recalculate minimum occupancy for rate setting. However, for facilities other than essential community providers which bank beds under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be revised upward, in accordance with department rules, in direct care, therapy care, support services, and variable return components only, by using the facility's decreased licensed bed capacity to recalculate minimum occupancy for rate setting, but no upward revision shall be made to operations, property, or financing allowance component rates.

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

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

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

(a) The variable return array and percentage ((~~assigned at the October 1, 1998, rate setting shall remain in effect until June 30,~~

~~2001~~)) shall be assigned whenever rebasing of noncapital rate allocations is scheduled under RCW 46.46.431 (4), (5), (6), and (7).

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

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

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

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

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

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

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

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

(4) Effective July 1, 2001, for the purpose of calculating a nursing facility's property component rate, if a contractor ((~~elects~~)) has elected to bank licensed beds prior to April 1, 2001, or elects to convert banked beds to active service at any time, under chapter 70.38 RCW, the department shall use the facility's ((~~anticipated resident occupancy level subsequent to the decrease or increase in licensed bed capacity~~)) new licensed bed capacity to recalculate minimum occupancy for rate setting and revise the property component rate, as needed, effective as of the date the beds are banked or converted to active service. However, in no case shall the department use less than

eighty-five percent occupancy of the facility's licensed bed capacity after banking or conversion. Effective July 1, 2002, in no case, other than essential community providers, shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after conversion.

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

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

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

(2) Effective July 1, 2001, the financing allowance shall be determined by multiplying the net invested funds of each facility by .10, and dividing by the greater of a nursing facility's total resident days from the most recent cost report period or resident days calculated on eighty-five percent facility occupancy. Effective July 1, 2002, the financing allowance component rate allocation for all facilities, other than essential community providers, shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy. However, assets acquired on or after May 17, 1999, shall be grouped in a separate financing allowance calculation that shall be multiplied by .085. The financing allowance factor of .085 shall not be applied to the net invested funds pertaining to new construction or major renovations receiving certificate of need approval or an exemption from certificate of need requirements under chapter 70.38 RCW, or to working drawings that have been submitted to the department of health for construction review approval, prior to May 17, 1999. If a capitalized addition, renovation, replacement, or retirement of an asset will result in a different licensed bed capacity during the ensuing period, the prior period total resident days used in computing the financing allowance shall be adjusted to the greater of the anticipated resident day level or eighty-five percent of the new licensed bed capacity. Effective July 1, 2002, for all facilities,

other than essential community providers, the total resident days used to compute the financing allowance after a capitalized addition, renovation, replacement, or retirement of an asset shall be set by using the greater of a facility's total resident days from the most recent cost report period or resident days calculated at ninety percent facility occupancy.

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

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

providers, shall the department use less than ninety percent occupancy of the facility's licensed bed capacity after conversion.

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

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

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

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

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

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

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

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

(ii) If a resident's significant change, quarterly, or annual assessment is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in

subsection (5) of this section, the start date shall be the date the assessment is completed;

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

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

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

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

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

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

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

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

assessment. The threshold is calculated by dividing ((~~the~~)) a facility's count of ((~~unique minimum data set assessments~~)) residents being assessed by the average census for ((~~each~~)) the facility. A daily census shall be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department shall use the facility's licensed beds as the denominator in computing the threshold.

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

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

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

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

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

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

(1) The direct care component rate allocation corresponds to the provision of nursing care for one resident of a nursing facility for one day, including direct care supplies. Therapy services and

supplies, which correspond to the therapy care component rate, shall be excluded. The direct care component rate includes elements of case mix determined consistent with the principles of this section and other applicable provisions of this chapter.

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

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

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

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

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

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

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

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

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

(e) Effective for July 1, 2001, rate setting, divide nursing facilities into at least two and, if applicable, three peer groups: Those located in ((~~metropolitan statistical areas as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government, and those not located in a metropolitan statistical area~~)) nonurban counties; those located in high labor-cost counties, if any; and those located in other urban counties;

(f) Array separately the allowable direct care cost per case mix unit for all ((~~metropolitan statistical area and for all nonmetropolitan statistical area facilities~~)) facilities in nonurban counties, for all facilities in high labor-cost counties, if applicable; and for all facilities in other urban counties, and determine the median allowable direct care cost per case mix unit for each peer group;

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

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

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

shall have a direct care component rate allocation equal to the facility's assigned cost per case mix unit multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c);

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

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

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

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

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

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

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

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

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

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

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

(ii) Between July 1, 2000, and June 30, 2002, the department shall compare each facility's direct care component rate allocation calculated under (h) of this subsection with the facility's direct care component rate in effect on June 30, 2000. A facility shall receive the higher of the two rates. Between July 1, 2001, and June 30, 2002,

if during any quarter a facility whose rate paid under (h) of this subsection is greater than either the direct care rate in effect on June 30, 2000, or than that facility's allowable direct care cost per case mix unit calculated in (d) of this subsection multiplied by that facility's medicaid average case mix index from the applicable quarter specified in RCW 74.46.501(7)(c), the facility shall be paid in that and each subsequent quarter pursuant to (h) of this subsection and shall not be entitled to the greater of the two rates.

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

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

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

Sec. 11. RCW 74.46.511 and 1999 c 353 s 6 and 1999 c 181 s 3 are each reenacted and amended to read as follows:

(1) The therapy care component rate allocation corresponds to the provision of medicaid one-on-one therapy provided by a qualified therapist as defined in this chapter, including therapy supplies and therapy consultation, for one day for one medicaid resident of a nursing facility. The therapy care component rate allocation for October 1, 1998, through June 30, 2001, shall be based on adjusted therapy costs and days from calendar year 1996. The therapy component rate allocation for July 1, 2001, through June 30, 2004, shall be based on adjusted therapy costs and days from calendar year 1999. The therapy care component rate shall be adjusted for economic trends and conditions as specified in RCW 74.46.431(5)(b), and shall be determined in accordance with this section.

(2) In rebasing, as provided in RCW 74.46.431(5)(a), the department shall take from the cost reports of facilities the following reported information:

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

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

(c) Therapy consulting expenses for all residents.

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

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

(a) Those facilities located within ((~~a metropolitan statistical area~~)) urban counties; and

(b) Those ((~~not~~)) located ((~~in a metropolitan statistical area~~)) within nonurban counties.

((~~Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States office of management and budget or other applicable federal office.~~)) The department shall array the facilities in each peer group from highest to lowest based on their total cost per unit of therapy for each therapy type. The department shall determine the median total cost per unit of therapy for each therapy type and add ten percent of median total cost per unit of therapy. The cost per unit of therapy for each therapy type at a nursing facility shall be the lesser of its cost per unit of therapy for each therapy type or the median total cost per unit plus ten percent for each therapy type for its peer group.

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

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

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

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

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

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

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

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

(7) The therapy care component rate shall be suspended for medicaid residents in qualified nursing facilities designated by the department who are receiving therapy paid by the department outside the facility daily rate under RCW 74.46.508(2).

Sec. 12. RCW 74.46.515 and 1999 c 353 s 7 are each amended to read as follows:

(1) The support services component rate allocation corresponds to the provision of food, food preparation, dietary, housekeeping, and laundry services for one resident for one day.

(2) Beginning October 1, 1998, the department shall determine each medicaid nursing facility's support services component rate allocation using cost report data specified by RCW 74.46.431(6).

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

(a) Array facilities' adjusted support services costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within ((~~a metropolitan statistical area~~)) urban counties, and for those ((~~not~~)) located ((~~in any metropolitan statistical area~~)) within nonurban counties and determine the median adjusted cost for each peer group;

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

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

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

Sec. 13. RCW 74.46.521 and 1999 c 353 s 8 are each amended to read as follows:

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

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

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

(a) Array facilities' adjusted general operations costs per adjusted resident day for each facility from facilities' cost reports from the applicable report year, for facilities located within ((~~a metropolitan statistical area~~)) urban counties and for those ((~~not~~)) located ((~~in a metropolitan statistical area~~)) within nonurban counties and determine the median adjusted cost for each peer group;

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

(i) The facility's per resident day adjusted operations costs from the applicable cost report period adjusted if necessary to a minimum occupancy of eighty-five percent of licensed beds before July 1, 2002, and ninety percent effective July 1, 2002; or

(ii) The adjusted median per resident day general operations cost for that facility's peer group, ((~~metropolitan statistical area~~)) urban counties or ((~~nonmetropolitan statistical area~~)) nonurban counties; and

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

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

Sec. 14. RCW 74.46.711 and 1995 1st sp.s. c 18 s 69 are each amended to read as follows:

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within ((~~forty-five~~)) thirty days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; but in the case of a resident who received long-term care services paid in whole or in part by the department, the funds and accounting shall be sent to the state of Washington, department of social and health services, office of financial recovery. The department shall establish a release procedure for use for burial expenses.

NEW SECTION. **Sec. 15.** A new section is added to chapter 74.46 RCW to read as follows:

The total capital authorization available for any biennial period shall be specified in the biennial appropriations act and shall be calculated on an annual basis. When setting the capital authorization

level, the legislature shall consider both the need for, and the cost of, new and replacement beds.

NEW SECTION. **Sec. 16.** A new section is added to chapter 74.46 RCW to read as follows:

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

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

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

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

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

NEW SECTION. **Sec. 17.** The joint legislative task force on nursing homes is hereby created.

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

(2) The task force shall:

(a) Consider reports from nursing home organizations, consumers of long-term care services, and the department of social and health services on key issues in the delivery of nursing home care in various areas of the state;

(b) Assess the alternative approaches for linking case-mix scores with service hours and costs developed in accordance with section 18 of this act;

(c) Approve the proposed study plans, and review the reports on nursing home access, quality of care, quality of resident life, and employee wage and benefit levels, which are to be submitted in accordance with section 18 of this act;

(d) Review the report which is to be prepared in accordance with section 18 of this act on the need for additional case mix groupings and weights; and

(e) Consider the evaluation of rebasing alternatives conducted in accordance with section 18 of this act.

(3) The task force shall complete its review and submit its recommendations to the appropriate policy and fiscal committees of the legislature by December 1, 2003.

(4) This section expires December 31, 2003.

Sec. 18. 1998 c 322 s 47 (uncodified) is amended to read as follows:

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

(2) The department of social and health services shall contract with an independent and recognized organization to study and evaluate the impacts of chapter 74.46 RCW implementation on access, quality of care, quality of life for nursing facility residents, and the wage and benefit levels of all nursing facility employees. The contractor shall submit a preliminary report of findings, and recommendations for further study, to the joint legislative task force on nursing homes by December 1, 2001. The department and contractor shall incorporate the task force's recommendations into the final evaluation plan, and submit interim reports on findings and recommendations to the task force by October 1, 2002, and July 1, 2003. The department ((~~shall require,~~)) and the contractor shall submit((~~,~~)) a final report with the results of this study and evaluation, including their findings and

recommendations, to the governor and legislature by ((~~December~~)) October 1, ((~~2001~~)) 2003.

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

(4) By ((~~December 12~~)) July 1, 2002, the department of social and health services shall report to the ((~~legislature~~)) joint legislative task force on nursing homes and provide an evaluation of the fiscal impact of rebasing future payments at different intervals, including the impact of averaging two years' cost data as the basis for rebasing. This report shall include the fiscal impact to the state and the fiscal impact to nursing facility providers.

(5) By December 1, 2001, the department of social and health services shall report to the joint legislative task force on nursing homes on alternative approaches for using client acuity to establish direct care rates. The alternatives shall link acuity, as measured by case mix, to the number of hours of service estimated to be provided for each client, and shall multiply those estimated service hours by standard wage and benefit rates which account for differences in direct care labor costs in various areas of the state. The alternatives reviewed shall provide cost controls and incentives at least equal to the current rate-setting system, and shall not contain automatic cost increases, automatic indexing, hold harmless provisions, or mandatory future rebasing of costs.

Sec. 19. RCW 70.38.115 and 1996 c 178 s 22 are each amended to read as follows:

(1) Certificates of need shall be issued, denied, suspended, or revoked by the designee of the secretary in accord with the provisions

of this chapter and rules of the department which establish review procedures and criteria for the certificate of need program.

(2) Criteria for the review of certificate of need applications, except as provided in subsection (3) of this section for health maintenance organizations, shall include but not be limited to consideration of the following:

(a) The need that the population served or to be served by such services has for such services;

(b) The availability of less costly or more effective alternative methods of providing such services;

(c) The financial feasibility and the probable impact of the proposal on the cost of and charges for providing health services in the community to be served;

(d) In the case of health services to be provided, (i) the availability of alternative uses of project resources for the provision of other health services, (ii) the extent to which such proposed services will be accessible to all residents of the area to be served, and (iii) the need for and the availability in the community of services and facilities for osteopathic physicians and surgeons and allopathic physicians and their patients. The department shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathic medicine and surgery and medicine at the student, internship, and residency training levels;

(e) In the case of a construction project, the costs and methods of the proposed construction, including the cost and methods of energy provision, and the probable impact of the construction project reviewed (i) on the cost of providing health services by the person proposing such construction project and (ii) on the cost and charges to the public of providing health services by other persons;

(f) The special needs and circumstances of osteopathic hospitals, nonallopathic services and children's hospitals;

(g) Improvements or innovations in the financing and delivery of health services which foster cost containment and serve to promote quality assurance and cost-effectiveness;

(h) In the case of health services proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

(i) In the case of existing services or facilities, the quality of care provided by such services or facilities in the past;

(j) In the case of hospital certificate of need applications, whether the hospital meets or exceeds the regional average level of charity care, as determined by the secretary; and

(k) In the case of nursing home applications:

(i) The availability of other nursing home beds in the planning area to be served; and

(ii) The availability of other services in the community to be served. Data used to determine the availability of other services will include but not be limited to data provided by the department of social and health services.

(3) A certificate of need application of a health maintenance organization or a health care facility which is controlled, directly or indirectly, by a health maintenance organization, shall be approved by the department if the department finds:

(a) Approval of such application is required to meet the needs of the members of the health maintenance organization and of the new members which such organization can reasonably be expected to enroll; and

(b) The health maintenance organization is unable to provide, through services or facilities which can reasonably be expected to be available to the organization, its health services in a reasonable and cost-effective manner which is consistent with the basic method of operation of the organization and which makes such services available on a long-term basis through physicians and other health professionals associated with it.

A health care facility, or any part thereof, with respect to which a certificate of need was issued under this subsection may not be sold or leased and a controlling interest in such facility or in a lease of such facility may not be acquired unless the department issues a certificate of need approving the sale, acquisition, or lease.

(4) Until the final expiration of the state health plan as provided under RCW 70.38.919, the decision of the department on a certificate of need application shall be consistent with the state health plan in effect, except in emergency circumstances which pose a threat to the public health. The department in making its final decision may issue a conditional certificate of need if it finds that the project is justified only under specific circumstances. The conditions shall

directly relate to the project being reviewed. The conditions may be released if it can be substantiated that the conditions are no longer valid and the release of such conditions would be consistent with the purposes of this chapter.

(5) Criteria adopted for review in accordance with subsection (2) of this section may vary according to the purpose for which the particular review is being conducted or the type of health service reviewed.

(6) The department shall specify information to be required for certificate of need applications. Within fifteen days of receipt of the application, the department shall request additional information considered necessary to the application or start the review process. Applicants may decline to submit requested information through written notice to the department, in which case review starts on the date of receipt of the notice. Applications may be denied or limited because of failure to submit required and necessary information.

(7) Concurrent review is for the purpose of comparative analysis and evaluation of competing or similar projects in order to determine which of the projects may best meet identified needs. Categories of projects subject to concurrent review include at least new health care facilities, new services, and expansion of existing health care facilities. The department shall specify time periods for the submission of applications for certificates of need subject to concurrent review, which shall not exceed ninety days. Review of concurrent applications shall start fifteen days after the conclusion of the time period for submission of applications subject to concurrent review. Concurrent review periods shall be limited to one hundred fifty days, except as provided for in rules adopted by the department authorizing and limiting amendment during the course of the review, or for an unresolved pivotal issue declared by the department.

(8) Review periods for certificate of need applications other than those subject to concurrent review shall be limited to ninety days. Review periods may be extended up to thirty days if needed by a review agency, and for unresolved pivotal issues the department may extend up to an additional thirty days. A review may be extended in any case if the applicant agrees to the extension.

(9) The department or its designee, shall conduct a public hearing on a certificate of need application if requested unless the review is expedited or subject to emergency review. The department by rule shall

specify the period of time within which a public hearing must be requested and requirements related to public notice of the hearing, procedures, recordkeeping and related matters.

(10)(a) Any applicant denied a certificate of need or whose certificate of need has been suspended or revoked has the right to an adjudicative proceeding. The proceeding is governed by chapter 34.05 RCW, the Administrative Procedure Act.

(b) Any health care facility or health maintenance organization that: (i) Provides services similar to the services provided by the applicant and under review pursuant to this subsection; (ii) is located within the applicant's health service area; and (iii) testified or submitted evidence at a public hearing held pursuant to subsection (9) of this section, shall be provided an opportunity to present oral or written testimony and argument in a proceeding under this subsection: PROVIDED, That the health care facility or health maintenance organization had, in writing, requested to be informed of the department's decisions.

(c) If the department desires to settle with the applicant prior to the conclusion of the adjudicative proceeding, the department shall so inform the health care facility or health maintenance organization and afford them an opportunity to comment, in advance, on the proposed settlement.

(11) An amended certificate of need shall be required for the following modifications of an approved project:

(a) A new service requiring review under this chapter;

(b) An expansion of a service subject to review beyond that originally approved;

(c) An increase in bed capacity;

(d) A significant reduction in the scope of a nursing home project without a commensurate reduction in the cost of the nursing home project, or a cost increase (as represented in bids on a nursing home construction project or final cost estimates acceptable to the person to whom the certificate of need was issued) if the total of such increases exceeds twelve percent or fifty thousand dollars, whichever is greater, over the maximum capital expenditure approved. The review of reductions or cost increases shall be restricted to the continued conformance of the nursing home project with the review criteria pertaining to financial feasibility and cost containment.

(12) An application for a certificate of need for a nursing home capital expenditure which is determined by the department to be required to eliminate or prevent imminent safety hazards or correct violations of applicable licensure and accreditation standards shall be approved.

(13)(a) Replacement of existing nursing home beds in the same planning area by an existing licensee who has operated the beds for at least one year shall not require a certificate of need under this chapter. The licensee shall give written notice of its intent to replace the existing nursing home beds to the department and shall provide the department with information as may be required pursuant to rule. Replacement of the beds by a party other than the licensee is subject to certificate of need review under this chapter, except as otherwise permitted by subsection (14) of this section.

(b) When an entire nursing home ceases operation, the licensee or any other party who has secured an interest in the beds may reserve his or her interest in the beds for eight years or until a certificate of need to replace them is issued, whichever occurs first. However, the nursing home, licensee, or any other party who has secured an interest in the beds must give notice of its intent to retain the beds to the department of health no later than thirty days after the effective date of the facility's closure. Certificate of need review shall be required for any party who has reserved the nursing home beds except that the need criteria shall be deemed met when the applicant is the licensee who had operated the beds for at least one year, who has operated the beds for at least one year immediately preceding the reservation of the beds, and who is replacing the beds in the same planning area.

(14) In the event that a licensee, who has provided the department with notice of his or her intent to replace nursing home beds under subsection (13)(a) of this section, engages in unprofessional conduct or becomes unable to practice with reasonable skill and safety by reason of mental or physical condition, pursuant to chapter 18.130 RCW, ((~~or~~)) dies, <u>or under state or federal law files for bankruptcy,</u> the building owner shall be permitted to complete the nursing home bed replacement project, provided the building owner has secured an interest in the beds.

***Sec. 19 was vetoed. See message at end of chapter.**

NEW SECTION. **Sec. 20.** RCW 74.46.908 (Repealer) and 1999 c 353 s 17 are each repealed.

NEW SECTION. **Sec. 21.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 22.** (1) Sections 1 through 19 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 2001.

(2) Section 20 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect June 29, 2001.

Passed the House May 24, 2001.
Passed the Senate May 24, 2001.
Approved by the Governor June 11, 2001, with the exception of certain items that were vetoed.
Filed in Office of Secretary of State June 11, 2001.

Note: Governor's explanation of partial veto is as follows:

"I am returning herewith, without my approval as to section 19, Substitute House Bill No. 2242 entitled:

"AN ACT Relating to Medicaid nursing home rates;"

Substitute House Bill No. 2242 modifies the current nursing home reimbursement formula, directs the Department of Social and Health Services to convene a study regarding issues related to nursing homes rates, and establishes a joint legislative task force to monitor and evaluate this issue and submit a report to the Legislature by December 1, 2003.

Section 19 of the bill would have allowed transfers of nursing home Certificates of Need (CONs) via bankruptcy without a review of whether subsequent operators meet CON criteria. Without a CON review, there would be no assurances that the new operator has the expertise or financial wherewithal to provide adequate resident care.

Over past several years, as a policy objective to help move nursing home residents toward housing more integrated in our communities, the Legislature has directed the Department of Health to reduce the number of nursing home beds approved through the CON process. Currently, a bankruptcy means that the Department of Health has an opportunity to reconsider its issuance of a CON. Section 19 would have allowed construction of nursing home beds to continue, without affording the Department the opportunity to reevaluate the need for the beds.

For these reasons, I have vetoed section 19 of Substitute House Bill No. 2242.

With the exception of section 19, Substitute House Bill No. 2242 is approved."