S-0067.2

SENATE BILL 5577

State of Washington 58th Legislature 2003 Regular Session

By Senators Winsley, Thibaudeau, Jacobsen, Keiser and Shin

Read first time 01/30/2003. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to payment for nursing care services; amending RCW 18.52C.040, 74.46.410, and 74.46.431; and declaring an emergency.

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

Sec. 1. RCW 18.52C.040 and 1997 c 392 s 528 are each amended to read as follows:

(1) The nursing pool shall document that each temporary employee or referred independent contractor provided or referred to health care facilities currently meets the applicable minimum state credentialing requirements.

(2) The nursing pool shall not require, as a condition of employment or referral, that employees or independent contractors of the nursing pool recruit new employees or independent contractors for the nursing pool from among the permanent employees of the health care facility to which the nursing pool employee or independent contractor has been assigned or referred.

(3) The nursing pool shall carry professional and general liability insurance to insure against any loss or damage occurring, whether professional or otherwise, as the result of the negligence of its employees, agents or independent contractors for acts committed in the

course of their employment with the nursing pool: PROVIDED, That a nursing pool that only refers self-employed, independent contractors to health care facilities shall carry professional and general liability insurance to cover its own liability as a nursing pool which refers self-employed, independent contractors to health care facilities: AND PROVIDED FURTHER, That it shall require, as a condition of referral, that self-employed, independent contractors carry professional and general liability insurance to insure against loss or damage resulting from their own acts committed in the course of their own employment by a health care facility.

(4) The uniform disciplinary act, chapter 18.130 RCW, shall govern the issuance and denial of registration and the discipline of persons registered under this chapter. The secretary shall be the disciplinary authority under this chapter.

(5) The nursing pool shall conduct a criminal background check on all employees and independent contractors as required under RCW 43.43.842 prior to employment or referral of the employee or independent contractor.

(6) The nursing pool providing employees or referring independent contractors to a nursing facility shall not bill or receive payments from the nursing facility at a rate higher than one hundred thirty-five percent of the weighted average wage rate, in the county in which the nursing facility is located, for nursing facility employees of like classification. Each county's weighted average wage rate for employee classifications, which includes related taxes and benefits, must be determined by the department of social and health services using the most recent and available nursing facility cost reports required under chapter 74.46 RCW. The department of social and health services must report this data to the secretary by June 1st each year. The secretary will immediately thereafter publish this data to all nursing pools registered under this chapter. Effective July 1st of each year, the maximum rate a nursing pool may charge a nursing facility, as specified in this subsection, must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the nursing pool employees or referred independent contractors supplied to the nursing facility.

Sec. 2. RCW 74.46.410 and 2001 1st sp.s. c 8 s 3 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, radios, and similar appliances in patients' private accommodations;

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

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

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

(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;

(y) Expenses of profit-sharing plans;

(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;

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

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

(cc) Costs related to agreements not to compete;

(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;

(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;

(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;

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

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

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

(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;

(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;~~

~~(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;

((~~(mm)~~)) (ll) 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;

((~~(nn)~~)) (mm) 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;

((~~(oo)~~)) (nn) 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;

((~~(pp)~~)) (oo) 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;

((~~(qq)~~)) (pp) 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;

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

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

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

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

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

((~~(ww)~~)) (vv) 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;

((~~(xx)~~)) (ww) 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

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

Sec. 3. RCW 74.46.431 and 2001 1st sp.s. c 8 s 5 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)(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)(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 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.

(15) The department shall recalculate the direct care component urban and nonurban medians to recognize purchased nursing services using 1999 cost report data and shall recalculate each contractor's direct care component rate allocation effective July 1, 2003.

NEW SECTION. **Sec. 4.** 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 immediately.

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