



RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Department of Social and Health Services, Aging and Long-Term Support Administration

Permanent Rule Only

Effective date of rule:

Permanent Rules

- 31 days after filing.
- Other (specify) _____ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

- Yes
 - No
- If Yes, explain:

Purpose:

WAC 388-96-381 will increase the time a facility has to return resident funds from one week to thirty days and will align with a similar WAC in chapter 388-97 WAC.

WAC 388-96-738 and WAC 388-96-739 will update references in the WAC to minimum data set (MDS) 3.0 to reflect the currently used terminology and clarify the department's position on who will be counted as a Medicaid resident.

WAC 388-96-718 will update the language to allow for notifications to be sent via email in addition to USPS mail.

WAC 388-96-585 will address unallowable expenses on the Nursing Facility cost reports used to determine the Nursing Facility Medicaid Rates. Currently, travel expenses outside of Idaho, Oregon, Washington, and British Columbia are generally not allowed. This would remove that restriction to allow travel expenses on the cost reports.

WAC 388-96-809 will allow a security held pursuant to this section to be released to the contractor if the new contractor assumes all liability. Previously, it was not clear what the proper and allowed course was in these situations.

Citation of existing rules affected by this order:

Repealed: None
 Amended: WAC 388-96-381, WAC 388-96-738, WAC 388-96-739, WAC 388-96-718, WAC 388-96-585, WAC 388-96-809
 Suspended: None

Statutory authority for adoption: RCW 74.46.431(9)

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 15-05-017 on 02/06/15 (date).
 Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: _____ phone () _____
 Address: _____ fax () _____
 e-mail _____

Date adopted:

April 6, 2015

NAME (TYPE OR PRINT)

Katherine Vasquez

SIGNATURE

TITLE

DSHS Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED

DATE: April 07, 2015
TIME: 2:13 PM
WSR 15-09-025

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	<u>6</u>	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	<u>6</u>	Repealed	_____

AMENDATORY SECTION (Amending WSR 90-20-075, filed 9/28/90, effective 10/1/90)

WAC 388-96-381 Procedure for refunding resident personal funds.

(1) When a resident is discharged or transferred, the balance of the resident's personal funds shall be returned to the individual designated in WAC 388-96-375 within (~~one week~~) thirty days and a receipt obtained. In some cases it may be advisable to mail the refund to the resident's new residence.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-585 Unallowable costs. (1) Unallowable costs listed in subsection (2) of this section represent a partial summary of such costs, in addition to those unallowable under chapter 74.46 RCW and this chapter.

(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 medical care program but not included in the medicaid per-resident day payment rate established under this chapter and chapter 74.46 RCW;

(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 WAC 388-96-556(4) 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 and chapter 74.46 RCW;

(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 nonTitle XIX recipients. Bad debts of Title XIX recipients are allowable only when:

(i) The debt is related to covered services;

(ii) It arises from the recipient's required contribution toward the cost of care;

(iii) The provider can establish reasonable collection efforts were made. Reasonable collection efforts shall consist of at least three documented attempts by the contractor to obtain payment demonstrating that the effort devoted to collecting the bad debts of Title XIX recipients is the same devoted by the contractor to collect the bad debts of nonTitle XIX recipients;

(iv) The debt was actually uncollectible when claimed as worthless; and

(v) Sound business judgment established 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 any nursing home employees or owners or relatives of any nursing home employees or owners;

(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 when the department's Board of Appeals upholds the department's actions in an administrative review decision. When the administrative review decision is pending, reported legal and consultant fees will be unallowable. To be allowable, the contractor must report legal and consultant fees related to an administrative review decision issued in the contractor's favor in the cost report period in which the Board of Appeals issues its decision irrespective of when the legal and consultant fees related to the administrative review were incurred;

(gg) Legal and consultant fees of a contractor or contractors in connection with a lawsuit against the department. Judicial review is 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 for in WAC 388-96-580;

(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) 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) 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) 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~~) that are not necessary, ordinary, and related to resident care;

(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;

(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;

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

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

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

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

(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;

(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;

(xx) Tax expenses that a nursing facility has never incurred;

(yy) Effective July 1, 2007, and for all future rate settings, any costs associated with the quality maintenance fee repealed by chapter 241, Laws of 2006;

(zz) Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits against the department shall be unallowable; and

(aaa) Increased costs resulting from a series of transactions between the same parties and involving the same assets (e.g., sale and lease back, successive sales or leases of a single facility or piece of equipment).

AMENDATORY SECTION (Amending WSR 99-24-084, filed 11/30/99, effective 12/31/99)

WAC 388-96-718 Public process for determination of rates. (1)

The purpose of this section is to describe the manner in which the department will comply with the federal Balanced Budget Act of 1997, Section 4711 (a)(1), codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For all material changes to the methodology for determining nursing facility medicaid payment rates occurring after October 1, 1997, and requiring a Title XIX state plan amendment to be submitted to and approved by the Health Care Financing Administration under applicable federal laws, the department shall follow the following public process:

(a) The proposed estimated initial payment rates, the proposed new methodologies for determining the payment rates, and the underlying justifications shall be published. Publication shall be:

(i) In the Washington State Register; or

(ii) In the Seattle Times and Spokane Spokesman Review newspapers.

(b) The department shall maintain and update as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility medicaid payment rate methodology, and all materials submitted for publication shall be sent either postage prepaid by regular mail to such individuals and organizations or by e-mail. Individuals and organizations wishing to receive notice shall notify the department in writing.

(c) Nursing facility contractors, their associations, nursing facility medicaid beneficiaries, representatives of contractors or bene-

ficiaries, and other concerned members of the public shall be given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment shall not be less than fourteen calendar days after the date of the Washington State Register containing the published material or the date the published material has appeared in both the Seattle Times and the Spokane Spokesman Review.

(d) If, after receiving and considering all comments, the department decides to move ahead with any change to its nursing facility medicaid payment rate methodology, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated initial rates, final rate determination methodologies and justifications. Publication shall be:

(i) In the Washington State Register; or

(ii) In the Seattle Times and Spokane Spokesman Review newspapers.

(e) Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication has occurred in the Register or in both designated newspapers. The department shall not be authorized to delay implementation of, or to alter, ignore or violate requirements of, state or federal laws in response to public process comments.

(f) Publication of proposed estimated initial payment rates and final estimated initial payment rates shall be deemed complete once the department has published:

(i) The statewide average proposed estimated initial payment rate weighted by adjusted medicaid resident days for all medicaid facilities from the most recent cost report year, including the change from the existing statewide average payment rate weighted by adjusted medicaid resident days for all medicaid facilities from the most recent cost report year; and

(ii) The statewide average final estimated initial payment rate weighted by adjusted medicaid resident days for all medicaid facilities from the most recent cost report year, including the change from the existing statewide average payment rate weighted by adjusted medicaid resident days for all medicaid facilities from the most recent cost report year.

(3) Nothing in this section shall be construed to prevent the department from commencing or completing the public process authorized by this section even though the proposed changes to the methodology for determining nursing facility medicaid payment rates are awaiting federal approval, or are the subject of pending legislative, gubernatorial or rule-making action and are yet to be finalized in statute and/or regulation.

(4)(a) Neither a contractor nor any other interested person or organization shall challenge, in any administrative appeals or exception procedure established in rule by the department under the provisions of chapter 74.46 RCW, the adequacy or validity of the public process followed by the department in proposing or implementing a change to the payment rate methodology, regardless of whether the challenge is brought to obtain a ruling on the merits or simply to make a record for subsequent judicial or other review. Such challenges shall be pursued only in courts of proper jurisdiction as may be provided by law.

(b) Any challenge to the public process followed by the department that is brought in the course of an administrative appeals or ex-

ception procedure shall be dismissed by the department or presiding officer, with prejudice to further administrative review and record-making, but without prejudice to judicial or other review as may be provided by law.

(5) The public process required and authorized by this section shall not apply to any change in the payment rate methodology that does not require a Title XIX state plan amendment under applicable federal laws, including but not limited to:

(a) Prospective or retrospective changes to nursing facility payment rates or to methodologies for establishing such rates ordered by a court or administrative tribunal, after exhaustion of all appeals by either party as may be authorized by law, or the expiration of time to appeal; or

(b) Changes to nursing facility payment rates for one or more facilities resulting from the application of authorized payment rate methodologies, principles or adjustments, including but not limited to: Partial or phased-in termination or implementation of rate methodologies; scheduled cost rebasing; quarterly or other updates to reflect changes in case mix or other private or public source data used to establish rates; adjustments for inflation or economic trends and conditions; rate funding for capital improvements or new requirements imposed by the department; changes to resident-specific or exceptional care rates; and changes to correct errors or omissions by the contractor or the department.

AMENDATORY SECTION (Amending WSR 98-20-023, filed 9/25/98, effective 10/1/98)

WAC 388-96-738 What default case mix group and weight must the department use for case mix grouping when there is no minimum data set resident assessment for a nursing facility resident? (1) When a resident:

(a) ~~((Dies))~~ Expires before the facility completes the resident's initial assessment, the department must assign the assessment to the special care case mix group - ~~((SSB))~~ HD2. The department must use the case mix weight assigned to the special care case mix group - ~~((SSB))~~ HD2. The department will count the case as a medicaid resident;

(b) Is discharged to an acute care facility before the nursing facility completes the resident's initial assessment, the department must assign the assessment to the special care case mix group - ~~((SSB))~~ HD2. The department must use the case mix weight assigned to the special care case mix group - ~~((SSB))~~ HD2. The department will count the case as a medicaid resident; or

(c) Is discharged for a reason other than those noted above before the facility completes the resident's initial assessment, the department must assign the assessment to the case mix group BC1 ~~((with a case mix weight of 1.000))~~. The department will count the case as a medicaid resident.

(2) If the resident assessment is untimely as defined in RCW 74.46.501 and as defined by federal regulations, then the department must assign the case to the default case mix group of BC1 ~~((which has a case mix weight of 1.000))~~. The department will count the case as a medicaid resident.

AMENDATORY SECTION (Amending WSR 98-20-023, filed 9/25/98, effective 10/1/98)

WAC 388-96-739 How will the department determine which resident assessments are medicaid resident assessments? The department must identify a medicaid resident assessment through the review of the minimum data set (MDS) (~~((payer source code))~~) medicaid number field. If the nursing facility (~~((codes the payer source as "medicaid per diem," regardless of whether any other payer source codes are checked))~~) completes the MDS medicaid number field with a valid medicaid number or the appropriate code for medicaid pending, then the department will count the case as a medicaid resident assessment.

AMENDATORY SECTION (Amending WSR 11-05-068, filed 2/14/11, effective 2/26/11)

WAC 388-96-809 Change of ownership—Final reports—Settlement securities. (1) When there is a change of ownership for any reason, final reports shall be submitted as required by WAC 388-96-022.

(2) Upon a notification of intent to change ownership, the department shall determine by settlement or reconciliation the amount of any overpayments made to the assigning or terminating contractor, including overpayments disputed by the assigning or terminating contractor. If settlements are unavailable for any period up to the date of assignment or termination, the department shall make a reasonable estimate of any overpayment or underpayments for such periods. The reasonable estimate shall be based upon prior period settlements, available audit findings, the projected impact of prospective rates, and other information available to the department. The department shall also determine and add in the total of all other debts and potential debts owed to the department regardless of source, including, but not limited to, interest owed to the department as authorized by this chapter, civil fines imposed by the department, or third-party liabilities.

(3) For all cost reports, the assigning or terminating contractor shall provide security, in a form deemed adequate by the department, equal to the total amount of determined and estimated overpayments and all debts and potential debts from any source, whether or not the overpayments are the subject of good faith dispute including but not limited to, interest owed to the department, civil fines imposed by the department, and third-party liabilities. Security shall consist of one or more of the following:

(a) Withheld payments due the assigning or terminating contractor under the contract being assigned or terminated;

(b) An assignment of funds to the department;

(c) The new contractor's assumption of liability for the prior contractor's debt or potential debt;

(d) An authorization to withhold payments from one or more medicaid nursing facilities that continue to be operated by the assigning or terminating contractor;

(e) A promissory note secured by a deed of trust; or

(f) Other collateral or security acceptable to the department.

(4) An assignment of funds shall:

(a) Be at least equal to the amount of determined or estimated debt or potential debt minus withheld payments or other security provided; and

(b) Provide that an amount equal to any recovery the department determines is due from the contractor from any source of debt to the department, but not exceeding the amount of the assigned funds, shall be paid to the department if the contractor does not pay the debt within sixty days following receipt of written demand for payment from the department to the contractor.

(5) The department shall release any payment withheld as security if alternate security is provided under subsection (3) of this section in an amount equivalent to the determined and estimated debt.

(6) If the total of withheld payments and assigned funds is less than the total of determined and estimated debt, the unsecured amount of such debt shall be a debt due the state and shall become a lien against the real and personal property of the contractor from the time of filing by the department with the county auditor of the county where the contractor resides or owns property, and the lien claim has preference over the claims of all unsecured creditors.

(7) A properly completed final cost report shall be filed in accordance with WAC 388-96-022, which shall be examined by the department in accordance with WAC 388-96-205.

(8) Security held pursuant to this section shall be released to the contractor after all debts, including accumulated interest owed the department, have been paid by the old owner.

(9) Security held pursuant to this section shall be released to the contractor if the new contractor assumes all liability.

(10) If, after calculation of settlements for any periods, it is determined that overpayments exist in excess of the value of security held by the state, the department may seek recovery of these additional overpayments as provided by law.

~~((10))~~ (11) Regardless of whether a contractor intends to change ownership, if a contractor's net medicaid overpayments and erroneous payments for one or more settlement periods, and for one or more nursing facilities, combined with debts due the department, reaches or exceeds a total of fifty thousand dollars, as determined by settlement, civil fines imposed by the department, third-party liabilities or by any other source, whether such amounts are subject to good faith dispute or not, the department shall demand and obtain security equivalent to the total of such overpayments, erroneous payments, and debts and shall obtain security for each subsequent increase in liability reaching or exceeding twenty-five thousand dollars. Such security shall meet the criteria in subsections (3) and (4) of this section, except that the department shall not accept an assumption of liability. The department shall withhold all or portions of a contractor's current contract payments or impose liens, or both, if security acceptable to the department is not forthcoming. The department shall release a contractor's withheld payments or lift liens, or both, if the contractor subsequently provides security acceptable to the department.

~~((11))~~ (12) Notwithstanding the application of security measures authorized by this section, if the department determines that any remaining debt of the old owner is uncollectible from the old owner, the new owner is liable for the unsatisfied debt in all respects. If the new owner does not accept assignment of the contract and the contingent liability for all debt of the prior owner, a new certification

survey shall be done and no payments shall be made to the new owner until the department determines the facility is in substantial compliance for the purposes of certification.

((~~12~~)) 13 Medicaid provider contracts shall only be assigned if there is a change of ownership, and with approval by the department.