



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10  
2201 Sixth Avenue, MS/RX-43  
Seattle, Washington 98121

September 27, 2010

Susan Dreyfus, Secretary  
Department of Social and Health Services  
Post Office Box 45010  
Olympia, Washington 98504-5010

**RE: Washington State Plan Amendment (SPA) Transmittal Number 10-012**

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 10-012.

Although the NIRT has already sent the State a copy of the approval for this SPA, the Seattle Regional office is following up with an additional copy for the reason that we were in receipt of the original, signed amendment request.

Therefore, enclosed is a copy of the official CMS form 179, amended page(s), and copy of the approval letter from the NIRT for your records.

If you have any questions or require any assistance concerning the Seattle Regional office role in the processing of this SPA, please contact me, or have your staff contact Daphne Hicks at (206) 615-2400 or [daphne.hicks@cms.hhs.gov](mailto:daphne.hicks@cms.hhs.gov).

Sincerely,

Barbara K. Richards  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Operations

Enclosure

cc: Douglas Porter, Medicaid Director, Medicaid Purchasing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, M/S S2-26-12  
Baltimore, MD 21244-1850



CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid, CHIP, and Survey & Certification**

SEP 22 2010

Susan Dreyfus, Secretary  
Department of Social and Health Services  
PO Box 45010  
Olympia, Washington 98504-5010

**Re: Washington State Plan Amendment (SPA) Transmittal Number 10-012**

Dear Ms Dreyfus:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan, submitted under transmittal number (TN) 10-012. This amendment updates Attachment 4.19-D of the State plan by modifying the formula used to compute nursing facility costs, raising minimum occupancy requirements for selected nursing facilities and updating the cost-rebasing periods for the nursing facility per diem rate calculation.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-024 is approved effective July 1, 2010. We are enclosing the HCFA-179 and the amended pages.

If you have any questions concerning this State plan amendment, please call Joe Fico of the National Institutional Reimbursement Team at (206) 615-2380.

Sincerely,

A handwritten signature in cursive script that reads 'Cindy Mann'.

Cindy Mann  
Director

Center for Medicaid, CHIP, and Survey & Certification

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**10-012**

2. STATE  
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
July 1, 2010

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

- a. FFY 2010 \$ <3,936,121>
- b. FFY 2011 \$ <11,851,616>

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-D Part 1 pages 1 - 4, 6, 6a, 7 - 16, 16a, 18 - 21

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Att. 4.19-D Part 1 pages 1 - 4, 6, 7, 7a (remove), 16, 18 - 20

10. SUBJECT OF AMENDMENT:

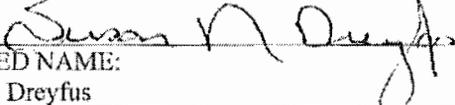
Nursing Facility Rates

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Susan N. Dreyfus

14. TITLE:

Secretary

15. DATE SUBMITTED:

June 30, 2010

16. RETURN TO:

Ann Myers

Department of Social and Health Services  
Health and Recovery Services Administration  
626 8<sup>th</sup> Ave SE MS: 45504  
Olympia, WA 98504-5504

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

**JUNE 30 2010**

18. DATE APPROVED:

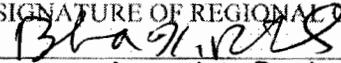
**SEP 22 2010**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

**JUL 01 2010**

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

**BARBARA K. RICHARDS**

22. TITLE:

**Associate Regional Administrator  
Division of Medicaid &  
Children's Health**

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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NURSING FACILITIES AND SWING BED HOSPITALS

Effective July 1, 2010

Section I. Introduction:

This State Plan Amendment (SPA) to Attachment 4.19-D, Part I, describes the overall payment methodology for nursing facility services provided to Medicaid recipients: (1) by privately-operated nursing facilities, both non-profit and for-profit; (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs; and (3) by nursing facilities operated by public hospital districts in the state. Both privately operated and veterans' nursing facilities share the same methodology. Facilities operated by public hospital districts share the methodology described below also, except for proportionate share payments described in Section XVII below, which apply only to them.

This SPA is submitted by the single state agency for Medicaid, the State of Washington Department of Social and Health Services ("department" below).

Excluded here is the payment rate methodology for nursing facilities operated by the department's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC), chapter 74.46, chapter 34.05, and chapter 70.38 of the Revised Code of Washington (RCW), and any other state or federal laws or regulations, codified or uncodified, as they exist as of July 1, 2010, as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW.

The methods and standards employed by the department to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## Section II. General Provisions:

Medicaid rates for nursing facility care in Washington continue to be facility specific. Prior to rate setting, nursing facilities' costs and other reported data, such as resident days, are examined, to ensure accuracy and to determine costs allowable for rate setting. Washington continues to be a state utilizing facility-specific cost data, subject to applicable limits, combined with facility-specific and regularly updated resident case mix data, to set rates.

A facility's Medicaid rate continues to represent a total of seven component rates: 1) direct care (DC), 2) therapy care (TC), 3) support services (SS), 4) operations (O), 5) variable return (VR), 6) property (P), and 7) financing allowance (FA).

Medicaid rates are subject to a "budget dial", under which the department is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. Under RCW 74.46.421, the statewide average payment rate for any state fiscal year (SFY) weighted by patient days shall not exceed the statewide weighted average nursing facility payment rate identified for that SFY in the biennial appropriations act (budgeted rate). After the department determines all nursing facility payment rates in accordance with chapter 74.46 RCW and chapter 388-96 WAC, it determines whether the weighted average nursing facility payment rate is equal to or likely to exceed the budgeted rate for the applicable SFY. If the weighted average nursing facility payment rate is equal to or likely to exceed the budgeted rate, then the department adjusts all nursing facility payment rates proportional to the amount by which the weighted average rate allocations would exceed the budgeted rate. Adjustments for the current SFY are made prospectively, not retrospectively and applied proportionately to each nursing facility's component rate allocation. The application of RCW 74.46.421 is termed applying the "budget dial".

For SFY 2011 (July 1, 2010 through June 30, 2011), the budget dial rate is per resident day \$166.24. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC. In the supplemental operating budget (ESSB 6444), the Legislature amended the budget dial rate for SFY 2010 (July 1, 2009 through June 30, 2010); the budget dial rate is per resident day \$169.85.

If any final order or final judgment, including a final order or final judgment resulting from an adjudicative proceeding or judicial review permitted by chapter 34.05 RCW would result in an increase to a nursing facility's payment rate for a prior fiscal year or years, the department shall consider whether the increased rate for that facility would result in the statewide weighted average payment rate for all facilities for such fiscal year or years to be exceeded. If the increased rate would result in the statewide average payment rate for such year or years being exceeded, the department shall increase that nursing facility's payment rate to meet the final order or judgment only to the extent that it does not result in an increase to the statewide average payment rate for all facilities.

For the period from 7/1/07 through 6/30/09, the direct care, operations, support services, and therapy care rate components are rebased to the 2005 cost report.

Beginning 7/1/09, those same four rate components will be subject to automatic biennial rebasing. That is, rates for the two-year period beginning 7/1/09 will be based on the 2007 cost report, and so on.

Direct care and operations component rates for July 1, 2006 are based on examined, adjusted costs and resident days from 2003 cost reports. Therapy care and support services component rates for July 1, 2006 are based on examined, adjusted costs and resident days from 1999 cost reports.

In contrast, property and financing allowance components continue to be rebased annually, utilizing each facility's cost report data for the calendar year ending six months prior to the commencement of the July 1 component rates.

TN# 10-012  
Supersedes  
TN# 09-024

Approval Date

Effective Date 7/1/10

**SEP 22 2010**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont):

For the direct care, operations, support services, and therapy care components, adjusted cost report data for calendar year 2007 will be used for rate setting for July 1, 2009 through June 30, 2012.

Beginning July 1, 2012, the direct care, operations, support services, and therapy care component rate allocations shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2010 will be used for July 1, 2012 through June 30, 2014 and so forth.

Effective July 1, 2006, each facility's variable return component rate allocation is set to its June 30, 2006 variable return component rate allocation. For July 1, 2010, the variable return component rate allocation for each facility shall be thirty percent of the facility's June 30, 2006, variable return component rate allocation. Effective July 1, 2011, the variable return component rate is repealed.

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds:

All component rates calculated and assigned to a facility require, directly or indirectly, use of the examined number of resident days at that facility for the applicable report period. Essentially, days are divided into allowable costs for that period, to obtain facility costs expressed as per resident day amounts.

Resident days for all facilities in all component rates continue to be subject to a minimum occupancy of each facility's licensed beds, regardless of how many beds are set up or in use. That is, when the resident days are below the minimum occupancy that applies to the rate component and category of provider, the days are increased to an imputed occupancy for rate setting, which has the effect of reducing per resident day costs and component rates based on them.

When occupancy is above the minimum, the facility's actual occupancy is used. The purpose of minimum occupancy is to prevent inflated rates based on inefficient use of facility resources or failure of the facility to maintain a viable census.

The minimum occupancy assumption is eliminated from the calculation of the direct care component rate for all facilities.

Minimum occupancy for rate setting for all facilities will be eighty-five percent in therapy care and support services component rates.

An "essential community provider" is defined as a facility which is the only nursing facility within a commuting distance radius of at least forty minutes duration, traveling by automobile.

"Large nonessential community providers" means nonessential community providers with more than sixty licensed beds, regardless of how many beds are set up or in use.

"Small nonessential community providers" means nonessential community providers with sixty or fewer licensed beds, regardless of how many beds are set up or in use.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds (cont)

Minimum facility occupancy of licensed beds, regardless of how many beds are set up or in use, for operations, property, and financing allowance component rate allocations shall be for:

- Essential community providers – 85%
- Small nonessential community providers – 90%
- Large nonessential community providers – 92%

The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

Effective July 1, 2010, the department shall include beds banked under chapter 70.38 RCW in licensed beds for the purpose of computing minimum occupancy.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section V: Adjustments to Payment Rates for Economic Trends and Conditions (cont)

For direct care, therapy care, support services, and operations component rate allocations, there will be no adjustments for economic trends and conditions in fiscal years 2010 and 2011.

The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the component rate allocations established in accordance with chapter 74.46 RCW. When no economic trends and conditions factor for either fiscal year is defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the component rate allocations established in accordance with chapter 74.46 RCW.

Section VI. Direct Care Component Rate:

This component rate, which averages approximately 55.0% of each participating facility's total Medicaid rate, corresponds to one resident day of care for in nursing services, including supplies, excluding therapy care services and supplies.

Effective July 1, 2010, the .06 percent add-on established in 2001 by the legislature to "increase the median price per case-mix unit" is eliminated. Since 2001, a regular rebase has been enacted in statute which takes into account actual changes in case mix, the costs therein, and makes funding adjustments accordingly.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

In applying case mix principles for direct care rate setting, data is taken from facility-completed, mandatory assessments of individual residents, and using a software program that groups residents by care needs, the department determines for each facility both a facility average case mix index (for all the facility's residents) and a Medicaid average case mix index (for Medicaid residents only). A case mix index is a number indicating intensity of need for services by a resident population, or group within a population.

Effective July 1, 2006, the facility average case mix index will be used throughout the applicable cost-rebasing period. Also, when establishing direct care component rates, the department will use an average of facility case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations.

Effective July 1, 2008, a "low-wage worker add-on" of \$1.57 per Medicaid resident is provided to those facilities electing to accept it, for the purpose of increasing wages and benefits, and/or staffing levels, in lower-paid job categories.

The add-on shall be used to increase wages, benefits, and/or staffing levels for certified nurse aides; or to increase wages and/or benefits for dietary aides, housekeepers, laundry aides, or any other category of worker whose statewide average dollars-per-hour wage was less than \$15 in calendar year 2008, according to cost report data. The add-on may also be used to address resulting wage compression for related job classes immediately affected by wage increases to low-wage workers.

In accordance with the above provisions, the "low wage worker add-on" of \$1.57 per Medicaid resident provided to those facilities electing to accept it, for the purpose of increasing wages and benefits, and/or staffing levels, in lower-paid job categories is continued for rate year July 1, 2010 through June 30, 2011.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

Each facility's allowable direct care cost per resident day is divided by the facility's average case mix index to derive the facility's allowable direct care cost per case mix unit.

Effective July 1, 2001, in setting direct care component rates, the department is required to array direct care costs per case mix unit separately for three groups of nursing facilities, also known as peer groups: (1) those located in high labor-cost counties; (2) those located in urban counties, which are not high labor cost counties; and (3) those located in nonurban counties.

A "high labor cost county" is "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." An "urban county" is "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." A "nonurban county" is "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."

Currently, the only high labor cost county in the state is King County, which means for July 1, 2001, through June 30, 2004 direct care component rates, direct care cost per case mix unit medians are calculated for: (1) Medicaid nursing facilities in King County; (2) Medicaid nursing facilities in all urban counties, excluding king County; and (3) Medicaid nursing facilities in all nonurban counties.

Effective July 1, 2006, the 90% floor in the cost per case mix unit is eliminated and the ceiling is increased to 112%.

The department shall determine and update semiannually 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 six-month period. The resident assessment data used for each update is taken from the calendar quarters commencing nine months prior and ending three months prior to the effective date of each semiannual update.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VII. Therapy Care Component Rate:

This component payment rate corresponds to average one-on-one care from qualified therapists delivered to a Medicaid resident during one day, and to average therapy consultation from qualified consultants delivered to a resident during one day. Four types of therapy are recognized for rate setting: speech, physical, occupational, and other. Two general service categories are recognized for each: one-on-one therapy and therapy consulting.

To set therapy care component rates, the department takes from cost reports direct one-on-one therapy charges for all residents by payer, including costs of supplies, and total units or modules of therapy care, for all residents from the report period by type of therapy provided. The department also takes from 1999 reports therapy consulting expenses for all residents by type of therapy.

The department determines the total one-on-one cost for each type of therapy care at each participating nursing facility, and divides by the facility's total units of therapy for each therapy type, to derive the per unit one-on-one cost for each type. A unit or module of therapy care is defined as fifteen minutes of one-on-one therapy.

The department determines total therapy consulting for each type of therapy at each nursing facility, and divides by the facility's resident days, increased if necessary to the applicable minimum occupancy, to derive per resident day consulting cost for each type of therapy.

The department ranks from lowest to highest per unit one-on-one therapy costs for each of the four types, both for urban and nonurban facilities. The department also ranks from lowest to highest per resident day therapy consulting costs for each of the four types of therapy, both for urban and nonurban facilities.

This constitutes sixteen separate arrays of therapy costs, which are used to determine eight median therapy costs for all facilities in each peer group (urban and nonurban). Four are one-on-one unit of therapy cost medians, and four are consulting resident day cost medians.

Sixteen cost limits are established, including both peer groups. The limits are one hundred ten percent of the median costs per unit of one-on-one therapy for the four types, and one hundred ten percent of the median costs per resident day for therapy consulting for the four types.

A facility's allowable one-on-one cost for rate setting, for each type of therapy care, is the lower of the facility's actual cost per unit or one hundred ten percent of the unit median cost for its peer group.

A facility's allowable consulting cost for rate setting, for each type of therapy care, is the lower of the facility's actual cost per resident day or one hundred ten percent of the resident day median cost for its peer group.

Each facility's allowable cost per case mix unit in each of the four therapy types is then multiplied by the units provided by the facility for the applicable year by type. The result is multiplied by the Medicaid percentage of charges for each category, and divided by adjusted Medicaid resident days from the report period, to derive the Medicaid resident day allowable one-on-one cost for each therapy type.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VII. Therapy Care Component Rate (cont.)

The facility's allowable Medicaid resident day one-on-one cost and its allowable resident day consulting cost are each multiplied by the facility's total adjusted 1999 resident days to calculate its total allowable one-on-one therapy expense and total allowable consulting therapy expense. These products are totaled for each type to derive each facility's total allowable cost for each therapy type.

The total allowable cost for each therapy type for each participating nursing facility is then combined and this total is divided by the facility's total adjusted resident days, or days increased, if needed, to the applicable minimum occupancy for rate setting from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds*, to derive its therapy care component rate.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VIII. Support Services Component Rate:

This component rate corresponds to one resident day of food, food preparation, other dietary services, housekeeping and laundry services.

A nursing facility's support services component rate is based on the applicable cost report data, subject to the budget dial and applicable adjustments for economic trends and conditions.

To set the component rate, the department takes from the facility's cost report total allowable support services cost, and divides by the greater of adjusted days from the same cost report or days imputed at the applicable minimum occupancy from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds*, whichever is greater.

The department arrays allowable support services costs separately for urban and non-urban facilities, and determines the median per resident day cost for each peer group. A limit is set at one hundred ten percent of the median cost of each group and the rate is set at the lower of actual allowable facility per resident day cost or the limit for its peer group.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section IX. Operations Component Rate:

This component corresponds to one resident day of operations. It includes administrative services, management, utilities, accounting, minor building maintenance, etc.

To set the operations component rate, the department takes data from the applicable cost report year allowable operations costs and divides by the greater of adjusted resident days from the same cost report, or days imputed at the applicable minimum occupancy from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds*, whichever is greater.

The department arrays allowable operations costs separately for urban and non-urban, and determines the median cost for each group. The limit is set at the median for each peer group without any percentage increase. Costs used to set each facility's operations component rate are the lower of actual allowable operations costs from the applicable cost report or the median limit for its peer group.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section X. Variable Return Component Rate:

The variable return component rate is an incentive to reduce overall costs.

Effective July 1, 2001, to compute the variable return for each participating facility, the department ranks all Medicaid facilities according to each facility's 1999 total combined and adjusted direct care, therapy care, support services and operations costs. One ranking exercise is done, without regard to urban or nonurban peer groups, and the ranked costs are not reduced by the peer group limits based on peer group median costs. The array is then divided into four quartiles, each containing, as nearly as possible, the same number of facilities.

The department then assigns a percentage to each facility, depending on what quartile it belongs to, as follows: 1 percent to those in the highest quartile, 2 percent to those in the next highest quartile, 3 percent to those in the next lowest quartile, and 4 percent to those in the lowest quartile.

The percentages calculated from 1999 costs shall remain in effect from July 1, 2001, until June 30, 2004. Facilities will not be ranked again and no new percentages will be determined after being done initially for July 1, 2001; rate setting. If a facility migrates from one quartile to another resulting from an increase or decrease in its 1999 allowable costs after the percentages are initially calculated and assigned, its percentage will be changed to reflect its new quartile, and its variable return component rate will be revised, effective July 1, 2001.

Once assigned, the applicable variable return percentage is multiplied by each facility's combined per resident day component rates in direct care, therapy care, support services, and operations to derive its variable return component rate; however, allowable direct care spending per resident day during the preceding calendar report year will be substituted for a facility's direct care component rate in calculating its variable return, if spending was lower than its current direct care component rate. The variable return component rate is adjusted each time one or more of these component rates is changed, whether to reflect an adjustment for economic trends and conditions, a quarterly update to reflect a change in case mix, or for any other reason.

Effective July 1, 2006, each facility's variable return component rate allocation is set to its June 30, 2006 variable return component rate allocation.

For July 1, 2010, the variable return component rate allocation for each facility shall be thirty percent of the facility's June 30, 2006, variable return component rate allocation. Effective July 1, 2011, the variable return component rate is repealed.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XI. Property Component Rate:

This component corresponds to an allowance for depreciation of real property improvements, equipment and personal property associated with the provision of resident care at a participating nursing facility.

The department rebases the property component rate annually using cost report depreciation data from the calendar year ending six months prior to the commencement of each July 1 rate. For example, the 2000 cost report is used for July 1, 2001, rate setting, and the 2001 cost report is used for July 1, 2002, etc. Allowable depreciation is divided by the actual, adjusted resident days from the applicable cost report period, increased, if needed, to imputed resident days at the applicable minimum occupancy for rate setting from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds.*

The property rate is subject to prospective revision to reflect the cost of capitalized additions and replacements. Effective July 1, 2001, to have additional assets included for rate setting the contractor must obtain from the department a certificate of capital authorization for future capitalized additions and replacements, which are available on a first-come, first-served basis. However, the department is authorized to consider untimely requests if the improvement project is in response to an emergency situation.

For assets that were acquired after January 1, 1980, the depreciation base of the assets used for rate setting cannot exceed the net book value which did exist or would have existed had the previous contract with the department continued, unless the assets were acquired after January 1, 1980, for the first time since that date, and before July 18, 1984.

The depreciation base that will be used for first-time sales after January 1, 1980, but occurring pursuant to a written and enforceable purchase and sale agreement in existence prior to July 18, 1984, and documented and submitted to the department prior to January 1, 1988, will be that of the first owner subsequent to January 1, 1980.

Subsequent sales during the period defined above and any subsequent sale of any asset, whether depreciable or not depreciable, on or after July 18, 1984, are ignored for payment purposes.

The department will issue no additional certificates of capital authorization for State Fiscal Year (SFY) 2010 and no new certificates of capital authorization for SFY 2011.

For fiscal year 2011, the department will not add-on to payment rates for capital improvements not requiring a certificate of need and a certificate of capital authorization.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XII. Financing Allowance Component Rate:

The financing allowance rate is paid in lieu of payment determined by actual lease and interest expense, except for the cost of leasing office equipment, which is factored into the operations component rate, subject to all system limits and principles.

Effective July 1, 2001, a facility's financing allowance component rate continues to be reset annually based on a facility's cost report data from the calendar year ending six months prior to the start of each July 1 rate. For example, July 1, 2001, financing allowance component rates are based on 1999 cost report data, and July 1, 2002, is based on 2000 data, etc.

A facility's net invested funds, for rate setting purposes, consists of the recognizable value of allowable tangible fixed assets and the allowable cost of land employed by the facility to provide nursing facility services. Valuation of allowable land and depreciable assets will be subject to the same purchase date limitations affecting depreciable assets for calculation of a facility's property component rate described in Section X. In calculating net invested funds, facilities continue to be subject to the cost basis of the last owner of record prior to July 18, 1984, for assets existing prior to that date.

The financing allowance component rate is computed by multiplying each facility's allowable net invested funds, taken from its cost report for the preceding calendar year by 10 percent in whole or in part and/or by 8.5 percent in whole or in part, as applicable. The products are then added, if needed, and divided by the greater of adjusted resident days from the same report period, increased, if needed, to imputed days at the applicable minimum occupancy for rate setting from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds.*

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 department shall have the authority to determine an amount for net invested funds based on an appraisal conducted according to department rule.

For a facility that was leased by a contractor as of January 1, 1980, in an arm's-length agreement, which continues to be leased under the same lease agreement, the financing allowance rate will be the greater of the rate existing on June 30, 2010 or the rate calculated under RCW 74.46.437.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIII. Settlement:

In a process called "settlement", direct care, therapy care, and support services component rate payments are compared to each participating nursing facility's expenditures in these categories each report period. The facility must return to the department all unspent rate payments in these three categories exceeding 1 percent of each average component rate, weighted by Medicaid resident days, for the report period. The purpose of settlement is to provide licensees of Medicaid nursing facilities additional incentive to make expenditures necessary for the care and well being of residents.

This recovery process does not exist for payments in excess of costs, if any, in the operations, variable return, property and financing allowance component rates. However, assets constituting net invested funds are subject to audit and a facility's financing allowance component rate is subject to adjustment at settlement, up or down, to reflect actual, documented net invested funds relating to resident care. If the financing allowance component rate is increased or reduced to reflect a change in net invested funds, the financing allowance underpayment or overpayment to the facility for the settlement period will be reflected in the settlement and amount due the contractor or department.

Normally settlement covers a calendar year corresponding to a calendar year report period, but a settlement will only cover a partial-year report period for facilities changing ownership during the year. The rate a provider is left with after the process of settlement at the lower of cost or rate in the affected cost areas is called the "settlement rate" and it represents final compensation for Medicaid nursing care services for the settlement period.

The rule which allows facilities to keep unspent payments in direct care, therapy care and support services up to 1 percent of each of these component rates, does not apply to facilities that provided substandard quality of care, or which were not in substantial compliance with state and federal care standards, during the settlement period, as these concepts are defined in federal survey regulations. Such facilities must return all unspent direct care, therapy care and support services rate payments, without exception, they received during the settlement period.

In comparing expenditures to component rate payments in direct care, therapy care, and support services for the purpose of calculating a facility's settlement rate and effecting recovery, some shifting of excess rate payments (if any) to other cost areas is allowed to cover in whole or in part costs exceeding component rates in those other areas (if any).

Effective July 1, 2001, savings in support services may be shifted to cover a deficit in direct care or therapy care, but not more than 20 percent of the total support services rate payment for the settlement period may be shifted out. Shifting of savings in direct care to therapy care, and from therapy care to direct care, to cover any deficit is allowed without a percentage of component rate limitation.

For calendar year 2009, the department shall calculate split settlements covering two periods January 1, 2009, through June 30, 2009, and July 1, 2009, through December 31, 2009. For the second period beginning July 1, 2009, the department may partially or totally waive settlements only in specific cases where a nursing home can demonstrate significant decreases in costs from the first period.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIV. Adjustments to Prospective Rates other than for Economic Trends and Conditions, Changes in Case Mix, Fluctuation in Licensed Beds or One-Time Specific Authorizations:

The department may grant prospective rate adjustment to fund new requirements imposed by the federal government or by the department, if the department determines a rate increase is necessary in order to implement the new requirement.

Rates may be revised prospectively to fund capitalized facility additions and replacements meeting all applicable conditions, such as certificate of need or exemption from certificate of need, and a certificate of capital authorization from the department, if required for the project.

Rates may be adjusted prospectively and retrospectively to correct errors or omissions on the part of the department or the facility, or to implement the final result of a provider appeal if needed, or to fund the cost of placing a nursing facility in receivership or to aid the receiver in correcting deficiencies.

Rates may be revised to reflect an increase in real property taxes resulting from a facility building construction, expansion, renovation or replacement project, but only up to the median cost limit in the affected component, the operations component rate. Also, to qualify, the project must require the purchase of additional land, must have been completed on or after July 1, 1997, and the rate increase cannot commence prior to the effective date of the tax increase.

The department shall establish, by rule, the procedures, principles, and conditions for a pay-for-performance supplemental payment structure that provides payment add-ons for high performing facilities. To the extent that funds are appropriated for this purpose, the pay-for-performance structure will include a one percent reduction in payments to facilities with exceptionally high direct care staff turnover, and a method by which the funding that is not paid to these facilities is then used to provide a supplemental payment to facilities with lower direct care staff turnover.

Section XV. Rates for Swing Bed Hospitals:

Rates for swing bed hospitals providing nursing facility care to Medicaid eligible residents continue to be set for each SFY (July 1 through June 30) at the approximate, weighted statewide average total paid to Medicaid nursing facilities during the preceding SFY. So the Medicaid swing bed rate effective July 1, 2001, is derived from the average nursing facility Medicaid rate for SFY 2000.

The average rate comprising the swing bed rate for July 1, 2001, is computed by first multiplying each nursing facility's approximate total rate on July 1 of the preceding fiscal year (July 1, 2000) by the facility's approximate number of Medicaid resident days for the month of July during the preceding SFY (July 2000), which yields an approximate total Medicaid payment for each facility for that month.

Total payments to all Medicaid facilities for July of the preceding SFY are added which yields the approximate total payment to all facilities for that month, and then the total is divided by statewide Medicaid resident days for the same month to derive a weighted average for all facilities.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XV. Rates for Swing Bed Hospitals (cont)

The average for July 2008 was \$158.10 per resident day, which comprises the swing bed rate for the July 1, 2008 to June 30, 2009 rate period. The same methodology is followed annually to reset the swing bed rate, effective July 1 of each year. Effective July 1 of each year, the department follows the same methodology to reset the swing bed rate. The swing bed rate is subject to the operation of RCW 74.46.421.

Approved SPA 09-026 reflects a FY 10 (July 1, 2009 through June 30, 2010) swing bed rate of \$156.37. This rate was the original budget dial rate challenged in WHCA vs. Dreyfus that resulted in a Temporary Restraining Order preventing the department from using the \$156.37 budget dial rate. The 2010 Legislature restored the FY 10 budget dial rate to \$169.85. The revised FY 10 swing bed rate is \$167.23 per patient day.

The swing bed rate for SFY 11 (July 1, 2010 through June 30, 2011) is \$166.24.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XVI. 1997 Balanced Budget Act. Section 4711 -- Public Process for Changes to Nursing Facility Medicaid Payment Rates (cont.)

(4) After receiving and considering all comments, if the department decides to move ahead with a change or changes to its nursing facility payment rate methodologies, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated rates, final rate determination methodologies and justifications. Publication shall be: (a) in the Washington State Register; or (b) in The Seattle Times and The Spokesman Review newspapers. 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 in the Register has occurred or publication in both designated newspapers has occurred. The department shall not be authorized to delay implementation of changes, or to alter, ignore or violate requirements of state or federal laws in response to public process comments.

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Section XVII. Proportionate Share Payments for Nursing Facilities Operated by Public Hospital Districts:

The following is effective for the period from July 1, 2005 to June 30, 2011:

An aggregate Upper Payment Limit is calculated each state fiscal year for supplemental payments to eligible providers of Medicaid nursing facility services. Eligible providers are public hospital districts that operate nursing facilities.

The public hospital districts are responsible for certifying costs eligible for the supplemental payments, which shall not exceed the maximum allowable under federal rules. The state will ensure that the public hospital districts certify these expenditures in accordance with 42 CFR 433.51.

The payments to public hospital districts shall be supplemental to, and shall not in any way offset or reduce, the normal Medicaid nursing facility payments calculated and provided in accordance with part E of Ch. 74.46 RCW. Costs to improve access to health care at nursing facilities operated by public hospital districts that are otherwise allowable for rate-setting and for settlement against payments made under Ch. 74.46 RCW shall not be disallowed solely because such costs have been paid by revenues retained by the nursing facility from these supplemental payments.

The supplemental payments are limited to the difference between Medicaid routine costs incurred by the public hospital district-operated nursing facilities and the total Medicaid routine payments received by the facility during the rate year in which the supplemental payments will be claimed. The process for identifying such eligible incurred Medicaid cost is defined in Supplement A to Attachment 4.19-D, Part 1. The Medicare upper payment limit analysis shall be performed prior to making the supplemental payments.

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Section XVIII. Supplemental Exceptional Care Payments

Effective July 1, 2001, the department makes available exceptional care payments to augment normally generated payment rates for Medicaid residents.

The payments take the form of increases in the direct care and/or therapy component rate allocations for residents with unmet exceptional care needs, as determined by the department criteria. Direct care and therapy payment increases made for these residents shall be offset against a facility's allowable direct care and therapy care costs for purposes of normal rate setting and settlement. The cost per patient day for caring for these clients in a nursing home setting may be equal to or less than the cost of caring for these clients in a hospital setting.

A nursing facility (NF) may receive an increase in its direct care and/or therapy component rate allocations for providing exceptional care to a Medicaid resident who:

1. Receives specialized services to meet chronic complex medical conditions and neurodevelopment needs of medically fragile children, and resides in an NF where all residents are under age twenty-one with at least fifty percent of the residents entering the facility before the age of fourteen;
2. Receives Expanded Community Services (ECS);
3. Is admitted to the NF as an Extraordinary Medical Placement (EMP) and the Department of Corrections (DOC) has approved the exceptional direct care and/or therapy payment;
4. Is ventilator or tracheotomy (VT)-dependent and resides in an NF that the department has designated as an active ventilator-weaning center;
5. Has a traumatic brain injury (TBI) established by a Comprehensive Assessment Reporting Evaluation (CARE) assessment administered by department staff and resides in an NF that the department has designated as capable of caring for TBI patients;
6. Has a TBI and currently resides in an NF specializing in the care of TBI residents where more than fifty percent of residents are classified with TBIs based upon the federal minimum data set assessment (MDS 2 or its successor); or
7. Is admitted to an NF from a hospital with an exceptional care need that the department staff has determined the NF has the ability to provide the care needed, and the Health and Recovery Services Administration (HRSA) or a successor administration that assumes HRSA's responsibilities has approved the exceptional direct care and/or therapy payment.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIX

To simplify the Medicaid Nursing Facility Payment System, the following acts or parts of acts are each repealed. The department will codify in WAC any portions of the repealed statutes that it determines are necessary to implement or support the Medicaid Nursing Facility Payment System.

- (1) RCW 74.46.030 (Principles of reporting requirements) and 1980 c 177 s 3;
- (2) RCW 74.46.040 (Due dates for cost reports) and 1998 c 322 s 3, 1985 c 361 s 4, 1983 1st ex.s. c 67 s 1, & 1980 c 177 s 4;
- (3) RCW 74.46.050 (Improperly completed or late cost report--Fines--Adverse rate actions--Rules) and 1998 c 322 s 4, 1985 c 361 s 5, & 1980 c 177 s 5;
- (4) RCW 74.46.060 (Completing cost reports and maintaining records) and 1998 c 322 s 5, 1985 c 361 s 6, 1983 1st ex.s. c 67 s 2, & 1980 c 177 s 6;
- (5) RCW 74.46.080 (Requirements for retention of records by the contractor) and 1998 c 322 s 6, 1985 c 361 s 7, 1983 1st ex.s. c 67 s 3, & 1980 c 177 s 8;
- (6) RCW 74.46.090 (Retention of cost reports and resident assessment information by the department) and 1998 c 322 s 7, 1985 c 361 s 8, & 1980 c 177 s 9;
- (7) RCW 74.46.100 (Purposes of department audits--Examination--Incomplete or incorrect reports--Contractor's duties--Access to facility--Fines--Adverse rate actions) and 1998 c 322 s 8, 1985 c 361 s 9, 1983 1st ex.s. c 67 s 4, & 1980 c 177 s 10;
- (8) RCW 74.46.155 (Reconciliation of medicaid resident days to billed days and medicaid payments--Payments due--Accrued interest--Withholding funds) and 1998 c 322 s 9;
- (9) RCW 74.46.165 (Proposed settlement report--Payment refunds--Overpayments--Determination of unused rate funds--Total and component payment rates) and 2001 1st sp.s. c 8 s 2 & 1998 c 322 s 10;
- (10) RCW 74.46.190 (Principles of allowable costs) and 1998 c 322 s 11, 1995 1st sp.s. c 18 s 96, 1983 1st ex.s. c 67 s 12, & 1980 c 177 s 19;
- (11) RCW 74.46.200 (Offset of miscellaneous revenues) and 1980 c 177 s 20;
- (12) RCW 74.46.220 (Payments to related organizations--Limits--Documentation) and 1998 c 322 s 12 & 1980 c 177 s 22;
- (13) RCW 74.46.230 (Initial cost of operation) and 1998 c 322 s 13, 1993 sp.s. c 13 s 3, & 1980 c 177 s 23;
- (14) RCW 74.46.240 (Education and training) and 1980 c 177 s 24;
- (15) RCW 74.46.250 (Owner or relative--Compensation) and 1980 c 177 s 25;
- (16) RCW 74.46.270 (Disclosure and approval or rejection of cost allocation) and 1998 c 322 s 14, 1983 1st ex.s. c 67 s 13, & 1980 c 177 s 27;
- (17) RCW 74.46.280 (Management fees, agreements--Limitation on scope of services) and 1998 c 322 s 15, 1993 sp.s. c 13 s 4, & 1980 c 177 s 28;
- (18) RCW 74.46.290 (Expense for construction interest) and 1980 c 177 s 29;
- (19) RCW 74.46.300 (Operating leases of office equipment--Rules) and 1998 c 322 s 16 & 1980 c 177 s 30;
- (20) RCW 74.46.310 (Capitalization) and 1983 1st ex.s. c 67 s 16 & 1980 c 177 s 31;
- (21) RCW 74.46.320 (Depreciation expense) and 1980 c 177 s 32;
- (22) RCW 74.46.330 (Depreciable assets) and 1980 c 177 s 33;
- (23) RCW 74.46.340 (Land, improvements--Depreciation) and 1980 c 177 s 34;
- (24) RCW 74.46.350 (Methods of depreciation) and 1999 c 353 s 13 & 1980 c 177 s 35;

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIX (cont)

- (25) RCW 74.46.360 (Cost basis of land and depreciation base of depreciable assets) and 1999 c 353 s 2, 1997 c 277 s 1, 1991 sp.s. c 8 s 18, & 1989 c 372 s 14;
- (26) RCW 74.46.370 (Lives of assets) and 1999 c 353 s 14, 1997 c 277 s 2, & 1980 c 177 s 37;
- (27) RCW 74.46.380 (Depreciable assets) and 1993 sp.s. c 13 s 5, 1991 sp.s. c 8 s 12, & 1980 c 177 s 38;
- (28) RCW 74.46.390 (Gains and losses upon replacement of depreciable assets) and 1980 c 177 s 39;
- (29) RCW 74.46.410 (Unallowable costs) and 2007 c 508 s 1, 2001 1st sp.s. c 8 s 3, 1998 c 322 s 17, 1995 1st sp.s. c 18 s 97, 1993 sp.s. c 13 s 6, 1991 sp.s. c 8 s 15, 1989 c 372 s 2, 1986 c 175 s 3, 1983 1st ex.s. c 67 s 17, & 1980 c 177 s 41;
- (30) RCW 74.46.433 (Variable return component rate allocation) and 2006 c 258 s 3, 2001 1st sp.s. c 8 s 6, & 1999 c 353 s 9; (for July 1, 2010, the variable return component rate allocation for each facility shall be thirty percent of the facility's June 30, 2006, variable return component rate allocation. Effective July 1, 2011, the variable return component rate is repealed);
- (31) RCW 74.46.445 (Contractors--Rate adjustments) and 1999 c 353 s 15;
- (32) RCW 74.46.533 (Combined and estimated rebased rates--Determination--Hold harmless provision) and 2007 c 508 s 6;
- (33) RCW 74.46.600 (Billing period) and 1980 c 177 s 60;
- (34) RCW 74.46.610 (Billing procedure--Rules) and 1998 c 322 s 32, 1983 1st ex.s. c 67 s 33, & 1980 c 177 s 61;
- (35) RCW 74.46.620 (Payment) and 1998 c 322 s 33 & 1980 c 177 s 62;
- (36) RCW 74.46.625 (Supplemental payments) and 1999 c 392 s 1;
- (37) RCW 74.46.630 (Charges to patients) and 1998 c 322 s 34 & 1980 c 177 s 63;
- (38) RCW 74.46.640 (Suspension of payments) and 1998 c 322 s 35, 1995 1st sp.s. c 18 s 112, 1983 1st ex.s. c 67 s 34, & 1980 c 177 s 64;
- (39) RCW 74.46.650 (Termination of payments) and 1998 c 322 s 36 & 1980 c 177 s 65;
- (40) RCW 74.46.660 (Conditions of participation) and 1998 c 322 s 37, 1992 c 215 s 1, 1991 sp.s. c 8 s 13, & 1980 c 177 s 66;
- (41) RCW 74.46.680 (Change of ownership--Assignment of department's contract) and 1998 c 322 s 38, 1985 c 361 s 2, & 1980 c 177 s 68;
- (42) RCW 74.46.690 (Change of ownership--Final reports--Settlement) and 1998 c 322 s 39, 1995 1st sp.s. c 18 s 113, 1985 c 361 s 3, 1983 1st ex.s. c 67 s 36, & 1980 c 177 s 69;
- (43) RCW 74.46.700 (Resident personal funds--Records--Rules) and 1991 sp.s. c 8 s 19 & 1980 c 177 s 70;
- (44) RCW 74.46.711 (Resident personal funds--Conveyance upon death of resident) and 2001 1st sp.s. c 8 s 14 & 1995 1st sp.s. c 18 s 69;
- (45) RCW 74.46.770 (Contractor appeals--Challenges of laws, rules, or contract provisions--Challenge based on federal law) and 1998 c 322 s 40, 1995 1st sp.s. c 18 s 114, 1983 1st ex.s. c 67 s 39, & 1980 c 177 s 77;
- (46) RCW 74.46.780 (Appeals or exception procedure) and 1998 c 322 s 41, 1995 1st sp.s. c 18 s 115, 1989 c 175 s 159, 1983 1st ex.s. c 67 s 40, & 1980 c 177 s 78;
- (47) RCW 74.46.790 (Denial, suspension, or revocation of license or provisional license--Penalties) and 1980 c 177 s 79;
- (48) RCW 74.46.820 (Public disclosure) and 2005 c 274 s 356, 1998 c 322 s 43, 1985 c 361 s 14, 1983 1st ex.s. c 67 s 41, & 1980 c 177 s 82;
- (49) RCW 74.46.900 (Severability--1980 c 177) and 1980 c 177 s 93;
- (50) RCW 74.46.901 (Effective dates--1983 1st ex.s. c 67; 1980 c 177) and 1983 1st ex.s. c 67 s 49, 1981 1st ex.s. c 2 s 10, & 1980 c 177 s 94;
- (51) RCW 74.46.902 (Section captions--1980 c 177) and 1980 c 177 s 89;
- (52) RCW 74.46.905 (Severability--1983 1st ex.s. c 67) and 1983 1st ex.s. c 67 s 43; and
- (53) RCW 74.46.906 (Effective date--1998 c 322 §§ 1-37, 40-49, and 52-54) and 1998 c 322 s 55.