Chapter 74.46 RCW
NURSING FACILITY MEDICAID PAYMENT SYSTEM

Sections

RCW 74.46.010 Short title—Purpose—Finding. (1) This chapter may be known and cited as the "nursing facility medicaid payment system."

(2) The purposes of this chapter are to set forth principles to guide the nursing facility medicaid payment system and specify the manner by which legislative appropriations for medicaid nursing facility services are to be allocated as payment rates among nursing facilities.

(3) The legislature finds that the medicaid nursing facility rates calculated under this chapter provide sufficient reimbursement to efficient and economically operating facilities and bear a reasonable relationship to costs. [2010 1st sp.s. c 34 s 1; 1998 c 322 s 1; 1980 c 177 s 1.]

Effective date—2010 1st sp.s. c 34: "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 July 1, 2010." [2010 1st sp.s. c 34 s 23.]

RCW 74.46.020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

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

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

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

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

(5) "Capital component" means a fair market rental system that sets a price per nursing facility bed.

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

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

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

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

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

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

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

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

(14) "Direct care component" means nursing care and related care provided to nursing facility residents and includes the therapy care component, along with food, laundry, and dietary services of the previous system.

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

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

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

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

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

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

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

(22) "Generally accepted accounting principles" means accounting principles approved by the financial accounting standards board (FASB) or its successor.

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

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

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

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

(27) "Indirect care component" means the elements of administrative expenses, maintenance costs, taxes, and housekeeping services from the previous system.

(28) "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.

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

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

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

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

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

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

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

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

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

(38) "Patient-driven payment method" means a case mix system implemented by the centers for medicare and medicaid services to classify skilled nursing facility patients into payment groups based on specific data-driven patient characteristics.

(39) "Qualified therapist" means:

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

(b) An intellectual disabilities professional who is a therapist approved by the department who has had specialized training or one year's experience in treating or working with persons with intellectual or developmental disabilities;

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

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

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

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

(40) "Quality enhancement component" means a rate enhancement offered to facilities that meet or exceed the standard established for the quality measures.

(41) "Rate" or "rate allocation" means the medicaid per-patient-day payment amount for medicaid patients calculated in accordance with the allocation methodology set forth in RCW 74.46.421 through 74.46.531.

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

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

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

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

(46) "Secretary" means the secretary of the department of social and health services.

(47) "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.

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

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

(50) "Urban county" means a county which is located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government. [2024 c 246 s 1. Prior: 2016 c 131 s 4; 2010 1st sp.s. c 34 s 2; 2010 c 94 s 29; 2007 c 508 s 7; 2006 c 258 s 1; 2001 1st sp.s. c 8 s 1; 1999 c 353 s 1; 1998 c 322 s 2; 1995 1st sp.s. c 18 s 90; 1993 sp.s. c 13 s 1; 1991 sp.s. c 8 s 11; 1989 c

372 s 17; 1987 c 476 s 6; 1985 c 361 s 16; 1982 c 117 s 1; 1980 c 177 s 2.]

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

Purpose—2010 c 94: See note following RCW 44.04.280.

Effective date—2007 c 508: "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 July 1, 2007." [2007 c 508 s 8.]

Effective date—2006 c 258: "This act takes effect July 1, 2006." [2006 c 258 s 8.]

Severability—2001 1st sp.s. c 8: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2001 1st sp.s. c 8 s 21.]

Effective dates—2001 1st sp.s. c 8: "(1) Sections 1 through 19 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect July 1, 2001.

(2) Section 20 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect June 29, 2001." [2001 1st sp.s. c 8 s 22.]

Effective dates—1999 c 353: "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. Section 11 of this act takes effect immediately [May 17, 1999], and sections 1 through 10 and 12 through 17 take effect July 1, 1999." [1999 c 353 s 18.]

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Effective date—1993 sp.s. c 13: "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 shall take effect July 1, 1993." [1993 sp.s. c 13 s 21.]

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

Savings—1985 c 361: "This act shall not be construed as affecting any existing right acquired or any obligation or liability incurred under the statutes amended or repealed by this act or any rule, regulation, or order adopted under those sections, nor as affecting any proceeding instituted under those sections." [1985 c 361 s 20.]

RCW 74.46.022 Nursing facility medicaid payment system—Establishing procedures, principles, and conditions. The department shall establish, by rule, the procedures, principles, and conditions for the nursing facility medicaid payment system addressed by the following principles:

(1) The department must receive complete, annual reporting of all costs and the financial condition of each contractor, prepared and presented in a standardized manner. The department shall establish, by rule, due dates, requirements for cost report completion, actions required for improperly completed or late cost reports, fines for any statutory or regulatory noncompliance, retention requirements, and public disclosure requirements.

(2) The department shall examine all cost reports to determine whether the information is correct, complete, and reported in compliance with this chapter, department rules and instructions, and generally accepted accounting principles.

(3) Each contractor must establish and maintain, as a service to the resident, a bookkeeping system incorporated into the business records for all resident funds entrusted to the contractor and received by the contractor for the resident. The department shall adopt rules to ensure that resident personal funds handled by the contractor are maintained by each contractor in a manner that is, at a minimum, consistent with federal requirements.

(4) The department shall have the authority to audit resident trust funds and receivables, at its discretion.

(5) Contractors shall provide the department access to the nursing facility, all financial and statistical records, and all working papers that are in support of the cost report, receivables, and resident trust funds.

(6) The department shall establish a settlement process in order to reconcile medicaid resident days to billed days and medicaid payments for the preceding calendar year. The settlement process shall ensure that any savings in the direct care or therapy care component rates be shifted only between direct care and therapy care component rates, and shall not be shifted into any other rate components.

(7) The department shall define and identify allowable and unallowable costs.

(8) A contractor shall bill the department for care provided to medicaid recipients, and the department shall pay a contractor for service rendered under the facility contract and appropriately billed. Billing and payment procedures shall be specified by rule.

(9) The department shall establish the conditions for participation in the nursing facility medicaid payment system.

(10) The department shall establish procedures and a rate setting methodology for a change of ownership.

(11) The department shall establish, consistent with federal requirements for nursing facilities participating in the medicaid program, an appeals or exception procedure that allows individual nursing home providers an opportunity to receive prompt administrative review of payment rates with respect to such issues as the department deems appropriate.

(12) The department shall have authority to adopt, amend, and rescind such administrative rules and definitions as it deems necessary to carry out the policies and purposes of this chapter. [2010 1st sp.s. c 34 s 19.]

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

RCW 74.46.024 Pay-for-performance supplemental payment structure—Establishing procedures, principles, and conditions. 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. [2010 1st sp.s. c 34 s 20.]

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

RCW 74.46.421 Purpose of part E—Nursing facility medicaid payment rates. (1) The purpose of *part E of this chapter is to determine nursing facility medicaid payment rates that, in the aggregate for all participating nursing facilities, are in accordance with the biennial appropriations act.

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

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

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

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

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

(c) 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 weighted average payment rate for all facilities. [2008 c 263 s 1; 2001 1st sp.s. c 8 s 4; 1999 c 353 s 3; 1998 c 322 s 18.]

***Reviser's note:** Chapter 74.46 RCW was previously divided by parts. Some of the sections that were included in Part E have since been repealed or have expired.

Severability—Effective dates—2001 1st sp.s. c 8: See notes following RCW 74.46.020.

Effective dates—1999 c 353: See note following RCW 74.46.020.

RCW 74.46.441 Public disclosure of rate-setting information. The department shall disclose to any member of the public all rate-setting information consistent with requirements of state and federal laws. [1998 c 322 s 20.]

RCW 74.46.475 Submitted cost report—Analysis and adjustment by department. The department shall analyze the submitted cost report or a portion thereof of each contractor for each report period to determine if the information is correct, complete, reported in conformance with department instructions and generally accepted accounting principles, the requirements of this chapter, and such rules as the department may adopt. If the analysis finds that the cost report is incorrect or incomplete, the department may make adjustments to the reported information for purposes of establishing payment rate allocations. A schedule of such adjustments shall be provided to contractors and shall include an explanation for the adjustment and the dollar amount of the adjustment. Adjustments shall be subject to review and appeal as provided in this chapter. [2010 1st sp.s. c 34 s 8; 1998 c 322 s 21; 1985 c 361 s 13; 1983 1st ex.s. c 67 s 23.]

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

Savings—1985 c 361: See note following RCW 74.46.020.

Effective dates—1983 1st ex.s. c 67: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions and shall take effect on July 1, 1983, with the exception of section 28 of this act, which shall take effect on January 1, 1985." [1983 1st ex.s. c 67 s 51.]

RCW 74.46.485 Case mix method implementation. (1) The legislature recognizes that staff and resources needed to adequately care for individuals with cognitive or behavioral impairments is not limited to support for activities of daily living. Therefore, the department shall:

(a) Beginning July 1, 2024, implement a method for applying case mix to the rate. This method should be informed by the minimum data set collected by the centers for medicare and medicaid services;

(b) Subject to the availability of amounts appropriated for this specific purpose, employ the case mix adjustment method to adjust rates of individual facilities for case mix changes;

(c) Upon the discontinuation of resource utilization group's scores, and in collaboration with appropriate stakeholders, create a new case mix adjustment method for adjusting direct care rates based on changes in case mix using the patient-driven payment method;

(d) By December 1, 2024, provide an initial report to the governor and appropriate legislative committees outlining a phased implementation plan; and

(e) By December 1, 2026, provide a final report to the appropriate legislative committees. These reports must include the following information:

(i) An analysis of the potential impact of the new case mix classification methodology on nursing facility payment rates;

(ii) Proposed payment adjustments for capturing specific client needs that may not be clearly captured in the data available from the centers for medicare and medicaid services; and

(iii) A plan to continuously monitor the effects of the new methodologies on each facility to ensure certain client populations or needs are not unintentionally negatively impacted.

(2) A default case mix group shall be established for cases in which the resident dies or is discharged for any purpose prior to completion of the resident's initial assessment. The default case mix group and case mix weight for these cases shall be designated by the department.

(3) A default case mix group may also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases shall be designated by the department. [2024 c 246 s 2; 2021 c 334 s 991; 2017 c 286 s 1; 2011 1st sp.s. c 7 s 4; 2010 1st sp.s. c 34 s 9; 2009 c 570 s 2; 1998 c 322 s 22.]

Conflict with federal requirements—Effective date—2021 c 334: See notes following RCW 43.79.555.

Purpose—Findings—Intent—Severability—Effective date—2011 1st sp.s. c 7: See RCW 74.48.005, 74.48.900, and 74.48.901.

Analysis—2011 1st sp.s. c 7: "(1) For fiscal years 2012 and 2013 and subject to appropriation, the department of social and health services shall do a comparative analysis of the facility-based payment rates calculated on July 1, 2011, using the payment methodology defined in chapter 74.46 RCW as modified by RCW 74.46.431, 74.46.435, 74.46.437, 74.46.485, 74.46.496, 74.46.501, 74.46.506, 74.46.515, and 74.46.521, to the facility-based payment rates in effect June 30, 2010. If the facility-based payment rate calculated on July 1, 2011, is smaller than the facility-based payment rate on June 30, 2011, the

difference shall be provided to the individual nursing facilities as an add-on payment per medicaid resident day.

(2) During the comparative analysis performed in subsection (1) of this section, if it is found that the direct care rate for any facility calculated under RCW 74.46.431, 74.46.435, 74.46.437, 74.46.485, 74.46.496, 74.46.501, 74.46.506, 74.46.515, and 74.46.521 is greater than the direct care rate in effect on June 30, 2010, then the facility shall receive a ten percent direct care rate add-on to compensate that facility for taking on more acute clients than they have in the past.

(3) The rate add-ons provided in subsection (2) of this section are subject to the reconciliation and settlement process provided in RCW 74.46.022(6)." [2011 1st sp.s. c 7 s 11.]

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

Effective date—2009 c 570: "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 [May 19, 2009]." [2009 c 570 s 3.]

RCW 74.46.496 Case mix weights—Determination. (1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility for each calendar quarter or six-month period during a calendar year shall be based on data from resident assessment instruments completed for the resident and weighted by the number of days the resident was in each case mix classification group. Days shall be counted as provided in this section.

(2) The case mix weights shall be based on finalized case mix weights as published by the centers for medicare and medicaid services in the federal register. [2024 c 246 s 3; 2011 1st sp.s. c 7 s 5; 2010 1st sp.s. c 34 s 10; 2006 c 258 s 4; 1998 c 322 s 23.]

Purpose—Findings—Intent—Severability—Effective date—2011 1st sp.s. c 7: See RCW 74.48.005, 74.48.900, and 74.48.901.

Analysis—2011 1st sp.s. c 7: See note following RCW 74.46.485.

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

Effective date—2006 c 258: See note following RCW 74.46.020.

RCW 74.46.501 Average case mix indexes determined quarterly—Facility average case mix index—Medicaid average case mix index. (1) From individual case mix weights for the applicable quarter, the department shall determine two average case mix indexes for each medicaid nursing facility, one for all residents in the facility, known as the facility average case mix index, and one for medicaid residents, known as the medicaid average case mix index.

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or

medicaid residents, as applicable, who were physically in the facility during the quarter in question based on the resident assessment instrument completed by the facility and the requirements and limitations for the instrument's completion and transmission (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

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

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

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

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

(6) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the cost-rebasing period facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by RCW 74.46.561, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate semiannually. [2024 c 246 s 4; 2021 c 334 s 992; 2016 c 131 s 5; 2015 2nd sp.s. c 2 s 2; 2013 2nd sp.s. c 3 s 2; 2011 1st sp.s. c 7 s 6; 2010 1st sp.s. c 34 s 11; 2006 c 258 s 5; 2001 1st sp.s. c 8 s 9; 1998 c 322 s 24.]

Conflict with federal requirements—Effective date—2021 c 334: See notes following RCW 43.79.555.

Effective date—2015 2nd sp.s. c 2: "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 July 1, 2015." [2015 2nd sp.s. c 2 s 10.]

Comparative analysis—2013 2nd sp.s. c 3: "(1) For fiscal years 2014 and 2015 and subject to appropriation, the department of social and health services shall do a comparative analysis of the facility-based payment rates calculated on July 1, 2013, using the payment methodology defined in chapter 74.46 RCW, to the facility-based payment rates in effect June 30, 2010. If the facility-based payment rate calculated on July 1, 2013, is smaller than the facility-based payment rate on June 30, 2010, the difference shall be provided to the individual nursing facilities as an add-on payment per medicaid resident day.

(2) During the comparative analysis performed in subsection (1) of this section, if it is found that the direct care rate for any facility calculated under chapter 74.46 RCW is greater than the direct care rate in effect on June 30, 2010, then the facility shall receive a ten percent direct care rate add-on to compensate that facility for taking on more acute clients than they have in the past.

(3) The rate add-ons provided in subsection (2) of this section are subject to the reconciliation and settlement process provided in RCW 74.46.022(6)." [2013 2nd sp.s. c 3 s 3.]

Effective date—2013 2nd sp.s. c 3: "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 July 1, 2013." [2013 2nd sp.s. c 3 s 4.]

Purpose—Findings—Intent—Severability—Effective date—2011 1st sp.s. c 7: See RCW 74.48.005, 74.48.900, and 74.48.901.

Analysis—2011 1st sp.s. c 7: See note following RCW 74.46.485.

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

Effective date—2006 c 258: See note following RCW 74.46.020.

Severability—Effective dates—2001 1st sp.s. c 8: See notes following RCW 74.46.020.

RCW 74.46.531 Department may adjust component rates—Contractor may request—Errors or omissions. (1) The department may adjust component rates for errors or omissions made in establishing component rates and determine amounts either overpaid to the contractor or underpaid by the department.

(2) A contractor may request the department to adjust its component rates because of:

(a) An error or omission the contractor made in completing a cost report; or

(b) An alleged error or omission made by the department in determining one or more of the contractor's component rates.

(3) A request for a rate adjustment made on incorrect cost reporting must be accompanied by the amended cost report pages prepared in accordance with the department's written instructions and by a written explanation of the error or omission and the necessity for the amended cost report pages and the rate adjustment.

(4) The department shall review a contractor's request for a rate adjustment because of an alleged error or omission, even if the time period has expired in which the contractor must appeal the rate when initially issued, pursuant to rules adopted by the department under *RCW 74.46.780. If the request is received after this time period, the department has the authority to correct the rate if it agrees an error or omission was committed. However, if the request is denied, the contractor shall not be entitled to any appeals or exception review procedure that the department may adopt under *RCW 74.46.780.

(5) The department shall notify the contractor of the amount of the overpayment to be recovered or additional payment to be made to

the contractor reflecting a rate adjustment to correct an error or omission. The recovery from the contractor of the overpayment or the additional payment to the contractor shall be governed by the reconciliation, settlement, security, and recovery processes set forth in this chapter and by rules adopted by the department in accordance with this chapter.

(6) Component rate adjustments approved in accordance with this section are subject to the provisions of RCW 74.46.421. [1998 c 322 s 31.]

***Reviser's note:** RCW 74.46.780 was repealed by 2010 1st sp.s. c 34 s 21.

RCW 74.46.541 Skilled nursing facility safety net assessment—Reimbursement of medicaid share. (1) The department shall establish a skilled nursing facility safety net assessment medicaid share pass-through or rate add-on to reimburse the medicaid share of the skilled nursing facility safety net assessment as a medicaid allowable cost consistent with RCW 74.48.030. This add-on shall not be considered an allowable cost for future year cost rebasing.

(2) As of July 1, 2011, supplemental payments to reimburse medicaid expenditures, including an amount to reimburse the medicaid share of the skilled nursing facility safety net assessment, not to exceed the annual medicare upper payment limit, must be provided for all years when the skilled nursing facility safety net assessment is levied, consistent with RCW 74.48.030. These supplemental payments, at a minimum, must be sufficient to reimburse the medicaid share of the assessment for those paying the assessment. The part of these supplemental payments that reimburses the medicaid share of the assessment are not subject to the reconciliation and settlement process provided in RCW 74.46.022(6). [2011 1st sp.s. c 7 s 10.]

Purpose—Findings—Intent—Severability—Effective date—2011 1st sp.s. c 7: See RCW 74.48.005, 74.48.900, and 74.48.901.

RCW 74.46.551 Facility-based payment rates—Comparative analysis—Rate add-ons. (1) For fiscal year 2016 and subject to appropriation, the department shall do a comparative analysis of the facility-based payment rates calculated on July 1, 2015, using the payment methodology defined in this chapter, to the facility-based rates in effect June 30, 2010. If the facility-based payment rate calculated on July 1, 2015, is smaller than the facility-based payment rate on June 30, 2010, the difference must be provided to the individual nursing facilities as an add-on per medicaid resident day.

(2) During the comparative analysis performed in subsection (1) of this section, for fiscal year 2016, if it is found that the direct care rate for any facility calculated under this chapter is greater than the direct care rate in effect on June 30, 2010, then the facility must receive a ten percent direct care rate add-on to compensate that facility for taking on more acute clients than it has in the past.

(3) The rate add-ons provided in subsection (2) of this section are subject to the reconciliation and settlement process provided in RCW 74.46.022(6). [2015 2nd sp.s. c 2 s 3.]

Effective date—2015 2nd sp.s. c 2: See note following RCW 74.46.501.

RCW 74.46.561 Nursing home payment rates—System components—Quality incentive—Reimbursement of safety net assessment—Rate reductions or increases limited. (1) The legislature adopts a new system for establishing nursing home payment rates beginning July 1, 2016. Any payments to nursing homes for services provided after June 30, 2016, must be based on the new system. The new system must be designed in such a manner as to decrease administrative complexity associated with the payment methodology, reward nursing homes providing care for high acuity residents, incentivize quality care for residents of nursing homes, and establish minimum staffing standards for direct care.

(2) The new system must be based primarily on industry-wide costs, and have three main components: Direct care, indirect care, and capital.

(3)(a) The direct care component must include the direct care and therapy care components of the previous system, along with food, laundry, and dietary services. Except as provided in (b) of this subsection, direct care must be paid at a fixed rate, based on one hundred percent or greater of statewide case mix neutral median costs, but shall be capped so that a nursing home provider's direct care rate does not exceed 118 percent of its base year's direct care allowable costs except if the provider is below the minimum staffing standard established in RCW 74.42.360(2). Direct care must be performance-adjusted for acuity every six months, using case mix principles. Direct care must be regionally adjusted using countywide wage index information available through the United States department of labor's bureau of labor statistics. There is no minimum occupancy for direct care. The direct care component rate allocations calculated in accordance with this section must be adjusted to the extent necessary to comply with RCW 74.46.421.

(b) Unless a nursing home provider is below the minimum staffing standard established in RCW 74.42.360(2), a provider's direct care rate relative to its base year's direct care allowable costs must be capped as follows:

(i) For fiscal year 2023, the cap must not exceed 165 percent;

(ii) For fiscal year 2024, the cap must not exceed 153 percent; and

(iii) For fiscal year 2025, the cap must not exceed 142 percent.

(4)(a) The indirect care component must include the elements of administrative expenses, maintenance costs, and housekeeping services from the previous system. Except as provided in (b) of this subsection, a minimum occupancy assumption of ninety percent must be applied to indirect care. Indirect care must be paid at a fixed rate, based on ninety percent or greater of statewide median costs. The indirect care component rate allocations calculated in accordance with this section must be adjusted to the extent necessary to comply with RCW 74.46.421.

(b) A minimum occupancy assumption must be applied to indirect care as follows:

(i) For fiscal year 2023, the assumption must be 75 percent;

(ii) For fiscal year 2024, the assumption must be 80 percent; and

(iii) For fiscal year 2025, the assumption must be 80 percent.

(5) The capital component must use a fair market rental system to set a price per bed. The capital component must be adjusted for the age of the facility, and must use a minimum occupancy assumption of ninety percent.

(a) Beginning July 1, 2016, the fair rental rate allocation for each facility must be determined by multiplying the allowable nursing home square footage in (c) of this subsection by the RSMeans rental rate in (d) of this subsection and by the number of licensed beds yielding the gross unadjusted building value. An equipment allowance of ten percent must be added to the unadjusted building value. The sum of the unadjusted building value and equipment allowance must then be reduced by the average age of the facility as determined by (e) of this subsection using a depreciation rate of one and one-half percent. The depreciated building and equipment plus land valued at ten percent of the gross unadjusted building value before depreciation must then be multiplied by the rental rate at seven and one-half percent to yield an allowable fair rental value for the land, building, and equipment.

(b) The fair rental value determined in (a) of this subsection must be divided by the greater of the actual total facility census from the prior full calendar year or imputed census based on the number of licensed beds at ninety percent occupancy.

(c) For the rate year beginning July 1, 2016, all facilities must be reimbursed using four hundred square feet. For the rate year beginning July 1, 2017, allowable nursing facility square footage must be determined using the total nursing facility square footage as reported on the medicaid cost reports submitted to the department in compliance with this chapter. The maximum allowable square feet per bed may not exceed four hundred fifty.

(d) Each facility must be paid at eighty-three percent or greater of the median nursing facility RSMeans construction index value per square foot. The department may use updated RSMeans construction index information when more recent square footage data becomes available. The statewide value per square foot must be indexed based on facility zip code by multiplying the statewide value per square foot times the appropriate zip code based index. For the purpose of implementing this section, the value per square foot effective July 1, 2016, must be set so that the weighted average fair rental value rate is not less than ten dollars and eighty cents per patient day. The capital component rate allocations calculated in accordance with this section must be adjusted to the extent necessary to comply with RCW 74.46.421.

(e) The average age is the actual facility age reduced for significant renovations. Significant renovations are defined as those renovations that exceed two thousand dollars per bed in a calendar year as reported on the annual cost report submitted in accordance with this chapter. For the rate beginning July 1, 2016, the department shall use renovation data back to 1994 as submitted on facility cost reports. Beginning July 1, 2016, facility ages must be reduced in future years if the value of the renovation completed in any year exceeds two thousand dollars times the number of licensed beds. The cost of the renovation must be divided by the accumulated depreciation per bed in the year of the renovation to determine the equivalent number of new replacement beds. The new age for the facility is a weighted average with the replacement bed equivalents reflecting an age of zero and the existing licensed beds, minus the new bed equivalents, reflecting their age in the year of the renovation. At no

time may the depreciated age be less than zero or greater than forty-four years.

(f) A nursing facility's capital component rate allocation must be rebased annually, effective July 1, 2016, in accordance with this section and this chapter.

(g) For the purposes of this subsection (5), "RSMeans" means building construction costs data as published by Gordian.

(6) A quality incentive must be offered as a rate enhancement beginning July 1, 2016.

(a) An enhancement no larger than five percent and no less than one percent of the statewide average daily rate must be paid to facilities that meet or exceed the standard established for the quality incentive. All providers must have the opportunity to earn the full quality incentive payment.

(b) The quality incentive component must be determined by calculating an overall facility quality score composed of four to six quality measures. For fiscal year 2017 there shall be four quality measures, and for fiscal year 2018 there shall be six quality measures. Initially, the quality incentive component must be based on minimum data set quality measures for the percentage of long-stay residents who self-report moderate to severe pain, the percentage of high-risk long-stay residents with pressure ulcers, the percentage of long-stay residents experiencing one or more falls with major injury, and the percentage of long-stay residents with a urinary tract infection. Quality measures must be reviewed on an annual basis by a stakeholder work group established by the department. Upon review, quality measures may be added or changed. The department may risk adjust individual quality measures as it deems appropriate.

(c) The facility quality score must be point based, using at a minimum the facility's most recent available three-quarter average centers for medicare and medicaid services quality data. Point thresholds for each quality measure must be established using the corresponding statistical values for the quality measure point determinants of eighty quality measure points, sixty quality measure points, forty quality measure points, and twenty quality measure points, identified in the most recent available five-star quality rating system technical user's guide published by the centers for medicare and medicaid services.

(d) Facilities meeting or exceeding the highest performance threshold (top level) for a quality measure receive twenty-five points. Facilities meeting the second highest performance threshold receive twenty points. Facilities meeting the third level of performance threshold receive fifteen points. Facilities in the bottom performance threshold level receive no points. Points from all quality measures must then be summed into a single aggregate quality score for each facility.

(e) Facilities receiving an aggregate quality score of eighty percent of the overall available total score or higher must be placed in the highest tier (tier V), facilities receiving an aggregate score of between seventy and seventy-nine percent of the overall available total score must be placed in the second highest tier (tier IV), facilities receiving an aggregate score of between sixty and sixty-nine percent of the overall available total score must be placed in the third highest tier (tier III), facilities receiving an aggregate score of between fifty and fifty-nine percent of the overall available total score must be placed in the fourth highest tier (tier II), and

facilities receiving less than fifty percent of the overall available total score must be placed in the lowest tier (tier I).

(f) The tier system must be used to determine the amount of each facility's per patient day quality incentive component. The per patient day quality incentive component for tier IV is seventy-five percent of the per patient day quality incentive component for tier V, the per patient day quality incentive component for tier III is fifty percent of the per patient day quality incentive component for tier V, and the per patient day quality incentive component for tier II is twenty-five percent of the per patient day quality incentive component for tier V. Facilities in tier I receive no quality incentive component.

(g) Tier system payments must be set in a manner that ensures that the entire biennial appropriation for the quality incentive program is allocated.

(h) Facilities with insufficient three-quarter average centers for medicare and medicaid services quality data must be assigned to the tier corresponding to their five-star quality rating. Facilities with a five-star quality rating must be assigned to the highest tier (tier V) and facilities with a one-star quality rating must be assigned to the lowest tier (tier I). The use of a facility's five-star quality rating shall only occur in the case of insufficient centers for medicare and medicaid services minimum data set information.

(i) The quality incentive rates must be adjusted semiannually on July 1 and January 1 of each year using, at a minimum, the most recent available three-quarter average centers for medicare and medicaid services quality data.

(j) Beginning July 1, 2017, the percentage of short-stay residents who newly received an antipsychotic medication must be added as a quality measure. The department must determine the quality incentive thresholds for this quality measure in a manner consistent with those outlined in (b) through (h) of this subsection using the centers for medicare and medicaid services quality data.

(k) Beginning July 1, 2017, the percentage of direct care staff turnover must be added as a quality measure using the centers for medicare and medicaid services' payroll-based journal and nursing home facility payroll data. Turnover is defined as an employee departure. The department must determine the quality incentive thresholds for this quality measure using data from the centers for medicare and medicaid services' payroll-based journal, unless such data is not available, in which case the department shall use direct care staffing turnover data from the most recent medicaid cost report.

(7) Reimbursement of the safety net assessment imposed by chapter 74.48 RCW and paid in relation to medicaid residents must be continued.

(8)(a) The direct care and indirect care components must be rebased in even-numbered years, beginning with rates paid on July 1, 2016. Rates paid on July 1, 2016, must be based on the 2014 calendar year cost report. On a percentage basis, after rebasing, the department must confirm that the statewide average daily rate has increased at least as much as the average rate of inflation, as determined by the skilled nursing facility market basket index published by the centers for medicare and medicaid services, or a comparable index. If after rebasing, the percentage increase to the statewide average daily rate is less than the average rate of inflation for the same time period, the department is authorized to

increase rates by the difference between the percentage increase after rebasing and the average rate of inflation.

(b) It is the intention of the legislature that direct and indirect care rates paid in fiscal year 2022 will be rebased using the calendar year 2019 cost reports. For fiscal year 2021, in addition to the rates generated by (a) of this subsection, an additional adjustment is provided as established in this subsection (8)(b). Beginning May 1, 2020, and through June 30, 2021, the calendar year costs must be adjusted for inflation by a twenty-four month consumer price index, based on the most recently available monthly index for all urban consumers, as published by the bureau of labor statistics. It is also the intent of the legislature that, starting in fiscal year 2022, a facility-specific rate add-on equal to the inflation adjustment that facilities received solely in fiscal year 2021, must be added to the rate. For fiscal year 2024, the direct care and indirect care components shall be rebased to the 2021 calendar year cost report plus a 4.7 percent adjustment for inflation. For fiscal year 2025, the direct and indirect care components shall be rebased to the 2022 calendar year cost report plus a five percent adjustment for inflation.

(c) To determine the necessity of regular inflationary adjustments to the nursing facility rates, by December 1, 2020, the department shall provide the appropriate policy and fiscal committees of the legislature with a report that provides a review of rates paid in 2017, 2018, and 2019 in comparison to costs incurred by nursing facilities.

(9) The direct care component provided in subsection (3) of this section is subject to the reconciliation and settlement process provided in RCW 74.46.022(6). Beginning July 1, 2016, pursuant to rules established by the department, funds that are received through the reconciliation and settlement process provided in RCW 74.46.022(6) must be used for technical assistance, specialized training, or an increase to the quality enhancement established in subsection (6) of this section. The legislature intends to review the utility of maintaining the reconciliation and settlement process under a price-based payment methodology, and may discontinue the reconciliation and settlement process after the 2017-2019 fiscal biennium.

(10) Compared to the rate in effect June 30, 2016, including all cost components and rate add-ons, no facility may receive a rate reduction of more than one percent on July 1, 2016, more than two percent on July 1, 2017, or more than five percent on July 1, 2018. To ensure that the appropriation for nursing homes remains cost neutral, the department is authorized to cap the rate increase for facilities in fiscal years 2017, 2018, and 2019.

(11) It is the intent of the legislature that a rate add-on be applied to the weighted average nursing facility payment rate referenced in the omnibus operating appropriations act in an amount necessary to ensure that the weighted average nursing facility payment rate for fiscal year 2026 is equal to the weighted average nursing facility payment rate for fiscal year 2025. [2023 c 475 s 942; 2023 c 475 s 1903; 2022 c 297 s 966; 2021 c 334 s 993; 2020 c 357 s 918; 2019 c 301 s 1; 2017 c 286 s 2; 2016 c 131 s 1; 2015 2nd sp.s. c 2 s 4.]

Effective date—2023 c 475: See note following RCW 16.76.030.

Effective date—2022 c 297: See note following RCW 43.79.565.

Conflict with federal requirements—Effective date—2021 c 334: See notes following RCW 43.79.555.

Effective date—2020 c 357: See note following RCW 43.79.545.

Effective date—2015 2nd sp.s. c 2: See note following RCW 74.46.501.

RCW 74.46.562 Indian health service or tribal facilities—Payment rates. Services provided by or through facilities of the Indian health service or facilities operated by a tribe or tribal organization pursuant to 42 C.F.R. Part 136 may be paid at the applicable rates published in the federal register or at a cost-based rate applicable to such types of facilities as approved by the centers for medicare and medicaid services and may be exempted from the rate determination set forth in this chapter. The department may enact emergency rules to implement this section. [2019 c 301 s 2.]

RCW 74.46.571 Nursing home payment rates—Rules. The department shall adopt rules as are necessary and reasonable to effectuate and maintain the new system for establishing nursing home payment rates described in RCW 74.46.561 and the minimum staffing standards described in RCW 74.42.360. The rules must be consistent with the principles described in RCW 74.46.561 and 74.42.360. In adopting such rules, the department shall solicit the opinions of nursing facility providers, nursing facility provider associations, nursing facility employees, and nursing facility consumer groups. [2015 2nd sp.s. c 2 s 5.]

Effective date—2015 2nd sp.s. c 2: See note following RCW 74.46.501.

RCW 74.46.581 Separate nursing facility quality enhancement account. A separate nursing facility quality enhancement account is created in the custody of the state treasurer. Beginning July 1, 2015, all net receipts from the reconciliation and settlement process provided in RCW 74.46.022(6), as described within RCW 74.46.561, must be deposited into the account. Beginning July 1, 2016, all receipts from the system of financial penalties for facilities out of compliance with minimum staffing standards, as described within RCW 74.42.360, must be deposited into the account. Only the secretary, or the secretary's designee, may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. The department shall use the special account only for technical assistance for nursing facilities, specialized training for nursing facilities, or an increase to the quality enhancement established in RCW 74.46.561, or as necessary for the reconciliation and settlement process, which requires deposits and withdrawals to complete both the preliminary and final settlement net receipt amounts for this account. [2016 c 131 s 7; 2015 2nd sp.s. c 2 s 8.]

Effective date—2015 2nd sp.s. c 2: See note following RCW 74.46.501.

RCW 74.46.800 Rule-making authority. (1) The department shall have authority to adopt, amend, and rescind such administrative rules and definitions as it deems necessary to carry out the policies and purposes of this chapter and to resolve issues and develop procedures to implement, update, and improve the nursing facility medicaid payment system.

(2) Nothing in this chapter shall be construed to require the department to adopt or employ any calculations, steps, tests, methodologies, alternate methodologies, indexes, formulas, mathematical or statistical models, concepts, or procedures for medicaid rate setting or payment that are not expressly called for in this chapter. [2010 1st sp.s. c 34 s 18; 1998 c 322 s 42; 1980 c 177 s 80.]

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

RCW 74.46.835 AIDS pilot nursing facility—Payment for direct care. (1) Payment for direct care at the pilot nursing facility in King county designed to meet the service needs of residents living with AIDS, as defined in *RCW 70.24.017, and as specifically authorized for this purpose under chapter 9, Laws of 1989 1st ex. sess., shall be exempt from case mix methods of rate determination set forth in this chapter and shall be exempt from the direct care wage index adjustment set forth in this chapter.

(2) Direct care component rates at the AIDS pilot facility shall be based on direct care reported costs at the pilot facility, utilizing the same rate-setting cycle prescribed for other nursing facilities, and as supported by a staffing benchmark based upon a department-approved acuity measurement system.

(3) The provisions of RCW 74.46.421 and all other rate-setting principles, cost lids, and limits, including settlement as provided in rule shall apply to the AIDS pilot facility.

(4) This section applies only to the AIDS pilot nursing facility. [2016 c 131 s 6; 2010 1st sp.s. c 34 s 17; 1998 c 322 s 46.]

***Reviser's note:** RCW 70.24.017 was amended by 2020 c 76 s 2, deleting the definition of "AIDS."

Effective date—2010 1st sp.s. c 34: See note following RCW 74.46.010.

RCW 74.46.840 Conflict with federal requirements. If any part of this chapter or RCW 18.51.145 or 74.09.120 is found by an agency of the federal government to be in conflict with federal requirements that are a prescribed condition to the receipts of federal funds to the state, the conflicting part of this chapter or RCW 18.51.145 or 74.09.120 is declared inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and such finding or determination shall not affect the operation of the remainder of this chapter or RCW 18.51.145 or 74.09.120 in its application to the

agencies concerned. In the event that any portion of this chapter or RCW 18.51.145 or 74.09.120 is found to be in conflict with federal requirements that are a prescribed condition to the receipt of federal funds, the secretary, to the extent that the secretary finds it to be consistent with the general policies and intent of chapters 18.51, 74.09, and 74.46 RCW, may adopt such rules as to resolve a specific conflict and that do meet minimum federal requirements. In addition, the secretary shall submit to the next regular session of the legislature a summary of the specific rule changes made and recommendations for statutory resolution of the conflict. [1998 c 322 s 44; 1983 1st ex.s. c 67 s 42; 1980 c 177 s 92.]

RCW 74.46.909 Retrospective application—Clarification of chapter 8, Laws of 2001 1st sp. sess.—2008 c 263. The legislature clarifies the enactment of *chapter 8, Laws of 2001 1st sp. sess. and intends this act be curative, remedial, and retrospectively applicable to July 1, 1998. [2008 c 263 s 5.]

***Reviser's note:** For codification of chapter 8, Laws of 2001 1st sp. sess., see Codification Tables.