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

Centers for Medicaid and State Operations , CMSO

#16887
Doug - fyi
C/ Susan
Kathy

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

DEC 17 2009

RE: WA 09-026

Dear Secretary Dreyfus:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-026. This amendment updates the State plan by making technical changes to the formula used to calculate the distribution ratio of payments between eligible providers of nursing facility services.

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 09-026 is approved effective July 1, 2009. 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,

Bill Lemm
for Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

Enclosures

cc: Kathy Leitch, Assistant Secretary DSHS, ADSA
Doug Porter, Assistant Secretary, DSHS, HRSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-026**

2. STATE: Washington

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, 2009

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 2009 $ ~~10,467,347~~ (see cover letter) $0 (PEI)
b. FFY 2010 $ ~~31,517,669~~ (see cover letter) $0 (PEI)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Part 1, pages 3, 6, 6a, 7a, 13, 16, 18, 19

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, Part 1, pages 3, 6, 6a, 13, 16, 18, 19
Note: Att. 4.19-D, Page 7a is removed

10. SUBJECT OF AMENDMENT:

Nursing Facility Rate Methodology

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: Susan N. Dreyfus 9/27/09

13. TYPED NAME: Susan N. Dreyfus

14. TITLE: Secretary

15. DATE SUBMITTED: Sept. 29, 2009

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
POB 5504
Olympia, WA 98504-5504

(MS: 45504)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 29 2009

18. DATE APPROVED: 12-17-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 1 - 2009

20. SIGNATURE OF REGIONAL OFFICIAL: William Lasowski R CM

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:
PEI changes authorized by State 11/09/09

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont):

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

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.

For July 1, 2001, rate setting, resident days for all facilities in all component rates continue to be subject to a minimum occupancy of 85 percent of each facility's licensed beds, regardless of how many beds are set up or in use. That is, if resident days are below this minimum for the applicable cost report period, they are increased to an imputed occupancy of 85 percent for rate setting, which has the effect of reducing per resident day costs and component rates based on them.

If 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.

Effective July 1, 2002, minimum occupancy for rate setting for all facilities will continue at 85 percent in direct care, therapy care, support services and variable return component rates. However, effective as of this date, except for facilities designated as essential community providers, minimum occupancy will be raised from 85 percent to 90 percent for calculation of operations, financing allowance and property component rates, and these components will be revised downward, if indicated, effective July 1, 2002, to reflect the higher minimum.

As noted, this increase in minimum occupancy for the affected components will not apply to essential community providers, who will continue to be subject only to an 85 percent minimum occupancy for all components on and after July 1, 2002. An "essential community provider" is defined by a minimum driving time of forty minutes to the next nearest nursing facility.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (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, 2001, direct care component rates are cost-rebased using adjusted direct care costs taken from 1999 cost reports, and applying case mix principles; however, the option to receive a "hold harmless" direct care component rate for qualifying nursing facilities will continue for the July 1, 2001, through June 30, 2002, prospective rate period. The direct care component rates of some facilities will be subject to upward adjustments for economic trends, as specified above, effective July 1, 2001, and July 1, 2002. (See Section V, Adjustments to Rates for Economic Trends and Conditions, above.)

Direct care components rates, as all component rates, are subject to potential prospective reduction under the budget dial described above.

The "hold harmless" direct care provision dates back to October 1, 1998, under which a facility's direct care component rate cannot fall below the facility's "nursing services" component rate in effect on September 30, 1998, subject to adjustment to eliminate therapy services and supplies.

The hold harmless option in direct care will be discontinued for all facilities effective July 1, 2002. Also, effective July 1, 2001, any facility having its direct care component rate established on case mix principles promulgated in law and regulation, shall be ineligible to return to a hold harmless direct care component rate.

Effective July 1, 2006, direct care component rates are based on 2003 cost reports.

For state fiscal year (SFY) 2002 (July 1, 2001, to June 30, 2002), 45 cents per resident day is added to the direct care component rates of all participating facilities, after cost-rebasing, updates for changes in case mix, and adjustments for economic trends and conditions, if any. The added money is intended for use by facilities to increase compensation for low wage earners in each nursing facility, subject to use monitoring by the department. For SFY 2003 (July 1, 2002, to June 30, 2003), to help preserve these funds earmarked for low wage workers, the department shall increase by .6 percent the median cost per case mix unit for all three direct care peer groups, and direct care component rates for all facilities will reflect this increase for SFY 2003.

Effective July 1, 2002, there will be a one-time increase in the median cost per case mix unit for rate setting of 2.64 percent for all peer groups, in order to ease the transition to case mix only direct care rates as of this date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

In setting July 1, 2001, direct care component rates, adjusted, allowable direct care costs are taken from each facility's 1999 cost report and, subject to all limitations, are divided by adjusted, total resident days for each facility from the same report, increased, if necessary to the imputed minimum occupancy specified above, to derive an allowable cost per resident day for each facility.

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.

For those facilities electing to accept it, the department shall continue to provide a "low-wage worker add-on" per Medicaid resident day per facility not to exceed $1.57. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

Effective July 1, 2001, the property component rate continues to be cost-rebased 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.

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.

Authorizations cannot exceed the following legislatively-imposed limits -- $16 million for state fiscal year (SFY) 2006, $16 million for SFY 2007, and $16 million for SFY 2008.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

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.

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.

The swing bed rate for July 1, 2009 through June 30, 2010 is the "budget dial" statewide weighted average nursing facility rate of $156.37.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

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

The following is effective for the period from July 1, 2006 to June 30, 2010:

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section XVIII. Supplemental Exceptional Care Payments

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

The payment takes the form of increases in the direct care component rate for residents with unmet exceptional care needs, as determined by the department criteria. Direct care payment increases made for these residents shall be offset against a facility's allowable direct care costs for purposes of normal rate setting and settlement.

The department may develop and pay enhanced rates for exceptional care to nursing homes for persons with traumatic brain injuries who are transitioning from hospital care. 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.