DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

October 25, 2011

Douglas Porter, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-009

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 11-009.

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 Jan Mertel at (206) 615-2317, or jan.mertel@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly by JM

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: MaryAnne Lindeblad, Assistant Secretary, ADSA

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and CHIP Services

Doug Porter, Administrator
Health Care Authority
Post Office Box 428682
Olympia, Washington 98504-2682

OCT 20 2011

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-009

Dear Mr. Porter:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-009. The purpose of this amendment is to update the State plan by setting the maximum statewide average NF per diem rate to $170.37 for SFY 2013 and $171.43 for SFY 2013. The maximum for swing beds is set at $167.23 for SFY 2013. This SPA also makes technical changes to the underlying NF per diem rate calculation. These changes include: 1) updating the cost-rebasing periods for the per diem calculations; 2) eliminating the variable rate component of the per diem calculation; 3) increasing the minimum NF occupancy requirement necessary to receive full reimbursement; and 4) establishing a per diem add-on payment to compensate the facilities that will take on more residents requiring acute-level care.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process, the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-D. Based upon your assurances, Medicaid State plan amendment 11-009 is approved effective July 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Joe Fico of the National Reimbursement Team at (206) 615-2380.

Sincerely,

Cindy Mann,
Director,
Centers for Medicaid and CHIP Services

cc
MaryAnne Lindeblad, Assistant Secretary, ADSA,
Ann Myers, State Plan Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

OCT 20 2011

Doug Porter, Director
State of Washington Health Care Authority
626 8th Avenue
PO Box 45502
Olympia, Washington 98504-5502

Dear Mr. Porter:

This is in response to your request for waiver of the broad-based and uniformity requirements related to a tax on certain nursing facility patient days. Upon review and consideration of the information formally provided to Centers for Medicare and Medicaid Services (CMS) on July 26, 2011, I am pleased to inform you that your request for waiver of the broad-based and uniformity provisions of section 1903(w)(3)(B) and (C) of the Social Security Act (the Act) is approved.

The tax structure for which Washington requested waiver would be imposed as follows:

(i) Medicare patient days are excluded from the tax;
(ii) Continuing care retirement community facilities are excluded from the tax;
(iii) Nursing facilities with 35 or fewer licensed beds are excluded from the tax;
(iv) State, tribal and county operated nursing facilities are excluded from the tax;
(v) Nursing facilities operated by public hospital districts and nursing facilities that are hospital based are excluded from the tax;
(vi) Nursing facilities with more than 32,000 Medicaid days or more than 203 licensed beds are assessed $1.00 per non-Medicare patient day;
(vii) All other facilities are assessed $11.00 per non-Medicare patient day.

Section 1903(w)(3)(E) of the Act specifies that the Secretary shall approve uniformity waiver applications if the net impact of the tax is generally redistributive and that the amount of the tax is not directly correlated to Medicaid payments.

The Federal regulation at 42 CFR 433.68(e)(2) describes the statistical test necessary for a state to demonstrate that the proposed tax structure is generally redistributive. Washington's statistical demonstration is addressed below. Moreover, the Federal regulation at 42 CFR 433.68(f) describes the circumstances in which a direct correlation would exist. Upon review of Washington's statute implementing the proposed nursing facility tax and the review of Washington's methodology for increasing Medicaid reimbursement to nursing facilities, it appears that no direct correlation exists between the tax and associated increase in Medicaid reimbursement.

Analysis
To determine the generally redistributive nature of the proposed nursing facility patient day tax, Washington calculated the slope (expressed as B1) of a linear regression for a uniform tax in which the dependent variable was each nursing facility's percentage share of the total tax paid, if the tax was uniformly imposed on all nursing facility patient days in the State and the independent variable was each nursing facility's number of Medicaid patient days.

Washington then calculated the slope (expressed as B2) of a linear regression for the State's actual proposed tax program in which the dependent variable was each nursing facility's percentage share of the total tax paid, and the independent variable was the number of Medicaid patient days for each nursing facility.

Using the patient day and tax rate data you provided, CMS also performed the regression analysis calculations required in the regulations for the proposed tax. CMS finds that the result of the generally redistributive calculation for the Washington nursing facility patient day tax is **1.2532.**
Therefore, we are able to approve your request for a waiver of the uniformity provisions of section 1903(w)(3)(C) of the Act for the proposed nursing facility patient day tax.

The Federal regulations at 42 CFR 433.72(c)(2) specify that a waiver will be effective for tax programs commencing on or after August 13, 1993, on the first day of the calendar quarter in which the waiver is received by CMS. CMS received the State of Washington's request for waiver of the uniformity requirements on July 26, 2011. Therefore, the effective date of Washington's request for waiver of the uniformity requirements is July 1, 2011.

CMS reserves the right to perform a financial management review at any time to ensure that the State operation of the tax on nursing facilities continues to meet the requirements of section 1903(w) of the Act.

I hope this information addresses all of your concerns, if you have further questions or need additional information please contact Stuart Goldstein at (410) 786-0694.

Sincerely,

Cindy Mann
Director

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: 11-09

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
~~March 1, 2011~~ **July 1, 2011 (P&I)**

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 2011 ~~($6,558,656)~~ ~~($10,700,584) (P&I)~~ $7,131,580 (P&I)
b. FFY 2012 ~~($19,746,236)~~ ~~($31,314,872) (P&I)~~ $22,377,609 (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D Part 1, pgs 1, 2, 3, 4, 6a, 7, 10, 11, 12, 14, ~~21~~ (P&I)
Attachment 4.19-D, Part 1, page 16a (P&I)

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

Attachment 4.19-D Part 1, pgs 1, 2, 3, 4, 6a, 7, 10, 11, 12, 14, ~~21~~ (P&I)
Attachment 4.19-D, Part 1, page 16a (P&I)

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:

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Medicaid Purchasing Administration
626 8th Ave SE MS 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **MAR 16 2011**

18. DATE APPROVED: October 20, 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
Carol J. C. Peverly by T&S

21. TYPED NAME: Carol J.C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS:

7/25/2011 - Pen & Ink (P&I) changes authorized by the State.
10/4/2011 - Pen & Ink (P&I) changes authorized by the State.
10/5/2011 - Pen & Ink (P&I) changes authorized by the State.
10/19/2011 - Pen & Ink (P&I) changes authorized by the State.

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: 11-09

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
~~March 1, 2011~~ July 1, 2011 (P&I)

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 2011 ($6,558,056) ~~($10,700,504) (P&I)~~ $7,131,580 (P&I)
b. FFY 2012 ~~($19,716,236)~~ ~~($31,314,872) (P&I)~~ $22,377,609 (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D Part 1, pgs 1, 2, 3, 4, 6a, 7, 10, 11, 12, 14, 21
Attachment 4.19-D, Part 1, page 16a (P&I)

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

Attachment 4.19-D Part 1, pgs 1, 2, 3, 4, 6a, 7, 10, 11, 12, 14, 21
Attachment 4.19-D, Part 1, page 16a (P&I)

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:

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED: 3/14/11

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Medicaid Purchasing Administration
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 16 2011

18. DATE APPROVED: OCT 20 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director

23. REMARKS:

7/25/2011 - Pen & Ink (P&I) changes authorized by the State.
10/4/2011 - Pen & Ink (P&I) changes authorized by the State.
10/5/2011 - Pen & Ink (P&I) changes authorized by the State

Pen & ink change made to block # 8

FORM ~~HCFA~~-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS

Effective July 1, 2011

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.

Excluded here is the payment rate methodology for nursing facilities operated by the State'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, 2011, 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 State 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

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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 six component rates: 1) direct care (DC), 2) therapy care (TC), 3) support services (SS), 4) operations (O), 5) property (P), and 6) financing allowance (FA). Prior to July 1, 2011, there was a seventh component, variable return (VR).

Medicaid rates are subject to a "budget dial", under which the State 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 State 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 State 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 was per resident day $166.24. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC. For SFY 2010 (July 1, 2009 through June 30, 2010); the budget dial rate is per resident day $169.85.

For SFY 2012 (July 1, 2011 through June 30, 2012), the budget dial rate is $170.37. For SFY 2013 (July 1, 2012 through June 30, 2013), the budget dial rate is $171.43. If the waiver requested from the Federal Centers for Medicare and Medicaid Services in relation to the "safety net assessment" created by c. 7, 2011 Laws 1st sp. sess. is not approved and implemented, the budget dial rate for SFY 2012 will be $159.87 and for SFY 2013 will be $160.93.

The State will provide an add-on to the Medicaid rate for facilities to reimburse them for the amount of the "safety net assessment" paid in relation to resident days for residents whose care is provided by Medicaid. This add-on is not subject to the normal settlement process. Adding the effect of this add-on, and adding the effect of the direct care 10% add-on described below, to the budget dial figures stated above, the total projected average payment figure for SFY 2012 will be $181.96 and for SFY 2013 will be $183.02.

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 State 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 State 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont):

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.

Rates for the period 7/1/09 through 6/30/13 are based on the 2007 cost report.

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.

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, 2013.

Beginning July 1, 2013, the direct care, operations, support services, and therapy care component rate allocations shall be rebased biennially during every odd-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2011 will be used for July 1, 2013 through June 30, 2015, 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.

For SFYs 2012 and 2013, the State will 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 it exists on that date to the facility-based payment rates in effect on June 30, 2010. If the former is smaller than the latter, the difference will be provided to the individual nursing facility as an add-on payment per Medicaid resident day.

During the comparative analysis described in the preceding paragraph, if it is found that the direct care rate for any facility calculated on July 1, 2011 is greater than the direct care rate in effect on June 30, 2010, the facility will receive a 10% add-on to the direct care rate to compensate the facility for taking on more acute residents than they have in the past. Any add-ons granted under this provision are subject to the normal settlement process.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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

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.

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 – 87%
- Small nonessential community providers – 92%
- Large nonessential community providers – 95%

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 State 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 State 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 State 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 State shall include beds banked under chapter 70.38 RCW in licensed beds for the purpose of computing minimum occupancy.

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 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 State 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 State 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.

The State may adjust the case mix index for any of the lowest ten resource utilization group categories beginning with PA1 through PE2 to any case mix index that aids in achieving the purpose and intent of RCW 74.39A.007 and cost-efficient care.

In determining case mix weights, the State will assign the lowest case mix weight to the resource utilization group III classification group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.

To allow for the transition to minimum date set 3.0 and implementation of resource utilization group IV for July 1, 2011, through June 30, 2013, the State will calculate rates using the Medicaid average case mix scores effective for January 1, 2011, rates adjusted under RCW 74.46.485 (1)(a), and the scores shall be increased each six months during the transition period by one-half of one percent. The July 1, 2013 direct care cost per case mix unit shall be calculated by utilizing 2011 direct care costs, patient days, and 2011 facility average case mix indexes based on the minimum data set 3.0 resource utilization group IV grouper 57.

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 SFYs 2012 and 2013.

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)

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 State 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%. Effective July 1, 2011, the ceiling is reduced to 110%.

The State 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 State 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 State 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 110% 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. Effective July 1, 2011, the limit is reduced to 108% 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 State 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 State 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 State 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 State then assigns a percentage to each facility, depending on what quartile it belongs to, as follows: I 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 I, 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 in 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 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 4%. The total is then 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 State shall have the authority to determine an amount for net invested funds based on an appraisal conducted according to State 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 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 State 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 SFY 2010 (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 State 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 2011 (July 1, 2010 through June 30, 2011) is $166.24. For SFY 2012 (July 1, 2011 through June 30, 2012) it is $168.10.