DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

February 21, 2007

Robin Arnold-Williams, Secretary
Department of Social and Health Services
PO Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment 06-015

Dear Ms. Arnold-Williams:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 06-015.

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 you will find 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 concerning the Seattle Regional office role in the processing of this state plan amendment, please contact Jan Mertel at (206) 615-2317 or jan.mertel@cms.hhs.gov.

Sincerely,

Karen S. O'Connor
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure

Cc: Douglas Porter, Assistant Secretary
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 State Operations

Robin Arnold-Williams, Secretary
Department of Social and Health Services
PO Box 45010
Olympia, Washington 98504-5010

FEB 2 1 2007

RE: State Plan Amendment 06-015

Dear Secretary Arnold-Williams:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State Plan submitted under transmittal number (TN) 06-015. This amendment makes technical changes to nursing facility rates and increases the uniform statewide daily rate ceiling for State Fiscal Year 2007 from $153.50 to $156.41. It is approved effective July 1, 2006.

Under regulations at 42 CFR 430.12(c)(i), States are required to amend State plans whenever necessary to implement changes in Federal law, regulations, policy interpretations, or court decisions. On January 18, 2007, CMS published a notice of proposed rule making that would modify Medicaid reimbursement and clarify State financing of their Medicaid programs. Should this proposed rule be adopted in final regulations, some or all of the payments under this plan amendment may no longer be allowable expenditures for federal Medicaid matching funds. States will be expected to review their payment methodologies and, if necessary, submit conforming amendments to reflect the new regulations. Approval of the subject State plan amendment does not relieve the State of its responsibility to comply with changes in federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

To carry out Federal oversight responsibilities, please be advised that the Seattle regional office will conduct a financial management review of the payments authorized under Attachment 4.19-D, Part I of the State Medicaid plan and funded through certified public expenditures. The purpose of this review will be to ensure that claimed expenditures are accurate and that claims for Federal funding are matched by adequate non-Federal

HEC

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

Sincerely,

Dennis G. Smith
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: 06-015

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, 2006

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. July 1, 2006 through Sept. 30, 2006 - $2,523,061
b. Oct 1, 2006 through Sept. 30, 2007 - $7,569,182

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-D, pages 1, 2, 4, 6, 6a, 7, 7a, ~~and~~ 11, and 12

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

Att. 4.19-D, pages 1, 2, 4, 6, 7, ~~and~~ 11, and 12

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:
Robin Arnold-Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:
Aug. 14, 2006

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
626 8th Street MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
AUG 14 2006

18. DATE APPROVED:
2-21-07

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2006

20. SIGNATURE OF REGIONAL OFFICIAL:
Richard Strauss F. D.S.

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

8/21 P:I change to add p. 12 to Blocks 8&9 per email from Ann Myers on 8/15/06 AKate

FORM HCFA-179 (07-92)

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: 06-015

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

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☒ OTHER, AS SPECIFIED: Exempt

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AUG 14 2006

18. DATE APPROVED:
FEB 21 2007

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2006

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Karen S. D'Connor

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

23. REMARKS:

8/21 P&I change to add p. 12 to Blocks 8&9 per email from Ann Myers on 8/15/06 AKatz

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, 2006

Section I. Introduction:

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

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

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

Chapter 388-96 of the Washington Administrative Code (WAC), chapter 74.46 of the Revised Code of Washington (RCW), as they existed on July 1, 2006, and any other state or federal laws or regulations, codified or uncodified, 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, as amended for July 1, 2001, and July 1, 2002, rate setting.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section II. General Provisions:

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

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

Medicaid rates are subject to a "budget dial", under which the department is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. For SFY 2006 (July 1, 2005, to June 30, 2006) the budget dial is $149.14 per resident day, and for SFY 2007 (July 1, 2006, to June 30, 2007) it is $156.41 per resident day. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

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

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

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.)

Rates in all components for all facilities on and after July 1, 2001, continue to be subject to a downward revision, if indicated, to reflect a recalculation of minimum occupancy when a facility's licensed beds are increased (or "unbanked") by converted previously de-licensed beds back to licensed status under chapter 70.38 RCW.

However, effective July 1, 2001, for all facilities except essential community providers, component rates in direct care, therapy care, support services, and variable return only continue to be subject to an upward revision, if indicted, when a facility's licensed beds are reduced (or "banked") under chapter 70.38 RCW.

Effective July 1, 2001, for all facilities except essential community providers, operations, property, and financing allowance component rates are not subject to increase when licensed beds are reduced under chapter 70.38 RCW, on or after May 25, 2001.

Effective July 1, 2001, for essential community providers, rates in all components will continue to be subject to an increase, if indicated, in response to a reduction in licensed beds under chapter 70.38 RCW, regardless of when the reduction occurs.

If a facility's affected component rates are revised downward or upward, in response to an increase or reduction, respectively, in its licensed beds under chapter 70.38 RCW, any revision is accomplished by a recalculation of minimum occupancy. The department tests the facility's 1999 resident days or prior year resident days, as applicable, against the facility's new licensed bed capacity.

A per resident day cost adjustment is made, reversed or modified, as may be indicated, and any rate revision is made prospectively, effective as of the date licensed bed capacity is increased or reduced.

Effective July 1, 2006, the minimum occupancy assumption is eliminated from the calculation of the direct care component rate for all facilities. This includes the calculation of the direct care component rate for facilities returning previously banked beds to active status.

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:

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.

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

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)

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.

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.

For July 1, 2001, rate setting, the department will continue to array facilities' 1999 direct care costs per case mix unit to determine median costs per case mix unit for setting rates in direct care.

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

A "high labor cost county" is "an urban county in which the median allowable facility cost per case mix unit is more than ten percent higher than the median allowable facility cost per case mix unit among all other urban counties, excluding that county." An "urban county" is "a county which is located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government." A "nonurban county" is "a county which is not located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government."

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

Continuing for July 1, 2001, rate setting, and all future rate setting, a facility's direct care cost per case mix unit is adjusted, if necessary, to bring it up to a floor of ninety percent, or down to a ceiling of one hundred ten percent, of the facility's peer group median cost per case mix unit (high labor cost, urban excluding high labor cost, or non-urban).

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, 2001, subject to applicable adjustments for economic trends and conditions, possible application of the budget dial, and the direct care hold harmless provision through June 30, 2002, a facility's direct care component rate is equal to its allowable direct care cost per case mix unit from its 1999 cost report, multiplied by its Medicaid average case mix index from the applicable quarter.

Direct care component rates are updated effective the first day of each calendar year quarter (January 1, April 1, July 1, and October 1) to reflect changes in a facility's case mix. The resident assessment data used for each update is taken from the calendar quarter commencing six months and ending three months prior to the effective date of each quarterly update.

Effective July 1, 2006, a new category of nursing facilities is established. A "vital local provider," or VLP, is defined as a nursing facility reporting a home office address located in Washington State, where the sum of Medicaid days for all Washington facilities reporting that address as their home office was greater than 215,000 in 2003.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

A "hold harmless" provision is granted to VLPs. For a VLP, the sum of the facility's direct care and operations component rates calculated as of July 1, 2006 will be compared to the sum of those same two component rates as of June 30, 2006. If the sum as of July 1, 2006 is lower than the sum as of June 30, 2006, then the VLP will continue to receive the direct care and operations component rate allocations calculated as of June 30, 2006. In setting economic trends and conditions adjustment factors for the direct care and operations components rate allocations, the Legislature may define different adjustment factors for vital local providers whose rates are set equal to their June 30, 2006 rates.

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.

Effective July 1, 2001, to set the component rate, the department takes data from a facility's 1999 cost report allowable operations cost, and divides by the greater of adjusted resident days from the same cost report, or days imputed at the applicable minimum occupancy, whichever is greater.

The department arrays allowable operations costs separately for urban and nonurban, 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 1999 operations cost at the facility or the median limit for its peer group.

Effective July 1, 2006, the operations component rate is based on examined, adjusted costs and resident days from 2003 cost reports.

Effective July 1, 2006, a new category of nursing facilities is established. A "vital local provider," or VLP, is defined as a nursing facility reporting a home office address located in Washington State, where the sum of Medicaid days for all Washington facilities reporting that address as their home office was greater than 215,000 in 2003.

A "hold harmless" provision is granted to VLPs. For a VLP, the sum of the facility's direct care and operations component rates calculated as of July 1, 2006 will be compared to the sum of those same two component rates as of June 30, 2006. If the sum as of July 1, 2006 is lower than the sum as of June 30, 2006, then the VLP will continue to receive the direct care and operations component rate allocations calculated as of June 30, 2006. In setting economic trends and conditions adjustment factors for the direct care and operations components rate allocations, the Legislature may define different adjustment factors for vital local providers whose rates are set equal to their June 30, 2006 rates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section X. Variable Return Component Rate:

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

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

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

The percentages calculated from 1999 costs shall remain in effect from July 1, 2001, until June 30, 2004. Facilities will not be ranked again and no new percentages will be determined after being done initially for July 1, 2001; rate setting. If a facility migrates from one quartile to another resulting from 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.