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 State Operations / National Institutional Reimbursement Team**

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

NOV 2 8 2007

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) 07-016. This amendment makes technical changes to nursing facilities rates and increases the uniform statewide daily rate ceiling from $156.41 for SFY 2007 to $158.11 for SFY and $164.18 for SFY 2009. It is approved effective July 1, 2007.

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 07-016 is approved effective July 1, 2007. We are enclosing the HCFA-179 and the amended pages.

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 May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register and that can be found at 72 Federal Register 29748 (May 29, 2007) that would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this plan amendment may no longer be allowable expenditures for federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007 instructed CMS to take no action to implement this final regulation for one year. CMS will abide by the time frames specified by the statute. States should, however, 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.

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

1. TRANSMITTAL NUMBER: 07-016

2. STATE: Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2007

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 2007 $2,350,290
b. FFY 2008 $8,250,870

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Part 1, pages 1, 2, 4, 5, 6a, 7, 9, 10, 11, 16, 18, 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D Part 1, pages 1, 2, 4, 5, 6a, 7, 7a, 9, 10, 11, 16, 18, 19

10. SUBJECT OF AMENDMENT:
NF Facilities Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robin Arnold-Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:
9-5-07

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

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
11-27-07

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2007

20. SIGNATURE OF REGIONAL OFFICIAL:
Bill Roswell for D.S.

21. TYPED NAME: William Lasowski

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS

Effective July 1, 2007

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), and any other state or federal laws or regulations, codified or uncodified, as they exist as of July 1, 2007, 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 (DC), 2) therapy care (TC), 3) support services (SS), 4) operations (O), 5) variable return (VR), 6) property (P), and 7) financing allowance (FA).

Medicaid rates are subject to a "budget dial", under which the department is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. For SFY 2008 (July 1, 2007 to June 30, 2008) the budget dial is $158.11 per resident day, and for SFY 2009 (July 1, 2008 to June 30, 2009) it is $164.18 per resident day. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

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

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

There is a hold harmless rate for qualifying facilities as of the 7/1/07 and 7/1/08 rate settings. To qualify, a facility must have combined rates in DC, SS, TH, and O for June 30, 2007 greater than its July 1, 2007 or July 1, 2008 rate adjusted for economic trends and conditions under the 2007-2009 biennial appropriations act, and must have overspent its combined DC, SS, TH, and O component rates in either 2004 or 2005. For qualifying facilities, the department compares a facility's July 1, 2007 or July 1, 2008 combined DC, SS, TC, and O rates adjusted for economic trends and conditions as specified in the 2007-2009 biennial appropriations act, with the combined DC, SS, TC, and O rates for June 30, 2007. If the combined rates for 6/30/07 are higher, then the facility will receive its 6/30/07 rates in DC, SS, TC, and O, adjusted for economic trends and conditions as specified in the 2007-2009 biennial appropriations act.

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.

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

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 resident days from the cost report used to set the rate 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 IV: Allowable Costs (cont.)

Allowable costs for rate setting, audit and settlement are documented costs, not expressly declared unallowable or otherwise limited under chapter 74.46 RCW or 388-96 WAC, that are necessary, ordinary and related to the care of nursing facility residents. To be ordinary nursing facility expenses, costs must be of the nature and magnitude that prudent and cost-conscious management would pay. Effective July 1, 2001, facility costs of televisions in residents' rooms acquired on and after July 1, 2001, will be included in allowable costs.

Costs in excess of limits or in violation of any rate setting or payment principles contained in chapters 74.46 RCW or 388-96 WAC are expressly unallowable. These limits include, but are not limited to, minimum occupancy for rate setting and peer group median costs in affected cost areas and component rates.

Allowable cost limits and principles of rate setting include, in the broad sense, not only those contained in chapters 74.46 RCW and 388-96 WAC, but also those contained an all applicable state and federal laws and regulations, whether codified or uncodified, as may be pertinent to all or part of the July 1, 2001, through June 30, 2004, rate period, as may be interpreted by courts of competent jurisdiction.

The Medicaid payment rate system for the State of Washington does not guarantee that all costs relating to the care of a nursing facility's Medicaid residents and allowable under the payment system rules will be fully covered or reimbursed in any payment period. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with state and federal laws, not to reimburse costs, however defined, of a provider.

Section V. Adjustments to Payment Rates for Economic Trends and Conditions:

Effective July 1, 2002, all facilities having their direct care component rates established on case mix principles promulgated in law and regulation, receive a 2.3 percent upward adjustment for economic trends and conditions to their direct care component rates. Any facilities continuing to receive a "hold harmless" direct care component rate as of July 1, 2002, receive no upward adjustment for economic trends and conditions to their direct care component rates; however, the hold harmless provision is terminated effective July 1, 2002, also, so unless this scheduled change to the methodology is eliminated for some facilities, all facilities should receive the 2.3 upward adjustment for economic trends and conditions effective July 1, 2002.

Effective July 1, 2005, all facilities receive a 1.3 percent upward adjustment for economic trends and conditions to their direct care, therapy care, support services, and operations component rates established in accordance with chapter 74.46 RCW and an additional 1.3 percent upward adjustment effective July 1, 2006.

Effective July 1, 2007, all facilities receive a 3.2 percent upward adjustment for economic trends and conditions to their direct care, support services, therapy care, and operations component rates established in accordance with chapter 74.46 RCW.

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 VII. Therapy Care Component Rate (cont.)

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

The total allowable cost for each therapy type for each participating nursing facility is then combined and this total is divided by the facility's total adjusted resident days, or days increased, if needed, to the applicable minimum occupancy for rate setting, to derive its therapy care component rate.

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.

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.

Effective July 1, 2001, a nursing facility's support services component rate is based on its 1999 cost report data, subject to the budget dial and applicable adjustments for economic trends and conditions.

To set the component rate, the department takes from the facility's 1999 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, whichever is greater.

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

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 2007 was $154.94 per resident day, which comprises the swing bed rate for the July 1, 2007 to June 30, 2008 rate period. The same methodology is followed annually to reset the swing bed rate, effective July 1 of each year.

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 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.

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

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, 2005 to June 30, 2008:

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

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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.