STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS

Effective July 1, 2012

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, 2012, 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The methods and standards employed by the State to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

Back to TOC

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 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". The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

For SFY 2012 (July 1, 2011 through June 30, 2012), the budget dial rate was $170.37. For SFY 2013 (July 1, 2012 through June 30, 2013), the budget dial rate is $171.43.

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.

Back to TOC

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 rates effective July 1, 2012, the State will do a comparative analysis of the facility-based payment rates calculated using the payment methodology defined in chapter 74.46 RCW as it exists on that date, and comparing it 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. When calculating the rates paid under chapter 74.46 RCW in performing this comparative analysis, the State will not include the comparative add-on itself, the acuity add-on described in the next paragraph below, or the safety net assessment reimbursement.

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, 2012, 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. When calculating the rates paid under chapter 74.46 RCW in performing this comparison of direct care rates, the State will not include the comparative add-on described in the next paragraph above, the acuity add-on itself, or the safety net assessment reimbursement.

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 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 2012 (July 1, 2011 through June 30, 2012) was $166.24. For SFY 2013 (July 1, 2012 through June 30, 2013) it is $173.38.

Back to TOC

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.

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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

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.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

This page intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

This page intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE

Summary of Medicare 2552--10 Cost Report and Step-Down Process for Hospital-Based Nursing Facilities

Worksheet A

The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

(i) Overhead;
(ii) Routine;
(iii) Ancillary;
(iv) Outpatient;
(v) Other reimbursable; and
(vi) Non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Hospital-Based Nursing Facility Costs for Upper Payment Limit Payments Based on Certified Public Expenditures

Worksheet B
Allocates overhead (originally identified as General Service Cost Centers, lines 1 – 24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Nursing Facility Costs
The NF costs are taken from Worksheet B, Part I, lines 44 and/or 45, column 26. These are the NF costs after the step-down allocation of overhead to all cost centers.

Nursing Facility Patient Days
The NF days are found on Worksheet S-3 Part I, column 8, lines 19 and/or 20.

Nursing Costs Per Patient Day
The cost per patient day is calculated by dividing the total NF costs by the total NF patient days described above. This amount is based on worksheet D-1, Part III, line 71, column 5 for the NF/SNF.

Upper Payment Limit Amount
The supplemental payments are subject to the federal Medicare upper payment limit for nursing facility payments. The Medicare upper payment analysis shall be performed prior to making the supplemental payments. The aggregate Upper Payment Limit is the maximum amount that can be paid out to the nursing facilities.

The cost per patient day less the Medicaid payment rate per patient day is the maximum UPL payment per Medicaid day that the nursing facility may receive. For example, if the UPL limit aggregate is $54 per Medicaid day, but the maximum payment gap between the routine costs

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE (CONT)

incurred by the NF and Medicaid payment received by the NF is $18 per day, the nursing facility will receive $18 per day. The aggregate amount is redistributed evenly to the facilities up to their specific cost limits.

The payments for each state fiscal year will be based on the as filed Medicare 2552-10 cost report from two years prior. For example, the payments for state fiscal year 2013 will be based on the cost information from the 2011 as filed Medicare 2552-10 cost report. The NF routine cost per patient day amount from worksheet D-1 will be multiplied by the 2011 Medicaid days from the State's MMIS payment system to compute Medicaid costs. The 2011 Medicaid base NF routine payments will be subtracted from the computed Medicaid costs to determine the NF's maximum supplemental payment amount. An interim reconciliation will be performed with the 2013 as filed 2552-10 cost report and a final reconciliation will be performed with the 2013 Intermediary audited 2552-10 cost report.

With both the interim and final reconciliations, there may be a recoupment if an NF's Medicaid costs are less than what it was paid. If a hospital's Medicaid costs are higher than what it was paid, then it could receive more money as long as the aggregate UPL is not exceeded. The Medicaid costs will be determined by multiplying the per diem costs by the Medicaid days. The Medicaid days will be reconciled to Washington State DSHS payment records for the cost reporting period.

Medicare 2540-10 Cost Report for Skilled Nursing Facilities Operated by Public Hospital Districts in Washington State

The process is essentially the same as for the Medicare 2552-10 cost report, although the line number references on the cost report schedules are not the same.

The schedule references where the nursing home costs and total days are found on the 2540-10 cost reports are as follows:

Skilled Nursing Facility costs are found on Worksheet B Part I, line 30, column 18.

Skilled Nursing total days are found on Worksheet S-3 Part I, line 1, column 7.

Routine cost per patient day is found on Worksheet D-1 Part I, line 16.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE (CONT)

The NH UPL for each state fiscal year will be based on the as filed Medicare 2540-10 cost report from two years prior. For example, the 2013 NH UPL payment is based on the 2011 cost information from the 2540-10 as filed. There will be an interim reconciliation with the 2013 as filed cost report 2540-10 and a final reconciliation with the Intermediary audited 2013 cost report 2540-10. The UPL payment will be adjusted using the same method as used with the 2552-10 cost report.

OS Notification

State/Title/Plan Number:	**Washington 12-018**	
Type of Action:	**SPA Approval**	
Required Date for State Notification:	**March 28, 2013**	
Fiscal Impact:	**FY 2012**	**$1,227,452**
	FY 2013	**$3,695,844**

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: Yes
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective July 1, 2012, WA-12-018 updates the state plan by setting the SFY 2013 nursing facility per diem cap/budget dial amount to $171.43, updating the base year for the 10 percent add-on payment to the direct care component of the nursing facility per diem rates and updating the cost report references to be consistent with the new Medicare cost report format.

- The budget dial is a per diem cap that is imposed when the statewide average NF per diem exceeds the amount set by the Legislature. When the limit/budget dial is reached, every NF's individual cost-based per diem is reduced proportionally until the average per diem payment in the State is equal to the budget dial amount of $171.43. Note: the statewide average per diem is weighted by volume.
- "Direct care" is one of seven components of the NF per diem cost calculation.
- The 10 percent direct care add-on component is paid to only privately owned or operated NFs that increase the annual number of acute care cases. Non-state NFs are already be reimbursed at full cost. There are no State NFs.

The UPL demonstration was acceptable. Public notice was timely. The non-federal share is from State appropriations made to the Medicaid agency, CPE's and a previously approved NF bed tax. CPEs fund only supplemental payments for non-state governmental NFs. Base payments are funded with appropriations.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the Governor.

Appropriate tribal notification was submitted timely.

This SPA has been reviewed in the context of the ACA and its approval is not in violation of the ACA provisions.

CMS Contact: Joe Fico (206) 615-2380
National Institutional Reimbursement Team