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State/Territory Name: Washington

State Plan Amendment (SPA) #: 13-16

This file contains the following documents in the order listed:

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 & CHIP SERVICES

NOV 20 2013

MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 42716
Olympia, Washington 98504-2716

RE: WA State Plan Amendment (SPA) Transmittal Number #13-016 – Approval

Dear Ms. Lindeblad:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-016. This SPA decreases the weighted average daily nursing facility rate for SFY 2014 by eight cents, increases the rate (over the SFY 2013 rate) by fifteen cents for SFY 2015; postpones the rebase of the non-capital rate components scheduled for July 1, 2013 to July 1, 2015; calculates rates for the period July 1, 2013 to June 30, 2015 using the Medicaid average case mix scores from January 1, 2013; and continues for SFYs 2014 and 2015 the comparative analysis and acuity rate add-ons applied to the 2012-2013 biennium.

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), and 1923 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 13-016 is approved effective as of July 1, 2013. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-334-9482 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Cindy Mann
Director

Enclosures

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: **13-16**

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, 2013

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 2013 $562,866
b. FFY 2014 $1,694,783

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-D Part 1 pgs 1, 2, 3, 5, 6, 6a, 7, 8, 9, 10, 12, 13, 14, 15, 16a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19-D Part 1 pgs 1, 2, 3, 5, 6, 6a, 7, 8, 9, 10, 12, 13, 14, 15, 16a

10. SUBJECT OF AMENDMENT:

Nursing Facility 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:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
9-17-13

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/17/2013

18. DATE APPROVED:
11/20/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/01/13

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

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

23. REMARKS:

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, 2013

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, 2013, 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

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).

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 2014 (July 1, 2013 through June 30, 2014), the budget dial rate is $171.35. For SFY 2015 (July 1, 2014 through June 30, 2015), the budget dial rate is $171.58.

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

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont):

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, 2015.

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.

Beginning July 1, 2015, 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 2013 will be used for July 1, 2015 through June 30, 2017, and so forth.

For rates effective July 1, 2013, 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, 2013, 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 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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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

For direct care, therapy care, support services, and operations component rate allocations, there will be no adjustments for economic trends and conditions in fiscal years 2014 and 2015.

The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the component rate allocations established in accordance with chapter 74.46 RCW. When no economic trends and conditions factor for either fiscal year is defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the component rate allocations established in accordance with chapter 74.46 RCW.

Section VI. Direct Care Component Rate:

This component rate, which averages approximately 55.0% of each participating facility's total Medicaid rate, corresponds to one resident day of care for in nursing services, including supplies, excluding therapy care services and supplies.

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 data set 3.0 and implementation of resource utilization group IV for July 1, 2013, through June 30, 2015, the State will calculate rates using the Medicaid average case mix scores effective for January 1, 2013, 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, 2015 direct care cost per case mix unit shall be calculated by utilizing 2013 direct care costs, patient days, and 2013 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 2014 and 2015.

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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, 2013, through June 30, 2015 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 was eliminated and the ceiling was increased to 112%. Effective July 1, 2011, the ceiling was 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 VII. Therapy Care Component Rate:

This component payment rate corresponds to average one-on-one care from qualified therapists delivered to a Medicaid resident during one day, and to average therapy consultation from qualified consultants delivered to a resident during one day. Four types of therapy are recognized for rate setting: speech, physical, occupational, and other. Two general service categories are recognized for each: one-on-one therapy and therapy consulting.

To set therapy care component rates, the department takes from cost reports direct one-on-one therapy charges for all residents by payer, including costs of supplies, and total units or modules of therapy care, for all residents from the report period by type of therapy provided. The department also takes from cost reports therapy consulting expenses for all residents by type of therapy.

The department determines the total one-on-one cost for each type of therapy care at each participating nursing facility, and divides by the facility's total units of therapy for each therapy type, to derive the per unit one-on-one cost for each type. A unit or module of therapy care is defined as fifteen minutes of one-on-one therapy.

The department determines total therapy consulting for each type of therapy at each nursing facility, and divides by the facility's resident days, increased if necessary to the applicable minimum occupancy, to derive per resident day consulting cost for each type of therapy.

The department ranks from lowest to highest per unit one-on-one therapy costs for each of the four types, both for urban and nonurban facilities. The department also ranks from lowest to highest per resident day therapy consulting costs for each of the four types of therapy, both for urban and nonurban facilities.

This constitutes sixteen separate arrays of therapy costs, which are used to determine eight median therapy costs for all facilities in each peer group (urban and nonurban). Four are one-on-one unit of therapy cost medians, and four are consulting resident day cost medians.

Sixteen cost limits are established, including both peer groups. The limits are one hundred ten percent of the median costs per unit of one-on-one therapy for the four types, and one hundred ten percent of the median costs per resident day for therapy consulting for the four types.

A facility's allowable one-on-one cost for rate setting, for each type of therapy care, is the lower of the facility's actual cost per unit or one hundred ten percent of the unit median cost for its peer group.

A facility's allowable consulting cost for rate setting, for each type of therapy care, is the lower of the facility's actual cost per resident day or one hundred ten percent of the resident day median cost for its peer group.

Each facility's allowable cost per case mix unit in each of the four therapy types is then multiplied by the units provided by the facility for the applicable year by type. The result is multiplied by the Medicaid percentage of charges for each category, and divided by adjusted Medicaid resident days from the report period, to derive the Medicaid resident day allowable one-on-one cost for each therapy type.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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 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 from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds*, to derive its therapy care component rate.

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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 was reduced to 108% of the median cost of each group and the rate was set at the lower of actual allowable facility per resident day cost or the limit for its peer group.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XI. Property Component Rate:

This component corresponds to an allowance for depreciation of real property improvements, equipment and personal property associated with the provision of resident care at a participating nursing facility.

The department rebases the property component rate annually using cost report depreciation data from the calendar year ending six months prior to the commencement of each July 1 rate. For example, the 2012 cost report is used for July 1, 2013, rate setting, and the 2013 cost report is used for July 1, 2014, rate setting, etc. Allowable depreciation is divided by the actual, adjusted resident days from the applicable cost report period, increased, if needed, to imputed resident days at the applicable minimum occupancy for rate setting from Attachment 4.19-D, Part 1 Section III. *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds.*

The property rate is subject to prospective revision to reflect the cost of capitalized additions and replacements. Effective July 1, 2001, to have additional assets included for rate setting the contractor must obtain from the department a certificate of capital authorization for future capitalized additions and replacements, which are available on a first-come, first-served basis. However, the department is authorized to consider untimely requests if the improvement project is in response to an emergency situation.

For assets that were acquired after January 1, 1980, the depreciation base of the assets used for rate setting cannot exceed the net book value which did exist or would have existed had the previous contract with the department continued, unless the assets were acquired after January 1, 1980, for the first time since that date, and before July 18, 1984.

The depreciation base that will be used for first-time sales after January 1, 1980, but occurring pursuant to a written and enforceable purchase and sale agreement in existence prior to July 18, 1984, and documented and submitted to the department prior to January 1, 1988, will be that of the first owner subsequent to January 1, 1980.

Subsequent sales during the period defined above and any subsequent sale of any asset, whether depreciable or not depreciable, on or after July 18, 1984, are ignored for payment purposes.

The department will issue no certificates of capital authorization for State Fiscal Year (SFY) 2014 or SFY 2015.

For SFYs 2014 and 2015, the department will not add-on to payment rates for capital improvements not requiring a certificate of need and a certificate of capital authorization.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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, 2013, financing allowance component rates are based on 2012 cost report data.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIII. Settlement:

In a process called "settlement", direct care, therapy care, and support services component rate payments are compared to each participating nursing facility's expenditures in these categories each report period. The facility must return to the department all unspent rate payments in these three categories exceeding 1 percent of each average component rate, weighted by Medicaid resident days, for the report period. The purpose of settlement is to provide licensees of Medicaid nursing facilities additional incentive to make expenditures necessary for the care and well being of residents.

This recovery process does not exist for payments in excess of costs, if any, in the operations, variable return, property and financing allowance component rates. However, assets constituting net invested funds are subject to audit and a facility's financing allowance component rate is subject to adjustment at settlement, up or down, to reflect actual, documented net invested funds relating to resident care. If the financing allowance component rate is increased or reduced to reflect a change in net invested funds, the financing allowance underpayment or overpayment to the facility for the settlement period will be reflected in the settlement and amount due the contractor or department.

Normally settlement covers a calendar year corresponding to a calendar year report period, but a settlement will only cover a partial-year report period for facilities changing ownership during the year. The rate a provider is left with after the process of settlement at the lower of cost or rate in the affected cost areas is called the "settlement rate" and it represents final compensation for Medicaid nursing care services for the settlement period.

The rule which allows facilities to keep unspent payments in direct care, therapy care and support services up to 1 percent of each of these component rates, does not apply to facilities that provided substandard quality of care, or which were not in substantial compliance with state and federal care standards, during the settlement period, as these concepts are defined in federal survey regulations. Such facilities must return all unspent direct care, therapy care and support services rate payments, without exception, they received during the settlement period.

In comparing expenditures to component rate payments in direct care, therapy care, and support services for the purpose of calculating a facility's settlement rate and effecting recovery, some shifting of excess rate payments (if any) to other cost areas is allowed to cover in whole or in part costs exceeding component rates in those other areas (if any).

Effective July 1, 2001, savings in support services may be shifted to cover a deficit in direct care or therapy care, but not more than 20 percent of the total support services rate payment for the settlement period may be shifted out. Shifting of savings in direct care to therapy care, and from therapy care to direct care, to cover any deficit is allowed without a percentage of component rate limitation.

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.

The swing bed rate for SFY 2014 (July 1, 2013 through June 30, 2014) is $174.22.