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State/Territory Name: Washington

State Plan Amendment (SPA) #: 17-0030

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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



Financial Management Group

NOV 21 2017

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

RE: WA State Plan Amendment (SPA) Transmittal Number #17-0030 – 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) 17-0030. This SPA increases the Medicaid swing bed rate for SFY 2018 from 184.75 per day to \$187.21, increases the quality measures for the quality enhancement program from four to six measures, updates the public notice process, and updates the qualification criteria for exceptional care payments.

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 17-0030 is approved effective as of July 1, 2017. 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 208-861-9838 or Thomas.Couch@cms.hhs.gov.

Sincerely,

A solid black rectangular box used to redact the signature of Kristin Fan.

Kristin Fan
Director

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

1. TRANSMITTAL NUMBER:
17-0030

2. STATE
Washington

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

4. PROPOSED EFFECTIVE DATE
July 1, 2017

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:
Section 1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 ~~\$8,288~~ \$1,977,000 (P&I)
b. FFY 2018 ~~\$33,243~~ \$7,932,000 (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Part 1 page 16 (P&I)
Attachment 4.19-D, Part 1 pages 1, 14, 16, 17 and 19 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)
Attachment 4.19-D, Part 1 page 16 (P&I)
Attachment 4.19-D, Part 1 pages 1, 14, 16, 17 and 19 (P&I)

10. SUBJECT OF AMENDMENT

July 1, 2017, Nursing Facility Swing Bed 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:

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
9-19-17

16. RETURN TO:

Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9-19-17

18. DATE APPROVED: NOV 21 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Kristin FAN

22. TITLE:
Director, FMCA

23. REMARKS:
9/19/17 - State authorized P&I change to boxes 8 and 9
9/27/17 - State authorized P&I change to box 7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS

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 uncoded, as they exist as of July 1, 2017, as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XII. Quality Enhancement

A quality enhancement of one percent of the statewide average daily rate is paid to facilities that meet or exceed the standard established for the quality enhancement. All providers have the opportunity to earn the full quality enhancement payment.

The quality enhancement component is determined by calculating an overall facility quality score composed of six quality measures for fiscal year 2018. The quality enhancement component is based on Minimum Data Set (MDS) quality measures for the percentage of long-stay residents who self-report moderate to severe pain, the percentage of high-risk long-stay residents with pressure ulcers, the percentage of long-stay residents experiencing one or more falls with major injury, the percentage of long-stay residents with a urinary tract infection, short-stay newly administered anti-psychotic medications, and turnover of direct care staff.

Quality measures are reviewed on an annual basis by a stakeholder workgroup established by the Department. The Department may risk adjust individual quality measures as it deems appropriate.

The facility quality score is point based using the facility's most recent available three-quarter average Centers for Medicare and Medicaid Services (CMS) data. Point thresholds for each quality measure are established using the corresponding statistical values for the quality measure (QM) point determinants of eighty QM points, sixty QM points, forty QM points, and twenty QM points, as identified in the most recent available five-star quality rating system technical user's guide published by CMS.

Facilities meeting or exceeding the highest performance threshold (top level) for a quality measure receive twenty-five points. Facilities meeting the second highest performance threshold receive twenty points. Facilities meeting the third level of performance threshold level receive fifteen points. Facilities in the bottom performance threshold level receive no points. Points from all quality measures must then be summed into a single aggregate quality score for each facility.

Facilities receiving an aggregate quality score of eighty percent of the overall available total score or higher are placed in the highest tier (Tier V). Facilities receiving an aggregate score of between seventy and seventy-nine percent of the overall available total score are placed in the second highest tier (Tier IV). Facilities receiving an aggregate score of between sixty and sixty-nine percent of the overall available total score are placed in the third highest tier (Tier III). Facilities receiving an aggregate score of between fifty and fifty-nine percent of the overall available total score are placed in the fourth highest tier (Tier II). Facilities receiving less than fifty percent of the overall available total score are placed in the lowest tier (Tier I).

The tier system is used to determine the amount of each facility's per patient day quality enhancement component. The per patient day quality enhancement component for Tier IV is seventy-five percent of the per patient day quality enhancement component for Tier V. The per patient day quality enhancement component for Tier III is fifty percent of the per patient day quality enhancement component for Tier V. The per patient day quality enhancement component for Tier II is twenty-five percent of the per patient day quality enhancement component for Tier V. Facilities in Tier I receive no quality enhancement payment.

Facilities with insufficient three-quarter average CMS quality data must be assigned to the tier corresponding to their five-star quality rating. For example, a facility with a five-star quality rating would be assigned to Tier V while a facility with a one-star quality rating would be assigned to Tier I.

The quality incentive rates are adjusted semiannually on July 1 and January 1 of each year.

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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 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.

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 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 2018 (July 1, 2017 through June 30, 2018) is \$187.21.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XVI. -- Public Process for Changes to Nursing Facility Medicaid Payment Rates:

For all material changes to the methodology for determining nursing facility Medicaid payment rates occurring on or after October 1, 1997, requiring a state plan amendment, the state follows the following public process:

- (1) The proposed estimated payment rates, the proposed new methodologies for determining payment rates, and the underlying justifications are published. Publication is: (a) in the Washington State Register; (b) in the newspapers in each city with a population over 50,000; or (c) on a CMS- approved website.
- (2) The state maintains and updates as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility. Medicaid payment rate methodology, and all materials submitted for publication are sent postage prepaid by regular mail to such individuals and organization.
- (3) Nursing facility providers, their associations, nursing facility Medicaid beneficiaries, representatives, and other concerned members of the public are given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment will not be less than fourteen (14) calendar days after the date of the Washington State Register containing the published material, or the date the published material has appeared in the appropriate newspapers, or the date the material appears on the website.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section XVIII. Supplemental Exceptional Care Payments

Effective July 1, 2001, the department makes available exceptional care payments to augment normally generated payment rates for Medicaid residents.

The payments take the form of increases in the direct care rate allocation 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 and therapy care costs for purposes of normal rate setting and settlement. The cost per patient day for caring for these clients in a nursing home setting may be equal to or less than the cost of caring for these clients in a hospital setting.

A nursing facility (NF) may receive an increase in its direct care component rate allocation for providing exceptional care to a Medicaid resident who:

- Receives specialized services to meet chronic complex medical conditions and neurodevelopment needs of medically fragile children, and resides in an NF where all residents are under age twenty-one with at least fifty percent of the residents entering the facility before the age of fourteen;
- Receives Expanded Community Services (ECS), ECS+, or ECS Respite;
- Is admitted to the NF as an Extraordinary Medical Placement (EMP) and the Department of Corrections (DOC) has approved the exceptional direct care and/or therapy payment;
- Is ventilator or tracheotomy (VT)-dependent and resides in an NF that the department has designated as an active ventilator-weaning center;
- Has a traumatic brain injury (TBI) established by a Comprehensive Assessment Reporting Evaluation (CARE) assessment administered by department staff and resides in an NF that the department has designated as capable of caring for TBI patients;
- Has a TBI and currently resides in an NF specializing in the care of TBI residents where more than fifty percent of residents are classified with TBIs based upon the federal minimum data set assessment (MDS 2 or its successor);
- Is admitted to an NF from a hospital with an exceptional care need that the department staff has determined the NF has the ability to provide the care needed, and the Health Care Authority (HCA) or a successor administration that assumes HCA's responsibilities has approved the exceptional direct care and/or therapy payment; or
- Is approved for the Community Home Project, which helps transition residents from an inpatient hospital setting to home.

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