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State/Territory Name: Washington

State Plan Amendment (SPA) # WA 23-0043

This file contains the following documents in the order listed:

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

September 22, 2023

Dr. Charissa Fotinos, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) 23-0043

Dear Director Fotinos:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 23-0043 effective for services on or after July 1, 2023. The purpose of this SPA is to increase the Nursing Facility budget dial, swing bed rate, and the Nursing Facility specialty rates for ventilator and tracheotomy rates; convert the Enhanced Behavioral Services (EBS), Enhanced Behavioral Services and Respite (EBS + Respite), and Enhanced Behavioral Services and Specialized Services (EBS + Specialized Services) from flat rates to add-ons; and adjust the minimum occupancy percentages for indirect care calculations.

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. We hereby inform you that Medicaid State plan amendment 23-0043 is approved effective July 1, 2023. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

[redacted]

Rory Howe
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0043

2. STATE: WA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
1902(a)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 7,275,000
b. FFY 2024 $ 29,018,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part 1 pgs 2, 4, 11, 16, 20

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Part 1 pgs 2 (TN#22-0029), 4 (TN# 18-0023), 11(TN#16-0017), 16(TN#22-0029), 20(TN#16-0017

9. SUBJECT OF AMENDMENT
Nursing Facility Services Rates

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Charissa Fotinos MD, MSC

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
September 5, 2023

15. RETURN TO
State Plan Coordinator
POB 42716
Olympia, WA 98504

FOR CMS USE ONLY

16. DATE RECEIVED
September 5, 2023

17. DATE APPROVED
September 22, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

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 is a state utilizing industry median cost data, subject to applicable limits, combined with facility-specific and regularly updated resident case mix data, to set the direct care and indirect care component. The capital rate is set using a fair market rental system. The quality enhancement is set using Centers for Medicare and Medicaid Services quality data.

A facility's Medicaid rate is a total of four component rates: 1) direct care (DC), 2) indirect care (IDC) , 3) capital (C), and 4) quality enhancement (QE).

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 2024 (July 1, 2023, through June 30, 2024), the budget dial rate is $ 341.41.

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.

For SFT 2020 and SFY 2021, any Medicaid payments provided to nursing facilities in response to the declared state of emergency related to COVID-19 will not be subject to Medicaid methodology found in RCW 74.46 and will not be included in the calculation of the budget dial.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds (cont)

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.

Resident days for all facilities in indirect and capital component rates is subject to a minimum occupancy of each facility's licensed beds, regardless of how many beds are set up or in use. That is, when the resident days are below the minimum occupancy that applies to the rate component and category of provider, the days are increased to an imputed occupancy for rate setting, which has the effect of reducing per resident day costs and component rates based on them.

When occupancy is above the minimum, the facility's actual occupancy is used. The purpose of minimum occupancy is to prevent inflated rates based on inefficient use of facility resources or failure of the facility to maintain a viable census.

Minimum occupancy for rate setting for all facilities will be eighty percent in the indirect care and ninety percent in capital component rates.

There is no minimum occupancy for direct care.

The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility’s indirect component rate allocation under RCW 74.46.521(3), the State shall apply the minimum facility occupancy adjustment before creating the array of facilities’ adjusted general indirect care costs per adjusted resident day.

Effective July 1, 2016, the State shall not include beds banked under chapter 246-310 WAC in effect on July 1, 2016, in licensed beds for the purpose of computing minimum occupancy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section IX. Indirect Component Rate

This component corresponds to one resident day of indirect care. It includes administrative services, management, housekeeping, utilities, accounting, minor building maintenance, etc.

To set the indirect care component rate, the State takes data from the applicable cost report year allowable indirect care costs and divides by the greater of adjusted resident 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 operations costs and determines the median cost. The rate is set at eighty percent or greater of the statewide median costs.

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:

The average rate comprising the swing bed rate for July 1, 2019, is computed by first multiplying each nursing facility's average daily rate of the preceding calendar year (2018) by the facility's approximate number of Medicaid resident days during the preceding year (2018), which yields an approximate total Medicaid payment for each facility for that calendar year.

Total payments to all Medicaid facilities for the preceding calendar year are added which yields the approximate total payment to all facilities for that year, and then the total is divided by statewide Medicaid resident days for the same year to derive a weighted average for all facilities.

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 2024 (July 1, 2023, through June 30, 2024) is $ 286.55.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section XIX. Specialized Add-on Services Payments

Payments to providers for medically necessary services must be pre-authorized by the Department. There are two fee schedules for these services, as follows:

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of specialized add-on services provided in the nursing facility. The Medicaid agency's rates were set as of July 1, 2023, and are effective for dates of services provided on and after that date. See 4.19-B I, #G for the agency's website where the fee schedules are published.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of habilitative services (i.e., those specialized add-on services not covered under the fee schedule described in section 1 above), provided to individuals with intellectual disabilities residing in a nursing facility. The rates for these habilitative services were established using existing home and community based services (HCBS) waiver fee schedules or, where those fee schedules do not include the particular specialized add-on service being authorized, by using other existing fee schedules or benchmarks, such as the Bureau of Labor Statistics Occupational Employment Statistics. The rates were set as of July 1, 2023, and are effective for dates of services provided on and after that date. The fee schedule can be found on the Department's website at https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/NF%20Specialty%20Rates.xlsx