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State/Territory Name: Washington

State Plan Amendment (SPA) #: 16-0017

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

DEC 06 2016

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

RE: WA State Plan Amendment (SPA) Transmittal Number #16-0017 – Approval

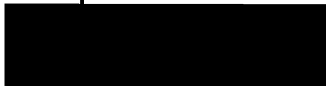
Dear Ms. Lindeblad:

We have reviewed the proposed amendment to Attachments 4.19-B&D of your Medicaid State plan submitted under transmittal number (TN) 16-0017. This SPA updates the fee schedule rates for adult family homes, independent providers, and home care agencies (Attachment 4.19-B) and revamps the reimbursement methodology for nursing facilities (Attachment 4.19-D.)

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 16-0017 is approved effective as of July 1, 2016. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan page.

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,



Kristin Fan
Director

Enclosure

This SPA was vetted by the NIRT at through E-mail communication and exchanges from November 28-30, 2016.

Section 5006(e) Tribal Consultation: The state fulfilled the requirements under section 5006(e) and their approved tribal solicitation SPA. An informational letter was distributed to interested tribal leaders and providers on May 10, 2016

Regional Office: Tom Couch - RO NIRT - (208) 861-9838

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: **16-0017**

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, 2016

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:
Sections 1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $31,033,187
b. FFY 2017 $124,271,919

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19-B page 32 ~~6a~~ (P&I)
4.19-D Part 1 page 2, 3, 4, ~~6,~~ 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20
6 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)
4.19-B page 32 6, 6a (remove) (P&I)
4.19-D Part 1 page 2, 3, 4, ~~6,~~ 6a ~~(remove)~~, 6b (remove), 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 16a (remove), 19, 20 (P&I)

10. SUBJECT OF AMENDMENT

Rate Updates for Nursing Facilities, Adult Family Homes, Independent Providers, & Home Care Agencies

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: 9-12-16

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: 9-12-16

18. DATE APPROVED: DEC 06 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

12/01/16: P&I change authorized for box 8 and 9
12/7/16: P&I change authorized for boxes 8 and 9

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XV. Personal Care Services (cont)

B. Service Rates

The fee schedule was last updated July 1, 2016, to be effective for dates of service on and after July 1, 2016.

Effective Jan. 1, 2008, the standard hourly rate for individual-provided personal care is based on comparable service units and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing the workers. The rate for personal care services provided by individual providers consists of provider wages and benefits. Benefits include health insurance, training, and industrial insurance.

The rate for personal care services provided by agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency.

The rate for personal care provided in boarding homes is based on a per day unit. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. The rates are based on components for provider staff, operations, and capital costs. The rate paid to residential providers does not include room and board.

The rate for personal care provided in an adult family home is based on a per day unit and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes.

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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 2017 (July 1, 2016 through June 30, 2017), the budget dial rate is $197.33.

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.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont)

For the direct care and indirect care components, adjusted cost report data for calendar year 2014 will be used for rate setting for July 1, 2016 through June 30, 2017.

In contrast, the capital component is 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 and RSMeans data.

Additionally, the quality enhancement data is evaluated every six months and the component adjusted accordingly every January 1 and July 1.

Beginning July 1, 2016, the direct care and indirect care component rate allocations shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2014 will be used for July 1, 2016 through June 30, 2018, and so forth.

For rates effective July 1, 2016, 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, 2016. If the former is smaller than the latter, the facility's rate reduction may be no more than one percent on July 1, 2016, no more than two percent on July 1, 2017, and no more than five percent on July 1, 2018. To ensure that the appropriation for nursing homes remains cost neutral, the department may cap the rate increase for facilities in fiscal years 2017, 2018, and 2019.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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.

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 ninety 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 V. Reserved for future use

Section VI. Direct Care Component Rate

This component rate, which averages approximately 70.0% of each participating facility's total Medicaid rate, corresponds to one resident day of care for nursing services, including supplies, therapy, laundry, food, and dietary services.

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 four resource utilization group categories beginning with PA1 through PB22 to any case mix index that aids in achieving the purpose and intent of RCW 74.39A.007 in effect on July 1, 2016, and cost-efficient care. PA1 through PB2 that also have behaviors will not receive an adjustment in case mix index.

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.

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.

Direct care is paid at a fixed rate based on one hundred percent or greater of statewide case mix neutral median costs. Direct care is performance adjusted for acuity using case mix principles. It is then regionally adjusted using county wide wage index information available through the United States Department of Labor's Bureau of Labor Statistics.

The State shall determine and update semiannually for each nursing facility serving Medicaid residents a facility-specific per-resident day direct care component rate adjustment for acuity to be effective on the first day of each six-month period.

Direct care includes therapy which is the average one-on-one care from qualified therapists delivered to a Medicaid resident during one day, and the 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.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

To determine allowable therapy costs, 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 to derive per resident day consulting cost for each type of therapy.

Each facility's allowable cost 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.

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.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VIII. Reserved for future use

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VIII. Reserved for future use

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 ninety percent or greater of the statewide median costs.

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section X. Capital Component Rate:

This component uses a fair rental system to set a price per bed associated with the provision of resident care at a participating nursing facility.

The department rebases the capital component rate annually using cost report data from the calendar year ending six months prior to the commencement of each July 1 rate and RSMeans data. For example, the 2015 cost report is used for July 1, 2016, rate setting, and the 2016 cost report is used for July 1, 2017, rate setting, etc.

The fair rental rate allocation for each facility is determined by multiplying the allowable nursing home square footage by the RSMeans rental rate and by the number of licensed beds yielding the gross unadjusted building value. The sum of the unadjusted building value and equipment allowance is then reduced by the average age of the facility as determined using a depreciation rate of one and one-half percent. The depreciated building and equipment plus land is then multiplied by the rental rate at seven and one-half percent to yield an allowable fair rental value for the land, building, and equipment.

Land is valued at ten percent of the gross unadjusted building value before depreciation.

The equipment allowance is ten percent of the unadjusted building value before depreciation.

The fair rental value determined is then divided by the greater of the actual total facility census from the prior full calendar year or imputed census based on number of licensed beds at ninety percent occupancy.

For the rate year beginning July 1, 2016, all facilities will be reimbursed using four hundred square feet per bed. For the rate year beginning July 1, 2017, allowable nursing facility square footage per bed must be determined using the total nursing facility square footage as reported on the Medicaid cost reports submitted to the Department. The maximum allowable square feet per bed may not exceed four hundred fifty.

Each facility is paid at eighty-three percent or greater of the median nursing facility 2015 RSMeans construction index value per square foot for Washington State. The statewide value per square foot must be indexed based on facility zip code by multiplying the statewide value per square foot times the appropriate zip code based index.

For the rate year beginning July 1, 2016 the value per square foot will be set so that the weighted average fair rental value rate is not less than ten dollars and eighty cents ppd.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XI. Capital Component Rate (cont):

The average age of a facility is the actual facility age reduced for significant renovations. Significant renovations are renovations that exceed two thousand dollars per bed in a calendar year as reported on the annual cost report. For the rate beginning July 1, 2016 the Department will use renovation data back to 1994 as submitted on facility cost reports. Beginning July 1, 2016, facility ages are to be reduced in future years if the value of the renovation completed in any year exceeds two thousand dollars times the number of licensed beds. The cost of the renovation is divided by the accumulated depreciation per bed in the year of the renovation to determine the equivalent number of new replacement beds. The new age for the facility is a weighted average with the replacement bed equivalents reflecting an age of zero and the existing licensed beds, minus the new bed equivalents, reflecting their age in the year of the renovation. At no time may the depreciated age be less than zero or greater than forty-four years.

A nursing facility's capital component rate allocation is rebased annually, effective July 1, 2016.

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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 four quality measures for fiscal year 2017. The quality enhancement component is based on Minimum Data Set (MDS) quality measures for the percentage of long-stay resdients 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, and the percentage of long-stay residents with a urinary tract infection.

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 meaure 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. Facillities in the bottom performance threshold level receive no points. Points from all q uality 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 socre 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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NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIII. Settlement:

In a process called "settlement", the direct care component rate payment is compared to each participating nursing facility's expenditures in the direct care category each report period. The facility must return to the department all unspent rate payments in this category exceeding 1 percent of the 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 indirect care, capital, or quality enhancement component rates.

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 area 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 up to 1 percent of the component rate 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 rate payments, without exception, they received during the settlement period.

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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 2017 (July 1, 2016 through June 30, 2017) is $184.75.

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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);
- 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); or
- 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 and Recovery Services Administration (HRSA) or a successor administration that assumes HRSA's responsibilities has approved the exceptional direct care and/or therapy payment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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, 2016, and are effective for dates of services provided on and after that date. See 4.19-B I, #G for the agency's websited 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, 2016, 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/All_HCS_Rates.xls