



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND DISABILITY SERVICES ADMINISTRATION  
*PO Box 45600 \* Olympia, WA 98504-5600*

June 30, 2011

**ADSA: NH Rates #2011-002**  
**RE: JULY 2011 MEDICAID RATES FOR NURSING HOMES**  
**AND 2010 EXAMINATION ADJUSTMENTS**

Dear Nursing Facility Administrator:

The July 1, 2011 Medicaid payment rate for your facility is enclosed. In creating the rate computation worksheet, the Department used wording and calculation descriptions as similar as possible to that used in prior rate settings to facilitate your review. Note that the July 1, 2011 non-capital component rates are still based on the 2007 Cost Report information.

The July 1, 2011 Medicaid payment rate is subject to administrative review in accordance with WAC 388-96-901 and 388-96-904. To appeal this rate, you must submit a request in writing within twenty-eight (28) calendar days after receiving this notice of the rate.

The desk examination summary and Reason Codes for the 2010 Medicaid Cost Report are also enclosed and subject to administrative review in accordance with WAC 388-96-901 and 388-96-904. To appeal these adjustments, you must submit a request in writing within twenty-eight (28) calendar days after receiving this notice of the adjustments.

The Department calculated your facility's July 1, 2011 adjusted rate using your facility's Medicaid Average Case Mix Index (with defaults) from the final RUG report for the six month period from April 1 through September 30, 2010.

If you wish to request an administrative review conference in relation to your July 1, 2011 rate or to the desk examination of the 2010 Cost Report, please keep in mind WAC 388-96-904, the regulation that controls such requests. The regulation provides in part:

- (1)...The contractor's request for administrative review shall:
  - (a) Be signed by the contractor or by a partner, officer, or authorized employee of the contractor;
  - (b) State the particular issues raised; and
  - (c) Include all necessary supporting documentation or other information.



(2) After receiving a request for administrative review conference that meets the criteria in subsection (1) of this section, the Department shall schedule an administrative review conference. The conference may be conducted by telephone.

(3) At least fourteen calendar days prior to the scheduled date of the administrative review conference, the contractor must supply any additional or supporting documentation or information upon which the contractor intends to rely in presenting its case. In addition, the Department may request at any time prior to issuing a determination any documentation or information needed to decide the issues raised, and the contractor must comply with such a request within fourteen calendar days after it is received...The Department shall dismiss issues that cannot be decided or resolved due to a contractor's failure to provide requested documentation or information within the required period.

(emphasis added)

The Department will enforce this regulation in responding to requests for administrative review. Requests that are not properly signed, that do not state the issues with particularity, or that are not supported by the required documentation or information, will be denied or dismissed. Mail your appeal to the Office of Rates Management at: P.O. Box 45600, Olympia, WA 98504-5600. Do not mail your appeal to our physical address of Blake West 4450 10<sup>th</sup> Ave SE, Lacey, WA 98503. Ground carriers such as UPS and FedEx can deliver to the physical address, but the Post Office will not.

If proof of the date of receipt of the Department's rate notification letter exists, then that date shall be used to determine the timeliness of your request for an administrative review conference. If there is no proof of the date of receipt of the Department's rate notification letter, then you will be deemed to have received notice by July 5, 2011 in accordance with WAC 388-96-904 (1).

The July 1 rates reflect changes to the rate methodology made earlier this year by the Legislature in c. 7, Laws of 2011, 1<sup>st</sup> sp. sess. (ESSB 5581). The law's more significant features include:

- 1) Elimination of the variable return component (which was already scheduled for July 1).
- 2) A rise in the minimum occupancy assumptions for the operations, property, and financing allowance components to 87% (from 85%) for nursing facilities that are essential community providers, to 92% (from 90%) for small non-ECPs, and to 95% (from 92%) for large non-ECPs.
- 3) Postponement of rebasing for one year, and movement of the cycle for future rebasing to odd-numbered years from the current even-numbered year cycle.
- 4) Reduction of the financing allowance percentage factor to a uniform 4%, from the current two-tier levels of 10% and 8.5% depending on date of acquisition.
- 5) Authorization of the Department to adjust the case mix index for the ten lowest acuity resource utilization groups to any case mix index that aids in achieving cost-efficient care. Also, removal of the "look-back" provision for adjusting rates in relation to the case mix adjustment under the change to MDS 3.0.

- 6) Direction to the Department to assign the lowest case mix weight (instead of the current 1.000) to the resource utilization group with the lowest total weighted minutes.
- 7) Allowance for the transition to MDS 3.0 and RUG IV. For July 1, 2011 through June 30, 2013, the Medicaid Average Case Mix Index (MACMI) effective January 1, 2011 will be used, increased by .5% every six months. The July 1, 2013 direct care cost per case mix unit will use 2011 direct care costs and 2011 Facility Average Case Mix Index (FACMI) based on MDS 3.0 and RUG IV grouper 57.
- 8) A decrease in the direct care cost lid to 110% (instead of 112%) of the peer group median.
- 9) A decrease in the support services cost lid to 108% (instead of 110%) of the peer group median.
- 10) A "hold harmless" rate for nursing facilities for State Fiscal Years 2012 and 2013 (July 1, 2011 through June 30, 2013). For the present rate-setting, each facility's rate as calculated on July 1, 2011 under the methodology changes in c. 7, Laws of 2011, 1<sup>st</sup> sp. sess., will be compared to the facility's rate in effect June 30, 2010. If the July 1, 2011 rate is lower, the difference will be paid as an add-on.
- 11) A direct care bonus. In doing the calculation described in #10 above, if a facility's July 1, 2011 direct care rate is greater than the June 30, 2010 direct care rate, the facility will receive a 10% direct care rate add-on to compensate for taking on more-acute clients. This add-on is subject to settlement.
- 12) Imposition of a "safety net assessment" (SNA) on non-Medicare resident days at nursing facilities. Please see the accompanying document titled "Safety Net Assessment" for more details. Note that beginning July 1, 2011 an add-on will be paid to facilities to cover their payment of the SNA in relation to residents whose care is funded by Medicaid. The SNA add-on is not subject to settlement.

Please note that the foregoing description is given as a courtesy only. It is not intended as a complete description of the provisions of the law, and you may not rely on it. You may find the law, the bill, its legislative history, and legislative reports on it at the Legislature's website, and I encourage you to review them. Each facility and contractor is responsible for understanding the law.

Also enclosed are a depreciation schedule for your facility, if adjustments were made to it, and a copy of your RUG scores. I encourage you to contact your analyst if you have questions about your rate or exam. The facility/analyst list is available on our website.

Finally, we note that the changes made by the Legislature in c. 7, Laws of 2011, 1<sup>st</sup> sp. sess., and the rate levels adopted in the operating budget for SFYs 2012 and 2013 are subject to CMS approval of a related State Plan Amendment (SPA). Likewise, the SNA is subject to CMS approval of a related waiver. The SPA and the waiver will both be filed shortly, so neither has been approved. In the federal litigation of the last two years over Washington's Medicaid nursing facility rates, the plaintiffs have taken the position that the state may not change Medicaid nursing facility rates, or take any action which requires CMS approval, until such approval has been given. The state has taken the position, consistent with the practice of many years, that CMS will approve a SPA

Nursing Facility Administrator

June 30, 2011

Page 4

retroactive to the first day of the calendar quarter in which it is filed and that the state may implement changes beginning that first day of the quarter subject to ultimate approval by CMS. The state's position on actions subject to a waiver issued by CMS is the same. The state will consider that any facility which accepts its July 1, 2011 Medicaid rate, as well as the add-on to reimburse the SNA for Medicaid residents under these circumstances, agrees with the state that such rate and add-on may lawfully be paid and accepted prior to CMS approval of the SPA and/or waiver.

Sincerely,

A handwritten signature in black ink that reads "Ken Callaghan". The signature is written in a cursive, slightly slanted style.

Ken Callaghan, Chief  
Office of Rates Management

Enclosures

cc: Interested Parties