



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX-43
Seattle, Washington 98121

September 1, 2010

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 09-025

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 09-025.

Although the NIRT Team has already sent the State a copy of the approval for this SPA, the Seattle Regional office is following up with an additional copy for the reason that we were in receipt of the original, signed amendment request.

Therefore, enclosed is a copy of the official CMS form 179, amended page(s), and copy of the approval letter from the NIRT Team for your records.

If you have any questions or require any assistance concerning the Seattle Regional office role in the processing of this state plan amendment, please contact me, or have your staff contact Daphne Hicks at (206) 615-2400 or daphne.hicks@cms.hhs.gov.

Sincerely,

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

Enclosure

cc: Douglas Porter, Assistant Secretary, HRSA, DSHS

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

1. TRANSMITTAL NUMBER:
09-025

2. STATE
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

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, 2009

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 2009 (\$ 6.17 M)(P&I) (\$1,203,000)(P&I)
b. FFY 2010 (\$ 25.26M)(P&I) (\$4,737,000)(P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Part 1, pages 2, ~~8, 9~~, 10, ~~11~~, 14, ~~15, 16, 17, 18~~, 21,
26, ~~29, 30, 39, 44~~, and 46. (P&I)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.19-A Part 1, pages 2, ~~8, 9~~, 10, ~~11~~, 14, ~~15, 16, 17, 18~~,
21, 26, ~~29, 30, 39, 44~~, and 46. (P&I)

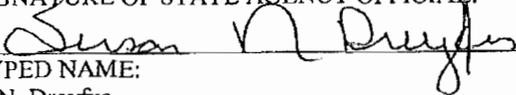
10. SUBJECT OF AMENDMENT:

Inpatient Hospital Rates

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Exempt
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Susan N. Dreyfus

14. TITLE:

Secretary

15. DATE SUBMITTED:

Sept. 29, 2009

16. RETURN TO:

Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
POB 5504
Olympia, WA 98504-5504

(MS: 45504)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **SEPTEMBER 29 2009**

18. DATE APPROVED: **AUG 31 2010**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **JUL 01 2009**

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

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

23. REMARKS:

10/22/2009 State authorized pen and ink changes.
6/04/2010 State authorized pen and ink changes.
8/26/2010 State authorized pen and ink changes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES**

A. INTRODUCTION

The State of Washington's Department of Social and Health Services (DSHS/Department) implemented a Diagnosis Related Groups (DRG)-based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's.

The hospital rates and payment methods described in this attachment are for the State of Washington Medicaid program. The standards used to determine payment rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. The system includes payment methods to hospitals for sub-acute care such as skilled nursing and intermediate care, and payment methods for other acute inpatient care such as Long Term Acute Care (LTAC). The rates for these services are lower than those for standard inpatient acute care.

The reimbursement system employs four major methods to determine hospital payment rates:

1. DRG cost-based rates;
2. Rates based on the hospitals' ratio of cost-to-charges (RCC);
3. Per diem rates (beginning August 1, 2007); and
4. Full cost rates (beginning July 1, 2005).

Chapter 388-550 of the Washington Administrative Code (WAC), Revised Code of Washington (RCW) 74.04.050, 74.04.057, 74.08.090, 74.09.500, and any other state or federal laws or regulations, codified or uncodified, as they exist as of July 1, 2009, as may be applicable, are incorporated by reference in Attachment 4.19-A Part I as if fully set forth.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES**

B. DEFINITIONS (cont.)

Per Diem Rate

The per diem rate, a cost-based rate, is a calculated amount based on the statewide, standardized, average cost per day adjusted by the Medicare wage index for each hospital's geographical location and any indirect medical education costs to reflect the hospital's specific costs (for more detail see Attachment 4.19A, part 1, page 32).

RCC

RCC means a hospital ratio of costs-to-charges (RCC) calculated using annual CMS 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues (more detail is available at Supplement 3 to Attachment 4.19-A, Part 1, pages 3 & 4). The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed covered charges for medically necessary services. This method is not used for hospitals reimbursed using the "full cost" CPE method except that the Medicaid RCC rates are used to determine "full cost" for those hospitals. A reduced RCC is used to calculate GAUDSH payments on RCC inpatient paid claims.

Trauma Centers

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)**

C. GENERAL REIMBURSEMENT POLICIES (cont.)

3. High Outlier Payments (cont)

Reimbursement for DRG psychiatric (DRGs 424-432) outliers is at the DRG rate plus 100 percent of the hospital RCC ratio applied to the allowed covered charges exceeding the outlier threshold.

For dates of admission on and after August 1, 2007, to qualify for a high outlier payment on a DRG paid claim, or non-specialty service per diem paid claim, the claim cost (claim covered charges multiplied by RCC) must be greater than both a fixed outlier threshold of \$50,000; and 175% of claim payment calculation (inlier payment allowed amount).

Different high outlier qualification criteria exists for Children's Hospital and Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped into neonatal and pediatric DRGs classifications. To qualify for a high outlier payment on a DRG paid claim, or non-specialty service per diem paid claim, the claim cost (claim covered charges multiplied by RCC) must be greater than both a fixed outlier threshold of \$50,000; and 150% of claim payment calculation (inlier payment allowed amount).

Reimbursement for the high outlier adjustment on high outlier cases other than cases in children's hospitals (Children's Hospital and Regional Medical Center, and Mary Bridge Children's Hospital and Health Center), and claims grouped into neonatal and pediatric DRGs classifications, is as follows:

Outlier adjustment = (Claim Cost less 175% of claim payment allowed amount, multiplied by 85% (90% for burn services))

Total Claim Payment Allowed Amount = Inlier Payment Allowed Amount plus the Outlier adjustment

Reimbursement for the high outlier adjustment on high outlier cases at the state's two children's hospitals (Children's Hospital and Regional Medical Center and Mary Bridge Children's Hospital and Health Center), and claims grouped into neonatal and pediatric DRGs classifications, is as follows:

Outlier adjustment = (Claim Cost less 175% of claim payment allowed amount, multiplied by 95%)

Total Claim Payment Allowed Amount = Inlier Payment Allowed Amount plus the Outlier adjustment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)**

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

h. Trauma Center Services (cont.)

The payment an eligible hospital receives from the quarterly payment pool is determined by first summing each hospital's qualifying payments for trauma cases from the beginning of the service year and expressing this amount as a percentage of total payments made by the Department to all Level I, II, and III hospitals for qualifying services provided during the service year to date. Each eligible hospital's payment percentage for the service year-to-date is multiplied by the trauma supplemental funds available for the service year-to-date, and then the Department subtracts previous quarterly payments made to the individual hospital for the service year-to-date to determine that hospital's portion of the current quarterly payment pool.

A fee-for service case qualifies for supplemental trauma payment if the Injury Severity Score (ISS) is 13 or greater for an adult patient or 9 or greater for a pediatric patient (through age 14 only). A transferred trauma case qualifies for supplemental payment regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

i. Inpatient Pain Center Services

Services in HRSA-authorized inpatient pain centers are paid using a fixed per diem rate.

9. Transfer Policy

For a hospital transferring a client to another acute care hospital or a facility with sub acute medical services, for a claim paid using the DRG payment method, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below:

For dates of admission before August 1, 2007, the payment allowed amount to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital, or the appropriate DRG payment allowed amount; and

For dates of admission on and after August 1, 2007, the payment allowed amount to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital plus one day, or the appropriate DRG payment allowed amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)**

C. GENERAL REIMBURSEMENT POLICIES (cont.)

19. Base Community Psychiatric Hospitalization Payment Rate

Under the DRG, RCC and "full cost" methods, and only for dates of admission before August 1, 2007, a base community psychiatric hospital payment rate may apply for psychiatric claims submitted by an in-state hospital that has already treated a patient covered under the state's Involuntary Treatment Act (ITA) in an ITA-certified bed. The base community psychiatric hospital payment rate is a per diem rate. The base community psychiatric hospitalization payment rate is used in conjunction with the DRG, RCC and "full cost" methods to determine the final allowable to be paid on qualifying claims.

D. DRG COST-BASED RATE METHOD

Rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) data. The cost report data used for rate setting must include the hospital fiscal year (HFY) data for a complete 12-month period for the hospital. Otherwise, the in-state average RCC rate is used.

For dates of admission on and after August 1, 2007, the claim estimated cost was calculated based on Medicaid paid claims and the hospital's Medicare Cost Report. The information from the hospital's Medicare cost report for fiscal year 2004 was extracted from the Healthcare Cost Report Information System ("HCRIS") for Washington in-state hospitals.

The database included only in-state, non-critical access hospital Medicaid data. Data for critical access, long term acute care, military, bordering city, critical border, and out-of-state hospitals were not included in the claims database for payment system development.

The Department applies the same DRG payment method that is applied to in-state hospitals to pay bordering city, critical border, and out-of-state hospitals. However, the payment made to bordering city, critical border and out-of-state hospitals may not exceed the payment amount that would have been paid to in-state hospital for a corresponding service.