



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

October 18, 2010

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

RE: Washington State Plan Amendment 10-005

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 10-005.

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 you will find 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 concerning the Seattle Regional office role in the processing of this state plan amendment, please contact Jan Mertel at (206) 615-2317 or Jan.Mertel@cms.hhs.gov.

Sincerely,

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

Enclosure

Cc: Douglas Porter, Assistant Secretary

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S2-26-12
Baltimore, MD 21244-1850



Center for Medicaid, CHIP, and Survey & Certification

OCT 12 2010

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

Re: Washington State Plan Amendment (SPA) Transmittal Number 10-005

Dear Ms Dreyfus:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan, submitted under transmittal number (TN) 10-005. This amendment updates Attachment 4.19-A of the State plan by identifying adverse events and hospital-acquired conditions ineligible for Medicaid reimbursement.

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 10-005 is approved effective January 1, 2010. We are enclosing the HCFA-179 and the amended pages.

If you have any questions concerning this State plan amendment, please call Joe Fico of the National Institutional Reimbursement Team at (206) 615-2380.

Sincerely,

A handwritten signature in black ink that reads "Bill Fawcett". The signature is written in a cursive style with a large initial "B".

Cindy Mann
Director

Center for Medicaid, CHIP, and Survey & Certification

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 10-005	2. STATE Washington
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE Jan. 1, 2010	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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 2010 \$0 [\$37,500] (P&I) b. FFY 2011 \$0 [\$50,000] (P&I)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A Part 1 pages 2, 4, 12, 15, 16, 23 (P&I) pages 2, 4, 7, 12, 15, 16, & 23 (P&I)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A Part 1 pages 2, 4, 12, 15, 16, 23 (P&I) pages 2, 4, 7, 12, 15, 16, & 23 (P&I)

10. SUBJECT OF AMENDMENT:

Adverse Events

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: <i>Susan N. Dreyfus 3/29/10</i>	16. RETURN TO: Ann Myers Department of Social and Health Services Health and Recovery Services Administration 626 8 th Ave SE MS: 45504 Olympia, WA 98504-5504
13. TYPED NAME: Susan N. Dreyfus	
14. TITLE: Secretary	
15. DATE SUBMITTED: 3-29-10	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MARCH 29 2010	18. DATE APPROVED: OCT 12 2010
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2010	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Barbara K. Richards</i>
21. TYPED NAME: Barbara K. Richards	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health
23. REMARKS: Pen and Ink (P&I) changes authorized by the State on 10/04/10.	

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, 74.08.090, 74.09.500, and any other state or federal laws or regulations, codified or uncoded, as they exist as of July 1, 2009, as may be applicable, are incorporated by reference in Attachment 4.19-A Part 1 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 (cont.)****B. DEFINITIONS**

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan. Allowed covered charges, where mentioned in this attachment to the state plan, refers to the DSHS covered charges on a claim that are used to determine any kind of reimbursement for medically necessary care.

Accommodation and Ancillary Costs

Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), and operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

Adverse Events

Adverse events (also known as "adverse health events" or "never events") are the events that must be reported to the Washington State Department of Health (DOH) under WAC 246-320-146 in effect as of January 1, 2010. These serious reportable events are clearly identifiable, preventable, and serious in their consequences for patients, and frequently their occurrence is influenced by the policies and procedures of the healthcare organization.

Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)

ADATSA is a program that provides a continuum of care to persons who are indigent and considered unemployable as a result of alcoholism and/or other drug addiction.

Bariatric Surgery Case Rate

The bariatric surgery per case rate is a cost-based rate used to pay a hospital that is prior authorized by the Department to provide bariatric surgery related services to an eligible medical assistance client for those services.

Base Community Psychiatric Hospitalization Payment Rate

For admissions before August 1, 2007, the base community psychiatric hospitalization payment rate is a minimum per diem allowable calculated for claims for psychiatric services provided to covered patients, to pay hospitals that accept commitments under the state's involuntary treatment act.

Case-Mix Index (CMI)

Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

"Full Cost" Payment Program

"Full cost" payment program means a hospital payment program for public hospitals located in the State of Washington that are owned by public hospital districts and are not Department-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. These hospitals are reimbursed based on the full cost of services as determined through the Medicare Cost Report and HRSA's RCC rate. Each of these hospitals' certified public expenditures represent the cost of the patients' medically necessary care. Each hospital's inpatient claims are paid by the "full cost" payment method, using the Medicaid RCC rate to determine cost.

HCFA/CMS

HCFA means the Department of Health and Human Services' former Health Care Financing Administration (HCFA), renamed the Centers for Medicare and Medicaid Services (CMS) in June 2001. CMS (formerly named HCFA) is the federal agency responsible for administering the Medicaid program.

Hospital

Hospital means a treatment facility which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

Hospital-acquired condition (HAC)

Hospital-acquired condition (HAC) is a condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at discharge or documented after admission. For Medicaid payment purposes, the department considers a HAC to be a condition that:

- (i) Is high cost or high volume, or both;
- (ii) Results in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis;
- (iii) Could reasonably have been prevented through the application of evidence-based guidelines; and
- (iv) Does not conflict with Medicare's hospital-acquired conditions policy.

Inpatient Services

Inpatient services means all services provided directly or indirectly by the hospital, subsequent to admission and prior to discharge of an inpatient, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, related services provided by the hospital within one calendar day of the client's admission as an inpatient.

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**

The following section describes general policies governing the reimbursement system. Payment will only be made to the provider for covered services for that portion of a patient admission during which the client is Medicaid eligible. Unless otherwise specified in this attachment, rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) data and Department determined base year(s) claims 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.

Effective dates of admission on and after January 1, 2010, the state does not pay for adverse events. Some Hospital Acquired Conditions (HACs) can become an adverse event if the:

- (i) Patient dies or is seriously disabled; or
- (ii) Level of severity is great, such as the patient develops level three or level four pressure ulcers.
- (c) The client cannot be held liable for payment.

1. DRG Payments

Except where otherwise specified (DRG-exempt hospitals, DRG-exempt services and special agreements), payments to hospitals for inpatient services are made on a DRG payment basis. The basic payment is established by multiplying the assigned DRG's relative weight for that admission by the hospital's rate as determined under the method described in Section D.

For claims with dates of admission on and after January 1, 2010, the state does not make additional payments for services on inpatient hospital claims that are attributable to Hospital Acquired Conditions (HAC) and are coded with Present on Admission Indicator codes "N" or "U". For HAC claims which fall under the DRG payment basis, the state does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).

Any client responsibility (spend-down) and third party liability, as identified on the billing invoice or otherwise by the Department, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission.

2. DRG Relative Weights

The reimbursement system uses Washington State, Medicaid-specific DRG relative weights.

For dates of admission before August 1, 2007, to the extent possible, the weights are based on Medical Assistance (Medicaid) claims for hospital fiscal years (HFYs) 1997 and 1998, spanning the period February 1, 1997 through December 31, 1998, and on Version 14.1 of the Health Information Systems (HIS) DRG All Patient Grouper software.

The relative weight calculations are based on Washington Medical Assistance claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care. Each DRG is statistically tested to assure that there is an adequate sample size to ensure that relative weights meet acceptable reliability and validity standards.

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.)

4. DRG Low Cost Outlier Payments

Low cost outliers are cases with dates of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. To qualify as a DRG low cost outlier, the allowed charges for the case must be equal to or less than the greater of 10 percent of the applicable DRG payment or \$450. Reimbursement for these cases is the case's allowed charges multiplied by the hospital's RCC ratio.

5. DRG Long-Stay Day Outlier Payments

Day Outlier payments are applicable for cases with dates of admission before August 1, 2007. Day outlier payments are included only for long-stay clients, under the age of six in disproportionate share hospitals, and for children under age one in any hospital. (See C.16 Day Outlier payments).

6. Non DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the per diem, per case rate, fixed per diem, RCC method, "full cost" method, CAH method, etc. For RCC and "full cost" payments, 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. Recipient responsibility (spend-down) and third party liability as identified on the billing invoice or otherwise by DSHS, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission. Other applicable adjustments may also be made. For the "full cost" method, only the federal funds participation (FFP) percentage is paid on the claim after all other adjustments to the allowed amount have been made.

For claims with admission dates on and after January 1, 2010 which qualify under the per diem payment method, the state does not pay for days of service beyond the average length of stay (LOS) attributable to Hospital Acquired Conditions (HAC) and are coded with Present on Admission Indicator codes "N" or "U".

For claims with admission dates on and after January 1, 2010 which qualify under the CAH payment method which uses the Departmental weighted costs to charges (DWCC) rates to calculate payments, under the Ratio of Cost to Charges (RCC) payment method, and under the per case payment method, the state does not pay for services attributable to the HAC.

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.)

7. DRG Exempt Hospitals (cont.)

The following hospitals are exempt from the DRG payment method for Medicaid.

a. *Psychiatric Hospitals*

Designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals are this type of facility. This currently includes, but is not limited to, Fairfax Hospital, Lourdes Counseling Center, West Seattle Psychiatric Hospital, the psychiatric unit at Children's Hospital and Regional Medical Center, and all other Medicare-certified and State-approved distinct part psychiatric units doing business with the State of Washington.

b. *Rehabilitation Units*

Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The criteria used to identify exempt hospitals and units are the same as those employed by the Medicare program to identify designated distinct part rehabilitation units.

In addition, services for clients in the Department's Physical Medicine and Rehabilitation program (PM&R), and who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for PM&R services and placement into the rehabilitation unit.

c. *Critical Access Hospital (CAHs)* Department-approved and Medicare-designated CAHs receive Medicaid prospective payment based on Departmental Weighted Cost-to-Charge (DWCC). Post-period cost settlement is then performed.

d. *Managed Health Care*

Payments for clients who receive inpatient care through managed health care programs. If a client is not a member of the plan, reimbursement for admissions to managed health care program hospital will be determined in accordance with the applicable payment methods for hospitals as described in this section and Section D, Section E and/or Section F.

e. *Out-of-State Hospitals*

For medical services provided, out-of-state hospitals are those facilities located outside of Washington and outside designated bordering cities as described in Section D. For psychiatric services and Involuntary Treatment Act (ITA) services, out-of-state hospitals are those facilities located outside the State of Washington. The Mental Health Division designee is responsible to screen for authorization of care and make payment for authorized services.

For dates of admission before August 1, 2007, for medically necessary treatment of emergencies that occur while a client is out-of-state, these hospitals are exempt from DRG payment methods, and are paid an RCC ratio based on the weighted average of RCC ratios for in-state hospitals.

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.)

12. Inpatient vs. Outpatient Stay Policy

Through October 31, 2004, stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are considered inpatient and are reimbursed under the respective inpatient payment method designated for the hospital and/ or the covered services. On and after November 1, 2004, a new clinical-based inpatient vs. outpatient stay determination rule is in effect.

An inpatient stay is an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

An outpatient hospital stay consists of outpatient hospital services that are within a hospital's licensure and provided to a client who is designated as an outpatient based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

13. Medicare Related Policies

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For clients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider cannot exceed DSHS's rates or fee schedule as if they were paid solely by Medicaid using the RCC payment method.

In cases where the Medicare crossover client's Part A benefits, including lifetime reserve days, are exhausted, and the Medicaid outlier threshold status is reached, the state will pay for those allowed charges beyond the threshold using the outlier policy described in C.3.above.

The state applies the following rules for HAC claims:

(a) If Medicare denies payment for a claim at a higher rate for the increased costs of care under its HAC and/or POA indicator policies:

- (i) The state limits payment to the maximum allowed by Medicare;
- (ii) The state does not pay for care considered non-allowable by Medicare; and
- (iii) The client cannot be held liable for payment.

(b) If Medicare denies payment for a claim under its National Coverage Determination authority from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

- (i) The state does not pay the claim, any Medicare deductible, and/or any co-insurance related to the inpatient hospital services; and
- (ii) The client cannot be held liable for payment.