DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

MAR 2 1 2012

Douglas Porter, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-022B

Dear Mr. Porter:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) Transmittal Number 11-022B.

Although the NIRT Team has already sent the State a copy of the approval for this SPA, the Seattle Regional Office (RO) 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 RO role in the processing of this SPA amendment, please contact me, or have your staff contact Joe Fico at (206) 615-2380 or via email at Joseph.Fico@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

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: **11-22B**

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 7, 2011

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 2012 ($23,259,193) P&I
b. FFY 2013 ($18,074,299) P&I

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A Part I, pgs. 2, 3,8, 13, 14, 16, 17, 19 - 47

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19-A Part I, pgs. 2, 3,8, 13, 14, 16, 17, 19 - 47

10. SUBJECT OF AMENDMENT:

Hospital Rates-Inpatient

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:
Doug Porter

13. TYPED NAME:
Doug Porter

14. TITLE:
Director

15. DATE SUBMITTED:
8-30-11

16. RETURN TO:
Ann Myers
Health Care Authority
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 30, 2011

18. DATE APPROVED:
MAR 2 1 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 07 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
Carol J. C. Peverly

21. TYPED NAME:
Carol J. C. Peverly

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

23. REMARKS:

8.31.11 state authorized P&I to box 7 to reflect savings.

FORM HCFA-179 (07-92)

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and CHIP Services

Doug Porter, Administrator
Health Care Authority
Post Office Box 428682
Olympia, Washington 98504-2682

MAR 31 2012

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-022B

Dear Mr. Porter:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-022B. The purpose of this amendment is to update the State plan by decreasing the inpatient hospital services reimbursement rates for privately owned or operated hospitals that reimbursed on a prospective basis.

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.

Medicaid State plan amendment 11-020 is approved effective July 7, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Joe Fico of the National Reimbursement Team at (206) 615-2380.

Sincerely,

Cindy Mann,
Director, CMCS

cc
Ann Myer, State Plan Coordinator

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: **11-22B**

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 7, 2011

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)*

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Hospital Rates-Inpatient

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Doug Porter

13. TYPED NAME:
Doug Porter

14. TITLE:
Director

15. DATE SUBMITTED:
8-30-11

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Ann Myers
Health Care Authority
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 30, 2011

18. DATE APPROVED:
MAR 21 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 7 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

8.31.11 state authorized P&I to box 7 to reflect savings.

FORM HCFA-179 (07-92)

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 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 amounts:

1. Diagnosis-Related Group (DRG);
2. Ratio of cost-to-charges (RCC);
3. Per diem (beginning August 1, 2007); and
4. Full cost (beginning July 1, 2005).

Chapter 182-550 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, 2011, 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 (cont.)

A. INTRODUCTION (cont.)

Other payment methods used include fixed per diem, cost settlement, per case rate (for Medicaid agency-approved bariatric surgery), disproportionate share hospital (DSH), and proportionate share hospital. All are prospective payment methods except the cost settlement payment method used to reimburse critical access hospitals. The DRG, "full cost," per diem, and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement provides reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly.

A fixed per diem payment method is used in conjunction with the LTAC program. A cost settlement payment method is used to reimburse hospitals participating in the state's Title XIX Critical Access Hospital (CAH) program.

Effective for admissions on and after July 1, 2005, public hospitals located in the State of Washington that are not Agency-approved and DOH-certified as CAH, are paid using the "full cost" payment method for inpatient covered services as determined through the Medicare Cost Report, using the Agency's Medicaid RCC to determine cost.

Each public hospital district, for its respective non-CAH public hospital district hospital(s), the Harborview Medical Center, and the University of Washington Medical Center, provide certified public expenditures which represent its costs of the patients' medically necessary care.

Hospitals and services exempt from the DRG payment methods are reimbursed under the per diem, per case rate, RCC, "full cost", cost settlement, or fixed per diem payment method for dates of admission on or after August 1, 2007, and for dates of admission before August 1, 2007, under, RCC, "full cost" methods, and a base community psychiatric hospitalization payment rate used to determine the allowable for certain psychiatric claims.

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.)

Involuntary Treatment Act (ITA)
The ITA designates mental health professionals to perform the duties of investigating and detaining persons who may be of danger to themselves or others, without the voluntary cooperation of those persons, when necessary.

Long Term Acute Care
Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State-designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have equaled or exceeded the DRG allowed amount (hospital-specific DRG rate times relative weight for the DRG code on the claim). At the point at which that determination is made, the mode of care and reimbursement may switch to LTAC under a fixed per diem rate if authorized by the Agency. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

Observation Services
Observation services means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital 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 (cont.)

2. DRG Relative Weights (cont.)

The relative weights are standardized to an overall case-mix index of 1.0 based on claims used during the recalibration process, but are not standardized to a case-mix index of 1.0 regarding the previous relative weights used.

For dates of admission on and after August 1, 2007, Washington State Medicaid recalibrated the relative weights using the All Patient DRG (AP-DRG) grouper version 23.0 classification software. The relative weights are cost-based and developed using estimated costs of instate hospitals' Medicaid fee-for-service claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care from SFY 2004 and 2005.

The AP-DRG classification is unstable if the number of claims within the DRG classification is less than the calculated N for the sample size. The AP-DRG classification is also considered low-volume if number of claims within the classification is less than 10 claims in total for the two-year period.

3. High Outlier Payments

High-outliers are cases with extraordinarily high costs when compared to other cases in the same DRG. The reimbursement system includes an outlier payment for these cases.

For dates of admission before August 1, 2007, to qualify as a DRG high-cost outlier the allowed covered charges for the case must exceed a threshold of three times the applicable DRG payment and $33,000.

Reimbursement for 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 psychiatric DRGs, is the applicable DRG payment allowed amount plus 75 percent of the hospital's RCC applied to the allowed covered charges exceeding the outlier threshold.

Reimbursement for the 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) is the applicable DRG payment allowed amount plus 85 percent of the hospital's RCC applied to the allowed covered charges exceeding the outlier threshold.

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 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 (inkier 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.)

7. DRG Exempt Hospitals

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 Agency'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) Agency-approved and Medicare-designated CAHs receive Medicaid prospective payment based on Agency/Department 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 based on the weighted average of RCCs 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.)

7. DRG Exempt Hospitals (cont.)

e. Out of State Hospitals (cont)

For dates of admission on and after 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 method only for those services that are exempt from the DRG payment method on and after that date.

For Agency referrals to out-of-state providers after the Agency's Medical Director or designee approved an Exception to Rule for the care:

(1) In absence of a contract, the Agency pays based on the payment methods mentioned above.

(2) When the Agency is successful negotiating a contract, out-of-state hospitals are paid using a negotiated contract rate. The Agency first negotiates for the rate mentioned above, then for the other state's Medicaid or Medicare rate, and finally for the best rate possible beyond the other tiers.

f. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed covered charges multiplied by the applicable RCC.

g. Public Hospitals Located In the State of Washington

Beginning on July 1, 2005, for public hospitals located in the State of Washington that are owned by public hospital districts and are not Agency-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, Medicaid and MCSDSH covered services are paid by the "full cost" public hospital certified public expenditure (CPE) payment method. The new payment methodology incorporates the use of certified public expenditures at each hospital as the basis for receiving federal Medicaid funding.

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.)

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

d. Bone Marrow and Other Major Organ Transplants

Services provided to clients receiving bone marrow transplants and other major organ transplants are exempt from the DRG payment method, and are reimbursed under the RCC method.

e. Chemically-Dependent Pregnant Women

For dates of admission before August 1, 2007, hospital-based intensive inpatient care for detoxification and medical stabilization provided to chemically-dependent pregnant women by a certified hospital are exempt from the DRG payment method, and are reimbursed under the RCC payment method. See subsection E.1., for information on the payment method for Chemically Using Pregnant (CUP) women program, for dates of admission on and after August 1, 2007.

f. Long-Term Acute Care Program Services

Long-Term Acute Care (LTAC) services, and other inpatient services provided by LTAC hospitals, are exempt from DRG payment methods. LTAC services covered under the LTAC rate are reimbursed using a fixed per diem rate. Other covered LTAC services are paid using the RCC method. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient. Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

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.)

g. Services provided in DRG classifications that do not have an Agency relative weight assigned.

For dates of admission before August 1, 2007, services provided in DRGs that do not have an Agency relative weight assigned, that would otherwise be paid using the DRG payment method, are reimbursed using the RCC, "full cost", or cost settlement payment method unless a different payment method has been specified.

For dates of admission on and after August 1, 2007, services provided in DRGs that do not have an Agency relative weight assigned, are paid using one of the other payment methods (e.g. RCC, per diem, per case rate, "full cost", or cost settlement).

h. Trauma Center Services

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.

Level I, II, and III trauma centers services will be reimbursed using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. The payment is made through lump-sum supplemental payments made quarterly.

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.)

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 Agency 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 Agency 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 Agency-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.)

9. Transfer Policy (cont.)

If a client is transferred back to the original hospital and subsequently discharged, the original hospital is paid the full DRG payment. It is not paid an additional per diem as a transferring hospital. The intervening hospital is paid a per diem payment based on the method described above.

The hospital that ultimately discharges the client is reimbursed based on the full DRG payment allowed amount. However, for dates of admission before August 1, 2007, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied, and for dates of admission on and after August 1, 2007, the high outlier payment methodology is applied if appropriate.

10. Readmission Policy

Readmissions occurring within 7 days of discharge, to the same or a different hospital that group to the same medical diagnostic category, may be reviewed to determine if the second admission was necessary or avoidable. If the second admission is determined to be unnecessary, reimbursement will be denied. If the admission was avoidable, the two admissions may be combined and a single DRG payment made. If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon a utilization review of the case. All psychiatric inpatient admissions must be prior authorized and are considered distinct admissions, regardless of the number of days occurring between admissions.

11. Administrative Days Policy

Administrative days are those days of hospital stay wherein an acute inpatient level of care is no longer necessary, and an appropriate non-inpatient hospital placement is not available. Administrative days are reimbursed at the statewide average Medicaid nursing home per diem rate.

When a hospital admission is solely for a stay until an appropriate sub acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The Administrative Day rate is adjusted November 1. For DRG exempt cases, administrative days are identified during the length of stay review process.

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 the Agency's rates or fee schedule as if they were paid solely by Medicaid using the payment method that would have applied had the claim been paid by Medicaid (i.e. DRG, RCC, per diem or per case rate).

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. 1935) 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.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

14. Fixed Per Diem Rate

A fixed per diem rate is used to reimburse for the LTAC program.

These fixed per diem rates are established through identification of historical claims costs for the respective services provided. Predetermined vendor rate adjustments are made annually if rates are not rebased.

15. Third-Party Liability Policy

For DRG cases involving third party liability (TPL), a hospital will be reimbursed the lesser of the billed amount minus the TPL payment and other appropriate deductible amounts, or the applicable allowed amount (basic payment) for the case minus the TPL payment and other appropriate deductible amounts. For RCC, per diem, per case rate, and CAH cases involving TPL, a hospital will be reimbursed the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For "full cost" cases involving TPL, a hospital will be reimbursed the federal match portion of the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts.

16. Day Outliers

Section 1923(a)(2)(C) of the Act, requires the state to provide payment adjustment for hospitals for medically necessary inpatient hospital services involving exceptionally long length of stay for individuals under the age of six in disproportionate share hospitals and any hospital for a child under age one.

A hospital is eligible for the day outlier payment only for dates of admission before August 1, 2007 and if it meets the following:

a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.

b. The patient payment is DRG methodology.

c. The charge for the patient stay is under $33,000 (cost outlier threshold).

d. Patient length of stay is over the day outlier threshold for the applicable DRG.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

16. Day Outliers (cont.)

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate. Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

17. Trauma Care Enhancement

The Agency's annual supplemental payments to hospitals for trauma services (inpatient and outpatient) total eleven million dollars, including federal match.

The Level I, II, and III trauma center enhanced payment is based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. The payment is made through lump-sum supplemental payments made quarterly.

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 Agency 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 Agency 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.

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.

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.

18. Adjustment for New Newborn Screening Tests

A payment adjustment is made for new legislatively approved and funded newborn screening tests not paid through other rates.

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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 between July 1, 2005 and 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 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 Agency 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.

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

D. DRG COST-BASED RATE METHOD (cont)

The methodology used in estimating cost is similar to Medicare's cost apportionment methodology. The estimated costs development processes are described as follows:

1. Estimating claim cost

   The costs for each claim were estimated for three separate components: operating (accommodation and ancillary services), capital (accommodation and ancillary services), and direct medical education (accommodation and ancillary services)

2. Establishing standard cost categories for accommodation and ancillary costs

   The estimated costs for all hospitals' claims were established based on the standard accommodation and ancillary cost categories. The approach is similar to the standard cost categories used during the January 1, 2001 Medicaid inpatient rebasing process with exceptions of some classifications added for new types of services provided by the hospitals since that last rebasing.

   For hospitals that do not use all of these standard cost categories, the Agency merged non-standard categories reported by hospitals into one of the standard categories by adding the reported amounts together.

3. Aligning hospital costs from Medicare cost report to claim revenue codes

   The hospital cost is categorized into standard cost centers in the Medicare cost report and the claim record is based on revenue codes. To estimate costs based on the hospital's RCC information from its Medicare cost reports and the hospital billed charges on paid claims, the Agency developed a standard revenue code crosswalk that maps the revenue codes covered by Washington Medicaid inpatient reimbursement to one of the standard cost categories shown in the Medicare cost report.

   The accommodation and ancillary standard cost categories from the Medicare cost report were aligned to the revenue codes reported on the claim based on the standard revenue code crosswalk table.

4. Estimating accommodation costs

   The average hospital cost per day was calculated by dividing the hospital's operating, capital, and direct medical education costs in each of the Accommodation Cost Categories by the hospital's total days in each of the categories.

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

D. DRG COST-BASED RATE METHOD (cont)

4. Estimating accommodation costs (cont)

The costs of accommodation services, which comprise the room and board and nursing components of hospital care, are calculated by multiplying the average hospital cost per day reported for each type of accommodation service (adult and pediatric, intensive care unit, psychiatric, nursery, etc.) by the number of patient days reported in the claim record by type of services.

5. Estimating ancillary costs

The costs of ancillary services are calculated by multiplying the RCCs reported in the Medicare cost report for each type of ancillary service (operating room, recovery room, radiology, lab, pharmacy, clinic, etc.) by the allowed charge amount reported in the claim record by type of services.

6. Inflation Adjustments

To account for changes in price index levels between hospitals' Medicare cost reporting periods and the claims data period, the Agency adjusted both accommodation and ancillary costs for inflation. The Agency adjusted the accommodation costs of the SFY 2004 and 2005 claims data for inflation based on the change in price index levels from the midpoint of the hospital fiscal year ending 2004 cost reporting period to the midpoint of SFY 2005 (December 31, 2004). The Agency adjusted the ancillary costs of the SFY 2004 claims data from the midpoint of the claims data period (December 31, 2003) to the midpoint of SFY 2005 (December 31, 2004). Ancillary costs for SFY 2005 claims data were based on SFY 2005 charges, and did not need to be inflated.

7. Data resources

a. State Medicaid Management Information System ("MMIS") fee-for-service (FFS) paid claim data

b. Inpatient Healthy Options (HO) claims extracted from the Department of Health's Comprehensive Hospital Abstract Reporting System ("CHARS") dataset for SFY 2004 (7/1/2003-6/30/2004) and 2005 (7/1/2004-6/30/2005)

c. Hospital Medicare Cost Report - CMS 2552 - Hospital fiscal year ending 2004

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

D. DRG COST-BASED RATE METHOD (cont)

8. Conversion Factor Determination

Washington State Medicaid uses the DRG-based payment method to pay for claims grouped into stable AP-DRG classifications. The DRG-based payment method is based on the DRG conversion factor and relative weights. Services grouped into one of the AP-DRG classifications with relative weights were identified as stable AP-DRGs.

The Agency determined the DRG conversion factors or DRG rates based on the statewide-standardized average cost per discharge. That cost per discharge was adjusted by the Medicare wage index, indirect, and direct medical education costs to reflect the hospital's specific costs.

The hospital's specific conversion factor determination processes are described as follows:

a. Statewide-standardized average operating and capital cost per discharge calculation:

Each hospital's estimated operating and capital costs were calculated based on Medicaid FFS and HO paid claims in the 2005 claims dataset for all in-state hospitals. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs. Adjusted operating and capital costs were divided by each hospital's facility-specific case-mix index to standardize the hospital's estimated costs related to the case-mix index of 1. The statewide-standardized average costs per discharge for operating and capital were calculated by dividing aggregate estimated costs of all hospitals by the total number of discharges associated with the estimated costs.

To remove the wage differences from the hospital estimated operating costs, the labor portion of the operating cost component was divided by the FFY 2004 Medicare wage index. The wage difference is related to the hospital location in different regions of the State

To remove the indirect costs from the hospital estimated operating and capital costs, the adjusted operating and capital costs were divided by the FFY 2004 Medicare indirect medical factors. The indirect costs are costs that relate indirectly to the approved medical education programs for hospitals with teaching programs.

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

D. DRG COST-BASED RATE METHOD (cont.)

b. Hospital-specific DRG conversion factors or DRG rate calculation:

The hospital-specific DRG conversion factors were based on the statewide-standardized average operating and capital costs per discharge amounts. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs.

To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs was multiplied by the FFY 2007 Medicare wage index.

To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs were multiplied by the FFY 2007 Medicare indirect medical factor.

The hospital's specific conversion factors are the total of the operating and capital amounts per discharge plus the facility-specific direct medical education cost per discharge (hospital-specific direct medical education cost per discharge divided by the hospital-specific case-mix index.)

The hospital-specific DRG conversion factor amounts were inflated using the CMS PPS Input Price Index to reflect the inflation between SFY 2005 and 2008.

Effective for dates of admission on or after February 1, 2010, DRG rates for hospitals paid under the prospective payment system (PPS) method, were increased by thirteen percent (13.0%) from the rates that were established for dates of admission on and after July 1, 2009. This rate adjustment was in accordance with RCW 74.60.080.

Effective for dates of admission on or after July 7, 2011, DRG rates for hospitals paid under the PPS method will decrease by eight percent (8.0%) from that rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with RCW 74.60.090, as amended by the Legislature in 2011. TheJuly 7, 2011 rates will be three and ninety-six one hundredths percent (3.96%) higher than the July 1, 2009 rates.

c. Hospital-specific DRG conversion factors for critical border hospitals and Bordering City Hospitals

The hospital-specific DRG conversion factors for critical border hospitals were calculated using a process similar to the hospital specific conversion factors process for instate hospitals. The conversion factor for bordering city hospitals that are not designated by the Agency as critical border hospitals is the lowest hospital specific conversion factor for a hospital located instate.

Bordering city hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River and Sandpoint.

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

D. DRG COST-BASED RATE METHOD (cont.)

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to August 1, 2007. A change in ownership does not necessarily constitute the creation of a new hospital. New hospitals' ratio of cost-to-charge rates are based on the instate average rate. For their DRG conversion factor or per diem rate, the statewide average rate is used. For new hospitals that have direct medical education costs and a submitted Medicare cost report with at least twelve months of data, the Agency will identify and include the direct medical education cost to the hospital-specific rate. For a new hospital that has direct medical education cost and Medicare cost report submitted to Medicare with less than twelve months of data, the Agency will not identify and include the direct medical education cost to the hospital-specific rate.

10. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities' rates. The blended rate is weighted by admission for the new entity.

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS

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, a proxy rate may be used for the hospital.

1. Per diem rate

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.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont)

1. Per diem rate (cont)

The Agency applies the same per diem payment method that is applied to instate 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 any in-state hospitals for the same service.

The methodology used in estimating cost is similar to Medicare's cost apportionment methodology. The estimated costs development processes are described as follows:

a. Estimating claim cost

The costs for each claim were estimated for three separate components: operating (accommodation and ancillary services), capital (accommodation and ancillary services), and direct medical education (accommodation and ancillary services)

b. Establishing standard cost categories for accommodation and ancillary costs

The estimated costs for all hospitals' claims were established based on the standard accommodation and ancillary cost categories. The approach is similar to the standard cost categories used during the January 1, 2001 Medicaid inpatient rebasing process with exceptions of some classifications added for new types of services provided by the hospitals since that last rebasing.

For hospitals that do not use all of these standard cost categories, the Agency merged non-standard categories reported by hospitals into one of the standard categories by adding the reported amounts together.

c. Aligning hospital costs from Medicare cost report to claim revenue codes

The hospital cost is categorized into standard cost centers in the Medicare cost report and the claim record is based on revenue codes. To estimate costs based on the hospital's RCC information from its Medicare cost reports and the hospital billed charges on paid claims, the Agency developed a standard revenue code crosswalk that maps the revenue codes covered by Washington Medicaid inpatient reimbursement to one of the standard cost categories shown in the Medicare cost report.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. Per diem rate (cont.)

The accommodation and ancillary standard cost categories from the Medicare cost report were aligned to the revenue codes reported on the claim based on the standard revenue code crosswalk table.

d. Estimating accommodation costs

The average hospital cost per day is calculated by dividing the hospital's operating, capital, and direct medical education costs in each of the Accommodation Cost Categories by the hospital's total days in each of the categories.

The costs of accommodation services, which comprise the room and board and nursing components of hospital care, are calculated by multiplying the average hospital cost per day reported for each type of accommodation service (adult and pediatric, intensive care unit, psychiatric, nursery, etc.) by the number of patient days reported in the claim record by type of services.

e. Estimating ancillary costs

The costs of ancillary services are calculated by multiplying the RCC reported in the Medicare cost report for each type of ancillary service (operating room, recovery room, radiology, lab, pharmacy, clinic, etc.) by the allowed charge amount reported in the claim record by type of services.

f. Inflation Adjustments

To account for changes in price index levels between hospitals' Medicare cost reporting periods and the claims data period, the Agency adjusted both accommodation and ancillary costs for inflation. The Agency adjusted the accommodation costs of the SFY 2004 and 2005 claims data for inflation based on the change in price index levels from the midpoint of the hospital fiscal year ending 2004 cost reporting period to the midpoint of SFY 2005 (December 31, 2004). The Agency adjusted the ancillary costs of the SFY 2004 claims data from the midpoint of the claims data period (December 31, 2003) to the midpoint of SFY 2005 (December 31, 2004). Ancillary costs for SFY 2005 claims data were based on SFY 2005 charges, and did not need to be inflated.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. Per diem rate (cont.)

g. Data resources

(1) State Medicaid Management Information System ("MMIS") fee-for-service (FFS) paid claim data

(2) Inpatient Healthy Options (HO) claims extracted from the Department of Health's Comprehensive Hospital Abstract Reporting System ("CHARS") dataset for SFY 2004 (7/1/2003-6/30/2004) and 2005 (7/1/2004-6/30/2005)

(3) Hospital Medicare Cost Report - CMS 2552 - Hospital fiscal year ending 2004

h. Per Diem Rates Determination for Unstable AP-DRG Classifications

Washington State Medicaid uses per diem method to pay for claims grouped into the unstable (or low-volume) AP-DRG classifications. Services identified as unstable AP-DRGs were grouped into one of the following four categories:

- Neonatal claims, based on assignment to MDC 15.
- Burn claims based on assignment to MDC 22
- Medical claims based on AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified above
- Surgical claims based on AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified above

The Agency determined the per diem rates for paying unstable AP-DRG classifications based on the statewide-standardized average cost per day. That cost per day was adjusted by Medicare wage index, indirect, and direct medical education costs to reflect the hospital's specific costs.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. PER DIEM RATE (cont.)

h. Per Diem Rates Determination for Unstable AP-DRG Classifications (cont.)

The hospital's specific per diem rate determination processes are described as follows:

- Statewide standardized average operating and capital cost per day calculation

Each hospital's estimated operating and capital costs were calculated based on Medicaid FFS and HO paid claims in the 2005 claims dataset for all in-state hospitals. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs. The statewide-standardized average costs per day for operating and capital were calculated by dividing aggregate estimated costs of all hospitals by the total number of days associated with the aggregate estimated costs.

To remove the wage differences from the hospital estimated operating costs, the labor portion of the operating cost component was divided by the FFY 2004 Medicare wage index. The wage difference is related to the hospital location in different regions of the State.

To remove the indirect costs from the hospital estimated operating and capital costs, the adjusted operating and capital costs were divided by the FFY 2004 Medicare indirect medical factors. The indirect costs are costs that indirectly relate to the approved medical education programs for hospitals with teaching programs.

The statewide-standardized average operating and capital cost per day were established for each four unstable AP-DRG classifications.

✓ Hospital-specific per diem rates for unstable AP-DRG classifications

The hospital-specific per diem rates were based on the statewide-standardized average operating and capital cost per day amounts. The cost per day amounts were adjusted by the wage index, indirect, and direct medical costs to reflect the hospital's specific costs.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. Per diem rate (cont.)

To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs was multiplied by the FFY 2007 Medicare wage.

To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs were multiplied by the FFY 2007 Medicare indirect medical factors.

The hospital's specific per diem rates are the total of the adjusted operating and capital costs per day plus the facility-specific direct medical education cost per day.

The hospital-specific per diem amounts were inflated using the CMS PPS Input Price Index to reflect the inflation between SFY 2005 and 2008.

i. Per Diem Rates Determination for Specialty Services

Washington State Medicaid uses per diem rates to pay for claims grouped into specialty services. AP-DRG classifications identified as specialty services were grouped into:

- Psychiatric Services. Psychiatric claims are claims with a psychiatric diagnosis (i.e., assigned to a psychiatric AP-DRG classification) at acute care hospitals.
- Rehabilitation Services. Rehabilitation claims are claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals.
- Detoxification Services. Detoxification claims are claims from freestanding detoxification hospitals, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.
- Chemically Using Pregnant Women (CUP) Program Services. CUP Program services are claims with units of service (days) submitted with revenue code 129 in the claim record.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. Per diem rate (cont.)

i. Per Diem Rates Determination for Specialty Services (cont.)

The Agency determined the per diem rates for paying specialty services based on the statewide-standardized average cost per day adjusted by Medicare wage index, indirect, and direct medical education costs to reflect the hospital's specific costs. There are exceptions to the process used in determining of psychiatric per diem rates that were directed by the Washington State legislature.

The hospital-specific per diem rate determination processes are described as follows:

✓ Statewide standardized average operating and capital cost per day calculation

Each hospital's estimated operating and capital costs were calculated based on Medicaid FFS and HO paid claims in the 2005 claims dataset for all in-state hospitals. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs. The state-wide standardized average cost per day for operating and capital were calculated by dividing aggregate estimated costs of all hospitals by the total number of days associated with aggregate estimated costs.

To remove the wage differences from the hospital's estimated costs, the labor portion of the operating cost component was divided by the FFY 2004 Medicare wage index. The wage difference is related to the hospital location in different regions of the State

To remove the indirect costs from the hospital estimated operating and capital costs, the adjusted operating and capital costs were divided by the FFY 2004 Medicare indirect medical factors. The indirect costs are costs that relate indirectly to the approved medical education programs for hospitals with teaching programs.

The statewide-standardized average operating and capital cost per day were established for each specialty services categories.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. PER DIEM RATE (cont.)

i. Per Diem Rates Determination for Specialty Services (cont.)

Exceptions to the psychiatric per diem development process, the statewide-standardized average operating and capital amounts were calculated twice:

- The first statewide-standardized average operating and capital amounts were calculated based on data including only hospitals with distinct psychiatric units and hospitals that have 200 or more Washington State Medicaid psychiatric days in SFY 2005. Excluded from the database were freestanding psychiatric hospitals and hospitals with non-distinct psychiatric units with less than 200 Washington State Medicaid psychiatric days.

- The second statewide-standardized average operating and capital amounts were calculated based on data including freestanding psychiatric hospitals, hospitals with distinct psychiatric units, and hospitals that have 200 or more Washington State Medicaid psychiatric days in SFY 2005. Excluded from the database were non-distinct psychiatric unit hospitals with less than 200 Washington State Medicaid psychiatric days.

  ✓ Hospital-specific per diem rates for specialty services

  The hospital-specific per diem rates were based on the statewide-standardized average operating and capital cost per day. The cost per day amounts were adjusted by the wage index, indirect, and direct medical costs to reflect the hospital's specific costs.

  To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs was multiplied by the FFY 2007 Medicare wage index.

  To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs were multiplied by the FFY 2007 Medicare indirect medical factor.

  The hospital's specific per diem rates were the total of the adjusted operating and capital amounts per day, plus the facility-specific direct medical education cost per day.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

1. PER DIEM RATE (cont.)

i. Per Diem Rates Determination for Specialty Services (cont.)

The hospital-specific per diem amounts were inflated using the CMS PPS Input Price Index to reflect the inflation between SFY 2005 and 2008.

Effective for dates of admission on or after February 1, 2010, the per diem rates for prospective payment system hospitals and rehabilitation hospitals will be increased thirteen percent.

Exceptions in the determination of psychiatric per diem rates:

- For freestanding psychiatric hospitals, hospitals with distinct psychiatric units, and hospitals with 200 or more Washington State Medicaid psychiatric days in SFY 2005:
  - ✓ The hospital-specific cost-based per diem rates were developed based on the hospital data. The calculation process is similar to the "Hospital-specific per diem rates for specialty services" process. In determining the hospital's cost-based per diem rate, the hospital's estimate operating, capital, and indirect and direct medical education costs were used to calculate the hospital-specific per diem rates instead of the statewide-standardized average amounts.
  - ✓ The hospital specific psychiatric per diem rates for these hospitals were defined as the greater of the hospital-specific cost-based per diem or the hospital-specific per diem rate calculated based on the statewide-standardized average amounts.
  - ✓ Effective for dates of admission on or after February 1, 2010, the psychiatric per diem rates for prospective payment system hospitals and psychiatric hospitals will be increased by thirteen percent.
- For non-distinct psychiatric unit hospitals with less than 200 psychiatric days in SFY 2005:
  - ✓ The hospital's specific per diem rates were defined as the greater of the two statewide-standardized average operating and capital costs adjusted by the wage differences, indirect medical education, and direct medical education calculation. The two statewide-standardized average operating and capital costs determination processes were described in the "Statewide-standardized average operating and capital cost per day calculation" section.
  - ✓ Effective for dates of admission on or after February 1, 2010, the psychiatric per diem rates for prospective payment system hospitals will be increased by thirteen percent.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

j. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to August 1, 2007. A change in ownership does not necessarily constitute the creation of a new hospital. For their per diem rate, the statewide average rate is used. For new hospitals that have direct medical education costs and a submitted Medicare cost report with at least twelve months of data, the Agency will identify and include the direct medical education cost to the hospital-specific rate. For a new hospital that has direct medical education cost and Medicare cost report submitted to Medicare with less than twelve months of data, the Agency will not identify and include the direct medical education cost to the hospital-specific rate.

k. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

2. PER CASE RATE

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 Medicaid FFS and HO paid claims in the 2005 claims dataset for University of Washington Medical Center and Sacred Heart Medical Centers.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

2. PER CASE RATE (cont.)

The methodology used in estimating cost is similar to Medicare's cost apportionment methodology. The estimated costs development processes are described as follows:

a. Estimating claim cost

The costs for each claim ware estimated for three separate components: operating (accommodation and ancillary services), capital (accommodation and ancillary services), and direct medical education (accommodation and ancillary services)

b. Establishing standard cost categories for accommodation and ancillary costs

The estimated costs for all hospitals' claims were established based on the standard accommodation and ancillary cost categories. The approach is similar to the standard cost categories used during the January 1, 2001 Medicaid inpatient rebasing process with exceptions of some classifications added for new types of services provided by the hospitals since that last rebasing.

For hospitals that do not use all of these standard cost categories, the Agency merged non-standard categories reported by hospitals into one of the standard categories by adding the reported amounts together.

c. Aligning hospital costs from Medicare cost report to claim revenue codes

The hospital cost is categorized into standard cost centers in the Medicare cost report and the claim record is based on revenue codes. To estimate costs based on the hospital's RCC information from its Medicare cost reports and the hospital billed charges on paid claims, the Agency developed a standard revenue code crosswalk that maps the revenue codes covered by Washington Medicaid inpatient reimbursement to one of the standard cost categories shown in the Medicare cost report.

The accommodation and ancillary standard cost categories from the Medicare cost report were aligned to the revenue codes reported on the claim based on the standard revenue code crosswalk table.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

2. Per case rate (cont.)

d. Estimating accommodation costs

The average hospital cost per day is calculated by dividing the hospital's operating, capital, and direct medical education costs in each of the Accommodation Cost Categories by the hospital's total days in each of the categories.

The costs of accommodation services, which comprise the room and board and nursing components of hospital care, are calculated by multiplying the average hospital cost per day reported for each type of accommodation service (adult and pediatric, intensive care unit, psychiatric, nursery, etc.) by the number of patient days reported in the claim record by type of services.

e. Estimating ancillary costs

The costs of ancillary services are calculated by multiplying the RCC reported in the Medicare cost report for each type of ancillary service (operating room, recovery room, radiology, lab, pharmacy, clinic, etc.) by the allowed charge amount reported in the claim record by type of services.

f. Inflation Adjustments

To account for changes in price index levels between hospitals' Medicare cost reporting periods and the claims data period, the Agency adjusted both accommodation and ancillary costs for inflation. The Agency adjusted the accommodation costs of the SFY 2004 and 2005 claims data for inflation based on the change in price index levels from the midpoint of the hospital fiscal year ending 2004 cost reporting period to the midpoint of SFY 2005 (December 31, 2004). The Agency adjusted the ancillary costs of the SFY 2004 claims data from the midpoint of the claims data period (December 31, 2003) to the midpoint of SFY 2005 (December 31, 2004). Ancillary costs for SFY 2005 claims data were based on SFY 2005 charges, and did not need to be inflated.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

2. PER CASE RATE (cont.)

g. Data resources

(1) State Medicaid Management Information System ("MMIS") fee-for-service (FFS) paid claim data
(2) Inpatient Healthy Options (HO) claims extracted from the Department of Health's Comprehensive Hospital Abstract Reporting System ("CHARS") dataset for SFY 2004 (7/1/2003-6/30/2004) and 2005 (7/1/2004-6/30/2005)
(3) Hospital Medicare Cost Report - CMS 2552 - Hospital fiscal year ending 2004

h. Per Case Rate Determination

Washington State Medicaid uses case rate method to pay for claims grouped into bariatric surgery services. The bariatric surgery services are identified by the primary diagnosis of 278.01 plus one of the listed ICD-9 procedure codes 4431, 4438, 4439, 4468, or 4495 at the University of Washington Medical Center, Sacred Heart Medical Center, or Oregon Health & Science University, and require prior authorization by the Agency.

The Agency determines the case rates based on the statewide-standardized average cost per discharge amount. The amount is adjusted by the Medicare wage index, direct, and indirect medical education costs to reflect the hospital's specific costs.

The hospital-specific case rate determination processes are described as follows:

✓ Statewide-standardized average operating and capital cost-per-day calculation

The hospital estimated operating and capital costs were calculated based on Medicaid FFS and HO paid claims in the 2005 claims dataset for University of Washington Medical Center and Sacred Heart Medical Center. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs. The statewide standardized average cost per case for operating and capital were calculated by dividing aggregate estimated costs of two hospitals by the total number of cases for the two hospitals.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

2. Per case rate (cont.)

To remove the wage differences from the hospital estimated costs, the labor portion of the operating cost component were divided by the FFY 2004 Medicare wage index. The wage difference is related to the hospital location in different regions of the State.

To remove the indirect costs from the hospital estimated operating and capital costs, the adjusted operating and capital costs were divided by the FFY 2004 indirect medical factors. The indirect costs are costs that relate indirectly to the approved medical education programs for hospitals with teaching programs.

✓ Hospital-specific per case rates for bariatric surgery

The hospital-specific per case rates were based on the statewide-standardized average operating and capital per discharge amounts. The amounts were adjusted by the wage index, indirect, and direct medical costs to reflect the hospital's specific costs.

To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs was multiplied by the FFY 2007 Medicare wage index.

To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs were multiplied by the FFY 2007 Medicare indirect medical factors.

The simple average of the adjusted operating and capital amounts was calculated for the two hospitals to determine statewide operating and capital components of the payment rate.

The hospital-specific case rates are the total of the statewide operating and capital amount per case plus the facility-specific direct medical education cost per case.

The hospital-specific per case amounts were inflated using the CMS PPS Input Price Index to reflect the inflation between SFY 2005 and 2008.

Effective for dates of admission on or after February 1, 2010, the bariatric per case rates for hospitals paid under the PPS method were increased by thirteen percent (13.0%) from the rates that were established for dates of service on and after July 1, 2009. This rate adjustment was in accordance with RCW 74.60.080.

Effective for dates of admission on and after July 7, 2011, the bariatric per case rates for hospitals paid under the PPS method will decrease by eight percent (8.0%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with RCW 74.60.080, as amended by the Legislature in 2011. The July 7, 2011, rates will be three and ninety-six one hundredths percent (3.96%) higher than the July 1, 2009, rates.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

2. Per case rate (cont.)

i. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to August 1, 2007. A change in ownership does not necessarily constitute the creation of a new hospital. For their per case rate, the average per case rate for service is used. For new hospitals that have direct medical education costs and a submitted Medicare cost report with at least twelve months of data, the Agency will identify and include the direct medical education cost to the hospital-specific rate. For a new hospital that has direct medical education cost and Medicare cost report submitted to Medicare with less than twelve months of data, the Agency will not identify and include the direct medical education cost to the hospital-specific rate.

j. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admissions for the new entity.

3. RCC PAYMENT METHOD

The RCC method is based on each hospital's specific RCC. The RCC allowed amount for payment is calculated by multiplying the hospital's allowed covered charges for the claim by the hospital's RCC.

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 is used.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

3. RCC PAYMENT METHOD (cont)

The RCC payment method is based on each hospital's specific RCC. The RCC allowed amount for payment is calculated by multiplying the hospital's allowed covered charges for the claim by the hospital's RCC.

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 is used.

The RCC payment method is used to reimburse some hospitals for their costs as described in Section C.7, and other hospitals for certain DRG exempt services as described in Section C.8. This method is not used for hospitals reimbursed using the "full cost" CPE method except that the Medicaid RCCs are used to determine "full cost" for those hospitals.

For dates of admission before August 1, 2007, the RCC for out-of-state hospitals is the average of RCCs for in-state hospitals. The RCC for in-state and bordering city hospitals, if the State determines a hospital has insufficient data or Medicaid claims to accurately calculate an RCC, is also the average of RCCs for in-state hospitals. Hospital's RCCs are updated annually with the submittal of new CMS 2552 Medicare cost report data. Increases in operating expenses or total rate-setting revenue attributable to a change in ownership are excluded prior to computing the ratio.

For dates of admission on and after August 1, 2007, the Agency uses the RCC payment method to pay some hospitals and services that are exempt from the DRG payment method. Hospitals' RCCs are updated annually with the submittal of new CMS 2552 Medicare cost report data. Increases in operating expenses or total rate-setting revenue attributable to a change in ownership are excluded prior to computing the ratio.

The Agency applies the same RCC 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 any in-state hospitals for the same service.

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

E. PER DIEM, PER CASE, AND RCC PAYMENT METHODS (cont.)

3. RCC PAYMENT METHOD (cont)

a. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to August 1, 2007. A change in ownership does not necessarily constitute the creation of a new hospital. New hospitals' cost-based rates are based on the in-state average rate.

b. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

F. "FULL COST" PAYMENT METHODOLOGY (effective July 1, 2005)

The public hospitals located in the State of Washington that are owned by public hospital districts and are not Agency-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, will be reimbursed using the "full cost" payment method using their respective Medicaid RCC to determine cost for covered medically necessary services. The payment method pays only the federal match portion of the allowable on claims based on federal Medicaid funding for the cost of medically necessary patient care. Recipient responsibility (spend-down) and third-party liability as identified on the billing invoice or by the Agency are deducted from the allowed amount (basic payment) to determine the actual payment for that admission. The costs as determined above will be certified as actual expenditures by the hospital and the Agency claim will be the allowed federal match on the amount of the related certified public expenditures. The Agency will verify that the expenditures certified were actually incurred. For a description of the Certified Public Expenditure protocol see Supplement 3 to Attachment 4.19-A Part 1.