Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 13-13

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2201 6th Avenue, Mailstop RX-43
Seattle, Washington 98121

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Division of Medicaid & Children's Health Operations

MAR 18 2014

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
P.O. Box 45502
Olympia, WA 98504-5502

RE: WA State Plan Amendment (SPA) Transmittal Number #13-13 – Approval

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 13-13.

Although the NIRT 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 for your records.

If you have any questions concerning the Seattle Regional Office role in the processing of this SPA, please contact me, or have your staff contact Tom Couch, CMS' RO NIRT Representative at 208-334-9482 or Thomas.Couch@cms.hhs.gov.

Sincerely,

[redacted]

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

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

MAR 18 2014

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

RE: WA State Plan Amendment (SPA) Transmittal Number #13-013 – Approval

Dear Ms. Lindeblad:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-013. This SPA implements a new supplemental inpatient hospital payment to private hospitals.

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 13-013 is approved effective as of July 1, 2013. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-334-9482 or Thomas.Couch@cms.hhs.gov.

Sincerely,

[redacted]

Cindy Mann
Director

Enclosures

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: **13-13**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

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 2013 ~~$3,1523134~~ $3,512,134 (P&I)
b. FFY 2014 $12,608,537

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A pages 11, 13, 14, 26, 30, 30a (new), 36, 39, 39a (new), 44a (new)

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

Att. 4.19-A pages 11, 13, 14, 26, 30, 36, 39

10. SUBJECT OF AMENDMENT:

Inpatient Hospital Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
7-24-13

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 7/24/13

18. DATE APPROVED:
March 18 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

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

23. REMARKS:
7.31.13 State authorized P&I change to box 7

FORM HCFA-179 (07-92)

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: **13-13**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
7-24-13

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 7/24/13

18. DATE APPROVED: MAR 18 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy & Financial Mgt. (MCS

23. REMARKS:
7.31.13 State authorized P&I change to box 7

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 (cont.)

B. DEFINITIONS (cont.)

Quality Incentive Payment
Effective for dates of admission on or between July 1, 2012 and June 30, 2013, an additional one percent increase in inpatient hospital rates will be added to inpatient hospital payments for all qualifying non-critical access hospital providers in accordance with Chapter 74.60 RCW.

RCC
RCC means a hospital ratio of costs-to-charges (RCC) calculated annually using the most recently filed CMS 2552 Medicare Cost Report data provided by the hospital. The RCC is calculated by dividing adjusted operating expense by adjusted patient charges. If a hospital's costs exceed charges, a hospital's RCC is limited to 100 percent.

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

Uninsured Patient
Means an individual who receives hospital services and does not have health insurance or other creditable third party coverage.

Back to TOC

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 on or after August 1, 2007 the Agency allows a high outlier payment for claims that meet high outlier qualifying criteria. To qualify, the claim's estimated cost must exceed a fixed outlier cost threshold of $50,000 and an outlier threshold factor (a multiplier times the inlier). Only DRG and specific Per Diem claims (medical, surgical, burn and neonatal) qualify for outlier payments. If a claim qualifies, the outlier payment is the costs in excess of the outlier factor threshold multiplied by an outlier adjustment factor. Total payment is outlier plus inlier. (The inlier is the hospital's specific DRG rate times the relative weight or for per diem claims, the hospital's specific Per Diem rate times allowed days).

a) Estimated Cost. The cost of a claim is estimated by multiplying the hospital's Ratio of Cost to Charges (RCC) by the billed charges.

b) Outlier Threshold Factor. The inlier is multiplied by a date specific factor to determine the threshold that must be met in order to qualify for an outlier payment. This factor is referred to as the outlier threshold factor. For dates of admission August 1, 2007 through July 31, 2012, the outlier threshold factor is 1.50 for pediatric services and pediatric hospitals, and 1.75 for all other services. For dates of admission on or after August 1, 2012, the outlier threshold factor is 1.429 for pediatric services and pediatric hospitals, and 1.667 for all other services. For dates of admission on or after July 1, 2013, the outlier threshold factor is 1.563 for pediatric services and pediatric hospitals, and 1.823 for all other services.

Back to TOC

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.)

c) Outlier Adjustment Factor. The costs that exceed the outlier threshold are multiplied by a date specific factor to determine the outlier payment. This factor is referred to as the outlier adjustment factor. For dates of admission August 1, 2007 through July 31, 2012, the outlier adjustment factor is 0.95 for pediatric services and pediatric hospitals, 0.90 for burn DRGs, and 0.85 for all other services. For dates of admission on or after August 1, 2012, the outlier adjustment factor is 0.998 for pediatric services and pediatric hospitals, 0.945 for burn DRGs, and 0.893 for all other services. For dates of admission on or after July 1, 2013, the outlier adjustment factor is 0.912 for pediatric services and pediatric hospitals, 0.864 for burn DRGs, and 0.816 for all other services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

19. Base Community Psychiatric Hospitalization Payment Rate

Under the DRG, RCC and "full cost" methods, and only for dates of admission 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.

20. Quality Incentive Payments

Effective for dates of admission on or between July 1, 2012 and June 30, 2013, a quality incentive payment of "an additional one percent increase in inpatient hospital rates" will be added to inpatient hospital payments for all qualifying non-critical access hospital providers in accordance with Chapter 74.60 RCW. In order to qualify, hospitals must score an average of five points or greater in five quality measurements. Hospitals may score in some or all of the following categories:

(a) Reduce hospital acquired infections by increasing healthcare worker influenza immunization. A hospital will be awarded 10 points for 80% or greater immunization rates, five points for 70-79%, three points for 61-69%, and no points for 60% or less. All non-critical access hospital providers are included in this measurement.

(b) Reduce re-hospitalizations by ensuring patients receive appropriate post-discharge information, as determined by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). A hospital will be awarded 10 points for 86% or greater response of "Yes" to Q19 and Q20, five points for 84-85%, three points for 82-83%, and no points for 81% or less. Psychiatric, rehabilitation, cancer, and childrens' hospitals are not included in this measurement.

(c) Ensure safe deliveries by reducing the number of elective deliveries prior to 39 weeks gestational age. A hospital will be awarded 10 points for 7% or less elective deliveries prior to 39 weeks, five points for 8-17%, three points for 18-30%, and no points for greater than 30%. Hospitals that do not have obstetrical programs are not included in this measurement.

Back to TOC

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 were decreased 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. The July 7, 2011, rates will be three and ninety-six one hundredths percent (3.96%) higher than the July 1, 2009, rates.

Effective for dates of admission on or after July 1, 2013, DRG rates for hospitals paid under the PPS method will decrease by seven and sixty-six one hundredths percent (7.66%) from the rates that were established for dates of admission on and after July 7, 2011. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be four percent (4.00%) lower than the July 1, 2009, rates.

Effective for dates of admission on or after July 1, 2013, supplemental payments will be paid for inpatient Medicaid services not to exceed the upper payment limit as determined by available federal financial participation for fee-for-service claims. The supplemental

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

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

payment is based on the distribution amount mandated by the legislature to the following hospital categories as defined in RCW 74.60.010:

1. Prospective payment hospitals other than psychiatric or rehabilitation hospitals,
2. Psychiatric hospitals
3. Rehabilitation hospitals, and
4. Border hospitals.

For hospitals designated as prospective payment system (PPS) hospitals, $58,450,000 per state fiscal year. For hospitals designated as freestanding psychiatric specialty hospitals, $1,250,000 per state fiscal year. For hospitals designated as freestanding rehabilitation specialty hospitals, $300,000 per state fiscal year. For hospitals designated as out-of-state border area hospitals, $500,000 per state fiscal year.

The payment is calculated by applying the Medicaid fee-for-service rates in effect on July 1, 2009 to each hospital's Medicaid and CHIP inpatient fee-for-service claims and Medicaid and CHIP managed care encounter data for the base year as defined in RCW 74.60.010. This sum is divided by the aggregate total of all hospitals within each category to determine the individual hospital pro rata share percentage. The individual hospital payment is the pro rata percentage multiplied by the amount mandated to be distributed by the Legislature within each hospital category.

The payment will be made quarterly, by dividing the total annual disbursement amount by four to calculate the quarterly amount.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

Effective for dates of admission on or after July 1, 2013, per diem rates for non specialty services will decrease by seven and sixty-six one hundredths percent (7.66%) from the rates that were established for dates of admission on and after July 7, 2011. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013 rates will be four percent (4.00%) lower than the July 1, 2009 rates.

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.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.

Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.

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.
  - ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.)

- 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.
  - ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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.)

Effective for dates of admission on or after July 1, 2013, per case rates for bariatric services will decrease by seven and sixty-six one hundredths percent (7.66%) from the rates that were established for dates of admission on and after July 7, 2011. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013 rates will be four percent (4.00%) lower than the July 1, 2009 rates.

Back to TOC