DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

May 28, 2008

Robin Arnold-Williams, Secretary
Department of Social and Health Services
PO Box 45010
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment 07-007

Dear Ms. Arnold-Williams:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) approved Washington State Plan Amendment (SPA) 07-007 on May 15, 2008.

Although the State should have already received a copy of the approval package 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 and the approved SPA page(s), and a copy of the NIRT approval package for your records.

If you have any questions concerning the Seattle Regional office role in the processing of this state plan amendment, please contact the Region 10 SPA coordinator, Jan Mertel at (206) 615-2317 or jan.mertel@cms.hhs.gov.

Sincerely,

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

Enclosure
cc: Douglas Porter, Assistant Secretary
Ann Myers, 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: **07-007**

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, 2007

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 2007 $1.6 Million
b. FFY 2008 $7 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, ~~pages 2 – 55~~ Part I, pages 2-60 (P+I)
Supplement 3 to Attachment 4.19-A, pages 1 - 9

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 2 – 43
Supplement 3 to Attachment 4.19-A, pages 1 - 9

10. SUBJECT OF AMENDMENT:

Inpatient Hospital Rates and Methodology

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:
Robin Arnold-Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:
Sept. 27, 2007

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Health and Recovery Services Administration
626 8th Street MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 27 2007

18. DATE APPROVED: MAY 15 2008

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2007

20. SIGNATURE OF REGIONAL OFFICIAL:
Barbara H. Richards

21. TYPED NAME:
Barbara H. Richards

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

23. REMARKS:
Pen + Inc changes authorized by the State on 3/19/08.

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 State of Washington's Department of Social and Health Services (DSHS) implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's. Revisions to this system are made as necessary through amendments to the Medicaid State plan (State Plan Amendments, or SPAs).

Effective July 1, 2005, SPA TN# 05-006 eliminated all disproportionate share and pro-share programs involving intergovernmental transfers.

This SPA, TN# 07-007, incorporates revisions that:

- Eliminate the hospital selective contracting program/payment method;
- Eliminate the base community psychiatric hospitalization payment rate;
- Eliminate some disproportionate share payment methods while adding and revising others;
- Eliminate the Proshare (UPL) payments effective July 1, 2007; and
- Effective for admissions on and after August 1, 2007, incorporate revised policy and payment methodology for outlier claims, DRG paid claims, RCC paid claims, per case paid claims, per diem paid claims, etc.

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

A. INTRODUCTION (cont.)

Other payment methods used include per member per month (PMPM) graduate medical education (GME) payments, fixed per diem, cost settlement, per case rate (for Department-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. Monthly PMPM GME payments are provided by HRSA directly to the University of Washington Medical Center and the Harborview Medical Center for GME related to Healthy Options care.

Effective for admissions on and after July 1, 2005, public hospitals located in the State of Washington that are not Department-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 HRSA's Medicaid RCC rate 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 before August 1, 2007, under the DRG, RCC and "full cost" methods, a base community psychiatric hospitalization payment rate is also used to determine the allowable for certain psychiatric claims.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS

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

1. *Accommodation and Ancillary Costs*

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

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

2. *Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*

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

3. *Bariatric Surgery Case Rate*

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

4. *Base Community Psychiatric Hospitalization Payment Rate*

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

5. *Case-Mix Index (CMI)*

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

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

6. *Children's Health Program (CHP)*

The CHP provides medical coverage for non-citizen children whose household income is less than 100% of the Federal Poverty Level.

7. *Cost Limit for DSH Payments*

For the purpose of defining cost under the DSH program, a ratio of costs-to-charges (RCC) is calculated prospectively using annual CMS 2552 Medicare Cost data. The RCC is applied through a prospective payment method to historical total hospital billed charges to arrive at the hospital's total cost.

8. *Critical Access Hospital (CAH) Program*

Critical Access Hospital (CAH) program means a Title XIX inpatient and outpatient hospital reimbursement program where in-state hospitals that are Department-approved and DOH Medicare-certified as a CAH, are reimbursed through a cost settlement method.

9. *DRG Conversion Factor (DRG rate)*

The DRG conversion factor, a cost-based DRG rate, is a calculated amount based on the statewide-standardized average cost per discharge adjusted by the Medicare wage index for each hospital's geographical location and any indirect medical education costs to reflect the hospital's specific costs.

10. *DSH Limit*

The DSH limit in Section B.15 is applicable for public hospitals. In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

11. *DSH One Percent Medicaid Utilization Rate*

All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the DSHS disproportionate share programs.

12. *DSHS or Department*

DSHS or Department means the Department of Social and Health Services. DSHS is the State of Washington's state Medicaid agency.

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

B. DEFINITIONS (cont.)

13. *Diagnosis Related Groups (DRGs)*

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program uses the All Patient Diagnosis Related Group (AP-DRG) classification software (Grouper) to classify claims into a DRG classification.

For dates of admission before August 1, 2007, the Department uses version 14.1 of the AP-DRG Grouper for this purpose, and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470.

The remainder of the 241 DRGs are exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

For dates of admission on and after August 1, 2007, the Department uses version 23.0 of the AP-DRG Grouper to classify claims into a DRG classification, and has established relative weights for 423 DRG classifications used in the DRG payment system. Of the remaining DRG classifications, two are used to identify ungroupable claims under DRG 469 and 470. The remainder of the DRG classifications in version 23.0 of the AP-DRG Grouper are either not used by the grouper software, or are used by the Department to pay claims using a non-DRG payment method.

14. *Emergency Services*

Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

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

B. DEFINITIONS (cont.)

15. *"Full Cost" Payment Program*

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

16. *HCFA/CMS*

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

17. *Hospital*

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

18. *Inpatient Services*

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

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

B. DEFINITIONS (cont.)

19. *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.

20. *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 exceeded high-cost outlier status. 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 DSHS. 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.

21. *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.

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

B. DEFINITIONS (cont.)

22. *Operating, Medical Education and Capital Costs*

Costs are the Medicare-approved costs as reported on the CMS 2552 and are divided into three components:

Operating costs include all expenses, except capital and medical education, incurred in providing accommodation and ancillary services; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, and interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, are deleted from the capital component.

23. *PII/GAU*

PII/GAU, as used in Paragraph H.2 and H.3 below, means the DSHS Limited Casualty Program Psychiatric Indigent Inpatient (PII) or General Assistance Unemployable (GAU) services. Included under GAU services is the Alcoholism and Drug Addiction Treatment Support Act (ADATSA).

24. *Peer Groups*

Peer groups mean HRSA-designated peer groups. HRSA's peer grouping has six classifications: Peer group A, which are rural hospitals other than peer group F hospitals; peer group B, which are urban hospitals without medical education programs and which are not in peer group E; peer group C, which are urban hospitals with medical education programs and which are not in peer group E; peer group D, which are specialty hospitals and which are not in peer group E; peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not DOH-approved and certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are DOH certified as a CAH.

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.)

25. *Per Diem Rate*

The per diem rate, a cost-based rate, is a calculated amount based on the statewide, standardized, average cost per day adjusted by the Medicare wage index for each hospital's geographical location and any indirect medical education costs to reflect the hospital's specific costs.

26. *RCC*

RCC means a hospital ratio of costs-to-charges (RCC) calculated using annual CMS 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed covered charges for medically necessary services. A reduced RCC is used to calculate GAUDSH payments on RCC paid claims.

27. *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.

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

B. DEFINITIONS (cont.)

28. *Uninsured Indigent Patient*

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system.

Charity care and bad debt, as defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and chapter 70.170 RCW "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section.

Services covered by an insurance policy are not considered an uninsured covered service.

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

C. GENERAL REIMBURSEMENT POLICIES

The following section describes general policies governing the reimbursement system. Payment will only be made to the provider for covered services for that portion of a patient admission during which the client is Medicaid eligible. Unless otherwise specified in this attachment, rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) data and Department determined base year(s) claims data. The cost report data used for rate setting must include the hospital fiscal year (HFY) data for a complete 12-month period for the hospital. Otherwise, the in-state average RCC rate is used.

1. DRG Payments

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

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

2. DRG Relative Weights

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

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

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

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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 ratio 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 ratio applied to the allowed covered charges exceeding the outlier threshold.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

3. High Outlier Payments (cont)

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

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

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

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

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

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

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

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

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

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

4. DRG Low Cost Outlier Payments

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

5. DRG Long-Stay Day Outlier Payments

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

6. Non DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the per diem, per case rate, fixed per diem, RCC method, "full cost" method, CAH method, etc. For RCC and "full cost" payments, the basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed covered charges for medically necessary services. Recipient responsibility (spend-down) and third party liability as identified on the billing invoice or otherwise by DSHS, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission. Other applicable adjustments may also be made. For the "full cost" method, only the federal funds participation (FFP) percentage is paid on the claim after all other adjustments to the allowed amount have been made.

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.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

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

c. Critical Access Hospital (CAHs)

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

d. Managed Health Care

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

e. Out-of-State Hospitals

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

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

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

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

(2) When DSHS is successful negotiating a contract, out-of-state hospitals are paid using a negotiated contract rate. DSHS 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 rate.

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 Department-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, Medicaid and GAUDSH 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.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services

a. Unstable, Low Volume, and Specialty Services DRG Classifications

For dates of admission before August 1, 2007, neonatal services, DRGs 620 and 629 (normal newborns) are reimbursed by DRG payment under the DRG payment method, but not under the RCC, "full cost" or cost settlement payment methods. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 are exempt from the DRG payment methods, and are reimbursed under the RCC, "full cost", or cost settlement payment method.

For dates of admission on and after August 1, 2007, the claims that classified to DRG classifications that have unstable DRG relative weights or are considered low volume DRG classifications, are exempt from the DRG payment methods, and are reimbursed under the per diem payment method unless the hospital is participating in the "full cost", or cost settlement payment method.

Specialty services, defined as psychiatric, rehabilitation, detoxification and Chemical Using Pregnant program services, are reimbursed under the per diem payment method unless the hospital is participating in the "full cost", or cost settlement payment method.

b. AIDS-Related Services

For dates of admission before August 1, 2007, AIDS-related inpatient services are exempt from DRG payment methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and other Human Immunodeficiency Virus (HIV) infections.

For dates of admission on and after August 1, 2007, AIDS-related inpatient services are not exempted from the DRG payment method and are paid based on the claim data matched to the criteria for the payment methods described in this attachment.

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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 rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through a vendor rate adjustment (VRA). Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

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 a Health and Recovery Services Administration (HRSA) relative weight assigned.

For dates of admission before August 1, 2007, services provided in DRGs that do not have a Health and Recovery Services Administration (HRSA) 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 a Health and Recovery Services Administration (HRSA) 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.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

h. Trauma Center Services (cont.)

The payment each hospital receives is proportional to the percentage that the Department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the Department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

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

i. *Inpatient Pain Center Services*

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

9. Transfer Policy

For a hospital transferring a client to another acute care hospital, 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.

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.

For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the 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.

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

12. Inpatient vs. Outpatient Stay Policy

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

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

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

13. Medicare Related Policies

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

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

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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. A fixed per diem is also used to pay for authorized inpatient pain center services.

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, per diem rate, and per case rate 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 cases involving TPL, a hospital will be reimbursed the RCC allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For 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.

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 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 each hospital receives is proportional to the percentage that the Department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the Department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients 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.

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

D. DRG COST-BASED RATE METHOD

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

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

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

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

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 Department 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 Department 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.

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 RCC ratios 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 Department adjusted both accommodation and ancillary costs for inflation. The Department 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 Department 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

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 Department 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.

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.

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 Department 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, HRSA 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, HRSA 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 RATE 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.

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

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

1. Per diem rate (cont)

The Department 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 Department 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 Department 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 RATE 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 ratios 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 Department adjusted both accommodation and ancillary costs for inflation. The Department 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 Department 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 RATE 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 Department 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 RATE 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.

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

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

1. Per diem rate (cont.)

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

The Department 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.

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

E. PER DIEM, PER CASE, AND RCC RATE 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.

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

E. PER DIEM, PER CASE, AND RCC RATE 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.

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.

- 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.

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

E. PER DIEM, PER CASE, AND RCC RATE 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, HRSA 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, HRSA 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 RATE 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 Department 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 Department 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 RATE 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 ratios 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 Department adjusted both accommodation and ancillary costs for inflation. The Department 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 Department 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.

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

E. PER DIEM, PER CASE, AND RCC RATE 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 either the University of Washington Medical Center, Sacred Heart Medical Center, or Oregon Health & Science University, and require prior authorization by the Department.

The Department 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 RATE 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.

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

E. PER DIEM, PER CASE, AND RCC RATE 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, HRSA 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, HRSA 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 RATE METHOD

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

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

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

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

3. RCC RATE METHOD (cont)

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

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

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 RCC rates are used to determine "full cost" for those hospitals.

For dates of admission before August 1, 2007, the RCC ratio for out-of-state hospitals is the average of RCC ratios for in-state hospitals. The RCC ratio for in-state and bordering city hospitals, if the State determines a hospital has insufficient data or Medicaid claims to accurately calculate an RCC ratio, is also the average of RCC ratios for in-state hospitals. Hospital's RCC ratios 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 Department uses the RCC payment method to pay some hospitals and services that are exempt from the DRG payment method. Hospitals' RCC ratios 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 Department 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 RATE METHODS (cont.)

3. RCC RATE 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 Department-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 rate 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 DSHS 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 DSHS claim will be the allowed federal match on the amount of the related certified public expenditures. DSHS 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.

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

G. BASE COMMUNITY PSYCHIATRIC HOSPITALIZATION PAYMENT RATE

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

The base community psychiatric hospitalization payment rate I used in conjunction with the DRG, RCC, and "full cost" methods as follows:
(1) The respective DRG, RCC, or "full cost" allowable on a qualifying claim is divided by the length of stay for the claim to determine an allowable per diem amount.

(2) The base community psychiatric hospital payment rate is then compared to that amount.

(3) If the base community psychiatric hospital payment rate is greater, then it is applied to the authorized length of stay for the claim to determine a revised allowable for the claim.

H. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for eligible hospitals. To be eligible for any disproportionate share program, a hospital must meet the minimum requirement of a Medicaid one-percent utilization rate to qualify. A hospital will receive any one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility requirements for that respective DSH payment component.

The total of all DSH payments will not exceed the State's DSH allotment. To accomplish this goal, it is understood in this State Plan that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont)

Cost is established through prospective payment methods and is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan, plus the cost of services to indigent and uninsured patients, less any cash payments made by them.

DSHS will not exceed the DSH statewide allotment nor allow a hospital to exceed the DSH limit. The following clarification of the process explains precautionary procedures.

All the DSHS DSH programs' payments are prospective payments, and these programs are: LIDSH, PIIDSH, GAUDSH including the ADATSA program, SRDSH, SRIADSH, NRIADSH, IMDDSH, CHPDSH, and PHDSH. DSH is available only to acute care non-psychiatric hospitals with the exception of IMDDSH, which is distributed to psychiatric hospitals. The IMDDSH is appropriated separately and is in the Mental Health state plan amendment.

The following DSH programs are supplemental payments: PHDSH, LIDSH, SRDSH, SRIADSH, and NRIADSH. Three DSH programs are paid on a per claim basis: GAUDSH, PIIDSH, and CHPDSH. To adjust for these unknowns in the PIIDSH, CHPDSH, and GAUDSH, HRSA uses claims data and estimates what expected expenditures would be paid during the current state fiscal year. This estimate then becomes a part of the hospital's cost limit.

The Health and Recovery Services Administration (HRSA) monitors payments monthly. Each month, HRSA will receive a PII Summary Report a CHP Summary Report, and a GAU Summary Report from the Medicaid Management Information System (MMIS) identifying expenditures paid to each hospital under the PIIDSH, CHPDSH, and GAUDSH programs.

Each month, HRSA will also receive the DSHS Allotment/Expenditure Transaction Register identifying the remaining DSH program expenditures. The figures in these reports will be accumulated monthly to determine that hospitals have not exceeded the DSH limit.

If a hospital reaches its DSH limit, payments will be stopped. The Department of Social and Health Services (DSHS) will determine the extent to which and how each DSH program is funded. Any specific guidance that may be provided by the State legislature will be followed by DSHS.

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont)

If a hospital exceeds its DSH limit, DSHS will recoup the DSH payments in the following program order: PHDSH, SRIADSH, SRDSH, NRIADSH, GAUDSH, CHPDSH, PIIDSH, IMDDSH, and LIDSH. For example, if a small rural hospital were receiving payments from all applicable DSH programs, the overpayment adjustment would be made in SRDSH to the fullest extent possible before adjusting LIDSH payments. If the DSH state-wide allotment is exceeded, DSHS will similarly make appropriate adjustments in the program order shown above.

The Medicaid Management Information System (MMIS) identifies expenditures paid to each hospital under the PIIDSH and GAUDSH programs.

1. Low-Income Disproportionate Share Hospital (LIDSH) Payment

Hospitals will be considered eligible for a LIDSH payment adjustment if:

a. The hospital's Medicaid inpatient utilization rate (as defined in Section 1923(b)(2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or,

b. The hospital's low-income utilization rate (as defined in Section 1923 (b) (3)) exceeds 25 percent;

c. The hospital qualifies under Section 1923 (d) of the Social Security Act; and

d. The hospital is not in Peer Group E effective July 1, 2005.

Hospitals considered eligible under the above criteria will receive disproportionate share payment amounts that in total will equal the funding set by the State's appropriations act for LIDSH. The process of apportioning payments to individual hospitals is as follows:

A single base payment is selected that distributes the total LIDSH appropriation. For each hospital, the Department divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals, then multiplies the result by the hospital's most recent DRG payment method Medicaid case mix index (CMI), and then by the hospital's base year Title XIX discharges. The Department then converts the product to a percentage of the sum of all such products for individual hospitals and multiplies this percentage by the legislatively appropriated amount for LIDSH. For DSH program purposes, a hospital's Medicaid CMI is the average diagnosis related group (DRG) weight for all of the hospital's Medicaid DRG-paid claims during the state fiscal year used as the base year for the DSH application.

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

The LIDSH appropriation amount may vary from year to year. Each hospital's disproportionate share payment is made periodically.

2. Psychiatric Indigent Inpatient Disproportionate Share Hospital (PIIDSH) Payment

Effective July 1, 2003, hospitals will be considered eligible for a PIIDSH payment if:

a. The hospital is an in-state (Washington) hospital;

b. The hospital provides emergency, voluntary inpatient services to low-income, Psychiatric Indigent Inpatient (PII) patients. PII persons are low-income individuals who are not eligible for any health care coverage and who are encountering a psychiatric condition; and,

c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for PIIDSH payments will receive a per-claim payment. The payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor.

3. General Assistance Unemployable Disproportionate Share Hospital (GAUDSH) Payment

Effective July 1, 1994, hospitals will be considered eligible for a GAUDSH payment if:

a. The hospital is an in-state (Washington) or border area hospital;

b. The hospital provides services to low-income, General Assistance Unemployable (GAU) patients. GAU persons are low-income individuals who are not eligible for any health coverage and who are encountering a medical condition; and,

c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for GAUDSH payments will receive a per claim payment. For all hospitals, except public hospitals located in the State of Washington that are owned by public hospital districts and are not Department-approved and DOH-certified as a Critical Access Hospital (CAH), the Harborview Medical Center, and the University of Washington Medical Center, the payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment.

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. For the excepted hospitals, the payment equals "full cost" using the Medicaid RCC to determine cost for the medically necessary care. The equivalency factor ensures that GAUDSH payments will equal the State's estimated GAUDSH appropriation level.

4. Small Rural Disproportionate Share Hospital (SRDSH) Payments

Effective July 1, 2007, hospitals will be considered eligible for a SRDSH payment if:

a. The hospital is an in-state (Washington) hospital;

b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state;

c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of no more than 17,115 in calendar year 2006, as determined by the Washington State office of financial management estimate, with this population standard to be increased by two percent each subsequent SFY;

d. The hospital qualifies under Section 1923(d) of the Social Security Act; and

e. The hospital is not in Peer Group E effective July 1, 2005.

Hospitals qualifying for SRDSH payments are paid from a legislatively appropriated pool. The apportionment formula is based on each SRDSH hospital's Medicaid and other low-income reimbursement during the base year less any low-income disproportionate share payments.

To determine each hospital's percentage of Medicaid payments, the sum of the Medicaid payments to the individual hospital is divided by the total Medicaid payments made to all SRDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

4. Small Rural Disproportionate Share Hospital (SRDSH) Payments (cont)

As of July 1, 2007, prior to calculation of the individual hospital's percentage of payments, hospitals with a low profitability margin will have their total payments set at 110% of actual payments.

HRSA will calculate each hospital's net operating margin based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines.

Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them. Dollars not allocated due to a hospital reaching the DSH limit are reallocated to the remaining hospitals in the SRDSH pool. The payments are made periodically. SRDSH payments are subject to federal regulation and payment limits.

5. Small Rural Indigent Assistance Disproportionate Share Hospital (SRIADSH) Payment

Effective July 1, 2007, hospitals will be considered eligible for a SRIADSH payment if:

a. The hospital is an in-state (Washington) hospital;

b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state;

c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of no more than 17,115 in calendar year 2006, as determined by the Washington State office of financial management estimate, with this population standard increased by two percent each subsequent SFY;

d. The hospital qualifies under Section 1923(d) of the Social Security Act;

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

5. Small Rural Indigent Assistance Disproportionate Share Hospital (SRIADSH) Payment (cont)

e. Effective July 1, 2007, the hospital provided services to charity patients during the calculation base year; and

f. The hospital is not in Peer Group E.

Hospitals qualifying for SRIADSH payments are paid from a legislatively appropriated pool. Beginning July 1, 2007, the apportionment formula is based on each SRIADSH-hospital's calculated costs for qualifying Charity patients during the most currently available state fiscal year.

To determine each hospital's percentage of SRIADSH payments, the sum of individual hospital calculated charity costs is divided by the total charity calculated costs of all SRIADSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2007, prior to calculation of the individual hospital's percentage of calculated charity costs, hospitals with a low profitability margin will have their total calculated charity costs adjusted to 110% of calculated charity costs. HRSA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Payments for SRIADSH will be made in conjunction with payments for SRDSH

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRIADSH pool. The payments are made periodically. SRIADSH payments are subject to federal regulation and payment limits.

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

6. Non-Rural Indigent Assistance Disproportionate Share Hospital (NRIADSH) Payment

Effective July 1, 2007, hospitals will be considered eligible for a NRIADSH payment if:

a. The hospital provides at least one percent of its services to low-income patients in Washington state;

b. The hospital does not qualify as a Small Rural Hospital as defined in section H.4. of this plan;

c. The hospital qualifies under Section 1923(d) of the Social Security Act;

d. The hospital is not in Peer Group E; and

e. The hospital is an in-state (Washington) or designated bordering city hospital that provided charity services to clients during the base year (for DSH purposes, the Department considers as non-rural any hospital located in a designated bordering city).

Hospitals qualifying for NRIADSH payments are paid from a legislatively appropriated pool. Beginning July 1, 2007, the apportionment formula is based on each NRIADSH hospital's calculated costs of charity care during the most currently available state fiscal year.

To determine each hospital's percentage of NRIADSH payments, the sum of individual hospital calculated charity costs is divided by the total calculated charity costs of all NRIADSH hospitals. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2007, prior to calculation of the individual hospital's percentage of costs for charity care, hospitals with a low profitability margin will have their total calculated charity costs adjusted to 110% of calculated charity costs. HRSA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

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

H. DSH PAYMENTS (cont.)

6. Non-Rural Indigent Assistance Disproportionate Share Hospital (NRIADSH) Payment (cont)

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the NRIADSH pool. The payments are made periodically. NRIADSH payments are subject to federal regulation and payment limits.

7. Public Hospital Disproportionate Share Hospital (PHDSH) Payment

Effective July 1, 2005, hospitals will be considered eligible for a PHDSH payment if:

a. The hospital provides at least 1 percent of its services to low-income patients;

b. The hospital is a public hospital in Washington State (includes the Harborview Medical Center, the University of Washington Medical Center, and public hospitals located in the State of Washington that are owned by public hospital districts);

c. The hospital qualifies under section 1923 (d) of the Social Security Act; and

d. The hospital is not Department-approved and DOH-certified as a CAH under Washington State Law and federal Medicare rules.

Harborview is a county-owned, state-operated hospital. The University of Washington Medical Center is a state-owned and operated hospital. Public hospital districts located in the State of Washington are organized and exist as a result of the Washington State Legislature's authorization of public hospital districts. Those public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

Hospitals that apply and are considered eligible under the above criteria will receive a disproportionate share payment for hospital services during the State's fiscal year that, in total, will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act, except as allowed by federal guidelines.

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

H. DSH PAYMENTS (cont.)

7. Public Hospital Disproportionate Share (PHDSH) Payment (cont.)

Payments in the program will be based on the amount of uncompensated care incurred by the hospital during the most recently reported fiscal year (usually two years prior) trended forward to the year of payment.

The DSH payment will be based on expenditures certified by the hospital in an amount as specified in the preceding paragraph.

8. Children's Health Program Disproportionate Share Hospital (CHPDSH) Payment

Effective July 1, 2007, hospitals will be considered eligible for a CHPDSH payment if:

a. The hospital is located in-state or in a designated bordering city;

b. The hospital provides services to patients eligible under the Children's Health Program (CHP). CHP children are low-income individuals who are not eligible for any other health coverage and who are encountering a medical condition; and

c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for CHPDSH payments will receive a per claim payment. For all hospitals, except public hospitals located in the State of Washington that are owned by public hospital districts and are not Department-approved and DOH-certified as a Critical Access Hospital (CAH), the Harborview Medical Center, and the University of Washington Medical Center, the payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. For the excepted hospitals, the payment equals "full cost" using the Medicaid RCC to determine cost for the medically necessary care. The equivalency factor ensures that GAUDSH payments will equal the State's estimated GAUDSH appropriation level.

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

I. CUSTOMARY CHARGE PAYMENT LIMITS

As required by 42 CFR 447.271, total annual Medicaid payments to each hospital for inpatient hospital services to Medicaid recipients will not exceed the hospital's customary charges to the general public. The state may recoup amounts of total Medicaid payments in excess of such charges. This customary charge limit does not apply to CAH cost settlement.

J. ADMINISTRATIVE POLICIES

1. Provider Appeal Procedure

A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the DSHS (the Health and Recovery Services Administration [HRSA]), except that no administrative appeals may be filed challenging the method described herein.

The grounds for rate adjustments include, but are not limited to, errors or omissions in the data used to establish rates, changes in capital costs due to licensing or certification requirements, and peer group change recommended by HRSA.

Additional documentation, as specified by DSHS, may be required in order to complete the appeal review. DSHS (HRSA) may have an audit and/or desk review conducted if necessary to complete the appeal review. A hospital may appeal its rates by submitting a written notice of appeal to the Office of Hospital Finance, HRSA.

Unless the written rate notification specifies otherwise, a hospital rate appeal requesting retroactive rate adjustments must be filed within 60 days after being notified of an action or determination the hospital wishes to challenge. The notification date of an action or determination is the date of the written rate notification letter.

A hospital rate adjustment appeal, filed after the 60-day period described in this subsection will not be considered for retroactive adjustments.

When an appeal is made, all aspects of this rate may be reviewed by DSHS.

Unless the written rate notification specifies otherwise, increases in rates resulting from an appeal filed within 60 days after the written rate notification letter that the hospital is challenging will be effective retroactively to the effective date of the rate change as specified in the notification letter.

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

J. ADMINISTRATIVE POLICIES (cont.)

1. Provider Appeal Procedure (cont.)

Increases in rates resulting from a rate appeal filed after the 60-day period or exception period will be effective the date the appeal is filed with DSHS. Appeals resulting in rate decreases will be effective on the date specified in the appeal decision notification.

A hospital may request a Dispute Conference to appeal an administrative review decision. The conference will be conducted by the HRSA's Assistant Secretary or designee. The hospital must submit a request for a conference within 30 days of receipt of the administrative review decision. The Dispute Conference decision is the state agency's final decision regarding rate appeals.

2. Uniform Cost Reporting Requirements

Hospitals are required to complete their official annual Medicare cost report (CMS 2552) according to the applicable Medicare statutes, regulations, and instructions and submit a copy of their official annual Medicare cost report (CMS 2552), including Medicaid related data, to HRSA. This submittal to HRSA should be an identical copy of the official Medicare cost report (CMS 2552) submission made by the hospital provider to the Medicare fiscal intermediary for the hospital's fiscal year.

The "as filed" Medicare cost report (CMS 2552) should be submitted to HRSA within one hundred fifty days from the end of the hospital's fiscal year, or if the hospital provider's contract with DSHS is terminated, within one hundred and fifty calendar days of the effective termination date.

The hospital may request up to a thirty-day extension of the deadline for submitting the Medicare cost report (CMS 2552) to HRSA. The extension request must be in writing and be received by HRSA at least ten calendar days prior to HRSA's established due date for receiving the report. The extension request must clearly explain the circumstances leading to the reporting delay. HRSA may grant the extension request if HRSA determines the circumstances leading to the reporting delay are valid.

In cases where Medicare has granted a hospital provider a delay in submitting its "as filed" Medicare cost report (CMS 2552) to the Medicare fiscal intermediary, HRSA may grant an equivalent reporting delay.

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

J. ADMINISTRATIVE POLICIES (cont.)

2. Uniform Cost Reporting Requirements (cont.)

This reporting delay may be granted when the hospital provider provides HRSA a copy of the written notice from Medicare that granted the delay in Medicare cost report (CMS 2552) reporting to the Medicare fiscal intermediary. The hospital provider should submit a written extension request to HRSA, along with the copy of the written notice from Medicare, at least ten calendar days prior to HRSA's established due date for receiving the Medicare cost report (CMS 2552).

If a hospital provider submits to HRSA a copy of an improperly completed Medicare cost report (CMS 2552) or a copy that is not the official Medicare cost report (CMS 2552) that has already been submitted for the fiscal year to the Medicare fiscal intermediary, or if the cost report is received after HRSA's established due date or approved extension date, HRSA may withhold all or part of the payments due the hospital until HRSA receives a copy of a properly completed Medicare cost report (CMS 2552) that has been submitted for that fiscal year to the Medicare fiscal intermediary.

For CAH and CPE hospitals, hospitals are also required to submit the final cost report approved by Medicare, within 60 days of Medicare approval.

In addition, hospitals are required to submit other financial information as requested by HRSA to establish rates.

3. Financial Audit Requirements

Cost report data used for rate setting will be periodically audited.

In addition, hospital billings and other financial and statistical records will be periodically audited.

4. Rebasing & Recalibration

DSHS will rebase the Medicaid payment system on a periodic basis using each hospital's Medicare cost report (CMS 2552) for its fiscal year ending during the base year selected for the rebasing.

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Certified Public Expenditures Incurred in Providing Services to Medicaid and Uninsured Patients

The Washington State Department of Social and Health Services uses the CMS 2552-96 cost report for its Medicaid program and all Washington State hospitals must submit this cost report each year. The Department will use the protocol outlined below to determine the allowable Medicaid and Uncompensated Care costs to be certified as public expenditures. The State Plan Year is the State Fiscal Year; the annual period from July 1 through June 30.

Summary of Medicare 2552-96 Cost Report and Step-Down Process

Worksheet A
The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:
(i) overhead;
(ii) routine;
(iii) ancillary;
(iv) outpatient;
(v) other reimbursable; and
(vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B
Allocates overhead (originally identified as General Service Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C
Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records. The cost-to-charge ratios are used in the Worksheet D series.

Worksheet D
This series is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. For example, an apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

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CPE Protocol (cont)

NOTES:

(i) For purposes of utilizing the Medicare 2552-96 cost report to determine Medicaid reimbursements described in the subsequent instructions, the following terms are defined:

The term "finalized" refers to the cost report that is settled by the Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement.

The term "filed" refers to the cost report that is submitted by the hospital to the Medicare fiscal intermediary and is normally due 5 months after the end of the cost reporting period.

Any revision to the finalized Medicare 2552-96 cost report as a result of Medicare appeals or reopening will be incorporated into the final determination.

Certified Public Expenditures – Determination of Allowable Medicaid Hospital Costs

To determine a governmentally-operated hospital's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

Interim Medicaid Inpatient Hospital Payment Rate

The purpose of an interim Medicaid inpatient hospital payment rate is to provide an interim payment that will approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable Medicaid inpatient hospital costs eligible for FFP begins with the use of each governmentally-operated hospital's most recently filed Medicare 2552-96 cost report.

2. To determine the interim Medicaid payment rate, the State should use the most recently filed Medicare 2552-96 cost report and determine an overall Ratio of Costs to Charges (RCC) rate for routine and ancillary services.

The specifics follow:

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CPE Protocol (cont)

DETERMINE RCC COSTS – FIRST STEP

Step 1: Compute costs by using HCFA Worksheet C, Part 1 – Computation of Costs to Charges, Column 1

a) Plus, line 103, subtotal
b) Minus, line 34, skilled nursing facility costs
c) Minus, line 35, intermediate care facility costs
d) Minus, line 36, other long-term care costs
e) Minus, line 63.50, rural health center costs
f) Minus, line 63.51, rural health center costs
g) Plus, line 95, wks B, Part 1, Col. 26, direct medical education costs
h) Deduct other non-hospital costs including Home Health Agency, Comprehensive Outpatient Rehabilitation Facility, Ambulatory Surgery Center, and hospice costs
i) Deduct FQHC costs on line 63.60
j) Plus Organ Acquisition Costs from Schedule B, Part 1

Result = Total Adjusted RCC Costs

RCC REVENUES – STEPS TWO AND THREE

Step 2: Compute revenues by using HCFA Worksheet G-2, Column 3, Statement of Patient Revenues and Operating Expenses, and wks B-1.

a) Plus, line 25, total patient revenue (less organ acquisition revenue)
b) Minus, line 6, skilled nursing facility revenue
c) Minus, line 7, intermediate care facility revenue
d) Minus, line 8, long-term care revenue
e) Minus, line 18.50, rural health center revenue
f) Minus, line 18.51, rural health center revenue
g) Minus, line 19, home health agency revenue
h) Minus, line 21, CORF revenue
i) Minus, line 22, ASC revenue
j) Minus, line 23, hospice revenue
k) Minus, line 24, non-allowable revenue
l) Minus, wks B-1, non-allowable cost center patient revenue included in line 25 above
m) Minus, FQHC revenue
n) Plus organ acquisition revenue if it is not included in line 25

Step 3: Provider Based Physicians (HBP) Adjustments.

a) Deduct Provider Based Physician Revenue if included in worksheet G-2, column 3, line 25, total patient revenue.

Subtract the results from Step 3 from the results of Step 2 to arrive at the Total Adjusted RCC revenue.

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CPE Protocol (cont)

Step 4: Divide Total Adjusted Cost by Total Adjusted Revenue

RESULT OF STEP 4 IS THE HOSPITAL'S RCC-Revenue

Compare the RCC computed above with the following RCC

DETERMINE RCC COSTS – FIRST STEP

Step 1: Compute costs by using HCFA Worksheet C, Part 1 – Computation of Costs to Charges, Column 1

a) Plus, line 103, subtotal
b) Minus, line 34, skilled nursing facility costs
c) Minus, line 35, intermediate care facility costs
d) Minus, line 36, other long-term care costs
e) Minus, line 63.50, rural health center costs
f) Minus, line 63.51, rural health center costs
g) Plus, line 95, wks B, Part 1, Col. 26, direct medical education costs
h) Deduct other non-hospital costs including Home Health Agency, Comprehensive Outpatient Rehabilitation Facility, Ambulatory Surgery Center, and hospice costs
i) Deduct FQHC costs on line 63.60
j) Plus Organ Acquisition Costs from Schedule B, Part 1

Result = Total Adjusted RCC Costs

RCC CHARGES – STEP TWO

Step 2: Compute charges by using HCFA Worksheet C, Part 1, Computation of Costs to Charges

a) Plus, line 103, col. 8 total charges
b) Minus, lines 34-36, nursing facility charges
c) Minus, lines 63.50, rural health center charges
d) Minus, lines 63.51, rural health center charges
e) Plus organ acquisition revenue
f) Minus any other charges related to non-hospital service cost centers included in line 103 above

Result = Total Adjusted Charges

Step 3: Divide Total Adjusted Cost by Total Adjusted Charges

RESULT OF STEP 3 IS THE HOSPITAL'S RCC-Charges

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CPE Protocol (cont)

The lower RCC determined by the two methods (Revenues or Charges) is the RCC used for the hospital.

The lower RCC rate calculated above is then applied to Title XIX inpatient claims, including Rehabilitation and Psychiatric claims, as they are submitted by the hospitals for payment. The cost for the claim is determined by multiplying the covered charges by the RCC rate. Third party and client responsibility payments are deducted from the cost to determine the reimbursement amount. The federal share of the reimbursement amount is then paid to the hospital for the claim.

Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments will be reconciled to its Medicare 2552-96 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period.

The State will adjust the cost used in the Worksheet C computation of each cost center's cost-to-charge ratio by adding back allowable interns and residents costs to the appropriate cost centers.

An updated RCC will be calculated based on the as filed cost report using the same methodology described on pages 2 and 3 of this protocol. The updated RCC will be applied to the service year covered Title XIX inpatient fee-for-service charges in the MMIS system to calculate costs incurred during the service year. Third party and client responsibility payments are deducted from the cost to determine the certifiable amount. The Department will compare the Medicaid CPEs as calculated from the as filed CMS 2552-96 cost report. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments and interim adjustments will also be subsequently reconciled to its Medicare 2552-96 cost report as finalized by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period.

The State will adjust the cost used in the Worksheet C computation of each cost center's cost-to-charge ratio by adding back allowable interns and residents costs to the appropriate cost centers.

The hospitals will use CMS 2552-96 Worksheet D series or substitute CMS-approved schedules that mirror the Worksheet D series to arrive at Title XIX inpatient hospital cost. Worksheet D series include 1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient hospital days for that cost center to the per diem amount; 2) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid inpatient hospital charges for each ancillary cost center; 3) computing organ-specific costs per organ and

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CPE Protocol (cont)

multiplying by the respective number of organs transplanted. Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid. The Title XIX days and charges should only pertain to covered Title XIX fee-for-service acute, rehabilitation, and psychiatric inpatient hospital services and should be derived from the State's Medicaid Management Information System (MMIS). The Department will compare the interim CPEs with the final CPEs, and any difference will be an adjustment on the CMS 64 report. Third party and client responsibility payments are deducted from the cost to determine the certifiable amount.

Specific Requirements for Medicaid Inpatient Rate Reconciliations for Period 7/1/05 – 12/31/05

For interim and final reconciliations of Medicaid inpatient hospital services, payments will be reconciled to hospital fiscal year (HFY) cost reports. Worksheet D or its CMS-approved substitute will be prepared for all cost reporting periods and reconciliations beginning with interim reconciliation of claims made for services in SFR 2006 (7/1/08-6/30/06). For HFYs ending 12/31/05, Worksheet D or its CMS-approved substitute will be used to capture Medicaid inpatient services for the six-month period of 7/1/05-12/31/05 only. The reconciliations for this six-month time period will be performed by matching the payments for Medicaid inpatient hospital costs computed based on the cost report of 1/1/2005-12/31/2005 but for services from 7/1/02005-12/31/2005. Both interim and final reconciliations will be required as described in the previous sections. All other interim and final reconciliations will be based on a full 12-months' services, costs and payments based on HFY reporting periods.

Certified Public Expenditures – Determination of Allowable DSH Costs

To determine a governmentally-operated hospital's allowable uncompensated care costs eligible for disproportionate share hospital (DSH) reimbursement when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Disproportionate Share Hospital (DSH) Payment

The purpose of an interim DSH payment is to provide an interim payment that will approximate the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care ("shortfall") eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The DSH limit is estimated using charge and payment data from a base year, two years prior. Uncompensated care will include the cost of providing care to uninsured patients; the cost of care for state-only programs; the difference between the cost of care and payments received for Medicaid managed care services; and the difference between the cost of care and payments for Medicaid outpatient services. Medicaid inpatient payments are made at full cost so there is no

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CPE Protocol (cont)

Disproportionate Share Hospital (DSH) Payment (cont.)

uncompensated Medicaid inpatient care.

The costs of care for the services provided are determined by the actual claims data in MMIS and additional auditable information provided by the hospitals on their DSH applications for the Medicaid managed care and the uninsured clients. The State pulls claims data for SFY04 for payments to be made in SFY06 and uses the hospital-provided supplemental data for managed care and uncompensated care for the hospital fiscal year 2004. The State pulls claims data for SFY05 for payments to be made in SFY07 and uses the hospital-provided supplemental data for managed care and uncompensated care for the hospital fiscal year 2005. The survey information for managed care and uncompensated care provided on the DSH application will be used to determine interim DSH payments only for SFY2006 and SFY2007. To determine interim DSH payments for SFY2008 forward, the cost report period ending two years prior (e.g. 2006 for SFY2008 payments) will be used to collect charges on Worksheet D or the CMS-approved equivalent.

The hospitals in the CPE program will complete CMS 2552-96 Schedule Ds, or substitute CMS-approved schedules that mirror the Schedule D series, for Medicaid fee for service, Medicaid Managed Care, and the Uninsured patients, beginning with the hospital fiscal year ending in 2006; the 2006 Schedule Ds, or CMS-approved substitute schedules, will be used to estimate DSH payments for SFY2008. Prior to this, for interim DSH payment setting, the hospitals' Medicaid Managed Care and Uninsured charges will be derived from hospital-provided supplemental data on submitted DSH applications.

Costs are estimated by multiplying the RCC rate times the allowed patient charges in MMIS as well as the charges provided by the hospitals on supplemental schedules for Medicaid managed care and the uninsured clients. Only charges related to inpatient and outpatient hospital services using Medicaid principles are allowed in the DSH computation. The RCC rate is determined from the most recent filed Medicare cost report, as described on pages 2 and 3 of this protocol. The same RCC rate is used for computing inpatient and outpatient costs since it is an overall RCC rate. Uninsured individuals are individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.

All Medicaid managed care payments, Medicaid outpatient payments, supplemental Medicaid payments other than DSH, and any payments made by or on behalf of the uninsured for such services (excluding State-only program payments), must be offset against the computed cost described above to arrive at the certifiable DSH expenditure. Under the CPE methodology, a hospital may receive DSH payments up to the certifiable DSH expenditure.
The charges and payments will be trended to current year based on Market Basket update factor(s), state forecasts or other hospital-related indices as approved by CMS. Interim DSH payments can be made based on the certifiable DSH expenditure computed above. The interim payments can be on a quarterly or other periodic basis.

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Interim Reconciliation of Interim DSH Payment Rate

Each governmentally-operated hospital's interim DSH payments will be reconciled based on its Medicare 2552-96 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period.

The same RCC computed from the as filed cost report for the Medicaid interim inpatient payment reconciliation will be applied to the outpatient Medicaid Charges from MMIS and the auditable charge information provided by the hospitals for Medicaid Managed care and Uninsured clients to determine costs allowable for DSH. The data used must correspond to the same period as the cost report. Only charges related to inpatient and outpatient hospital services using Medicaid principles are allowed in the DSH calculation. Beginning with the hospital fiscal year ending in SFY 2006, the hospitals in the CPE program will complete CMS 2552-96 Worksheet D series, or CMS-approved schedules that mirror the Schedule D series, for Medicaid fee for service, Medicaid Managed Care, and the Uninsured patients. An audit factor may be applied as necessary. All Medicaid managed care payments, Medicaid outpatient payments, Supplemental Medicaid payments other than DSH, and any payments made by or on behalf of the uninsured for such services (excluding State-only programs), must be offset against the computed cost from above to arrive at the certifiable DSH expenditure. For the hospital cost report period ending 12/31/05, the Worksheet D series is required only for the period 7/1/05-12/31/05.

Any difference between the calculation above and the interim DSH payments will be an adjustment on the CMS 64 report.

Final Reconciliation of Interim DSH Payment Rate

Each governmentally-operated hospital's interim DSH payments (and any interim adjustments) will subsequently be reconciled based on its Medicare 2552-96 cost report as finalized by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period.

In computing the Medicaid managed care shortfall, Medicaid outpatient shortfall and the uninsured hospital inpatient and outpatient cost based on the finalized Medicare 2552-96 cost report, the Department will use the same cost center based RCCs from Worksheet C that are used for the final reconciliation of the Medicaid Inpatient Hospital Rate, having been adjusted by adding back the allowable interns and residents costs for Medicaid.

Beginning with the hospital fiscal year ending in 2006, the hospitals in the CPE program will use CMS 2552-96 Worksheet D series, or CMS-approved schedules that mirror the Worksheet D series, to arrive at the hospital's uncompensated care hospital cost. For the hospital cost report period ending 12/31/05, the Worksheet D series is required only for the period 7/1/05-12/31/05. Worksheet D series include 1) computing a per diem for each routine cost center and applying the applicable uninsured and Medicaid managed care hospital patient days for that cost center to the per diem amount; 2) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable uninsured, Medicaid managed care, and Medicaid outpatient hospital charges for each

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ancillary cost center; 3) computing organ-specific costs per organ and multiplying by the respective number of organs transplanted. Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid. The days and charges used should only pertain to hospital services allowable for DSH and should be derived from the State's MMIS and other auditable hospital records. This should include data that wasn't mature at the time the as filed cost report was completed.

Any applicable Medicaid managed care payments, Medicaid outpatient payments, Medicaid Supplemental payments other than DSH payments, and any payments made by or on behalf of the uninsured for such services (excluding State-only program payments) must be offset against the computed cost to arrive at the final DSH reconciliation.

Uncompensated care for the service year will be compared to uncompensated care used in the DSH limit calculation. Any difference will be an adjustment on the CMS 64 report.

Specific Requirements for DSH Reconciliation in instances where the hospital cost reporting period differs from the State Fiscal Year.

In instances where the hospital cost reporting period differs from the State Fiscal Year, the State must allocate the costs from two cost report periods based on the number of months applicable to the SFY in each of the cost report periods. To do so, the State must simply capture the actual outpatient Medicaid, Medicaid managed care, and uninsured days and charges for the hospital's own cost, and then allocate the cost into the State Plan rate year using the number of months as an allocation basis. For example, for a hospital period ending 12/31/02006, the UCC cost and days/charges from that hospital cost reporting period cover half of SFY 2006 and half of SFY 2007. The hospital/State would run MMIS reports and also capture managed care and uninsured days/charges for services furnished 1/1/2006-12/31/2006 to compute a full year's UCC, and then divide that UCC in half and apply six months UCC costs to match DSH payments to. The result will be that each for SFY, DSH payments will be matched to six months (50%) of UCC costs from two different HFYs. The State must ensure that total costs claimed in the two State Plan Rate years related to that division of HFY cost equal no more than the total costs justified on the HFY cost report. For the cost report period 1/1/05-12/31/05, a Schedule D or its CMS-approved substitute must be prepared only for the period 7/1/05-12/31/05.

NOTES:

(i) All disproportionate share hospital (DSH) payments funded through certified public expenditures or otherwise, are subject to the State's aggregate DSH allotment.

(ii) Based on the State's proposal to certify total Medicaid inpatient hospital costs, there won't be any Medicaid inpatient hospital cost "shortfall" for purposes of the hospital-specific DSH limits.