DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

September 27, 2010

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

RE: Washington State Plan Amendment (SPA) Transmittal Number 10-001A

Dear Ms. Dreyfus:

The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Washington State Plan Amendment (SPA) 10-001A.

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

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

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

Sincerely,

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

Enclosure

cc: Douglas Porter, Medicaid Director, Medicaid Purchasing Administration

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

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

SEP 22 2010

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

Re: Washington State Plan Amendment (SPA) Transmittal Number 10-001A

Dear Ms Dreyfus:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan, submitted under transmittal number (TN) 10-001A. This amendment updates Attachment 4.19-A of the State plan by establishing admission status codes known as "present on admission" indicators, and by implementing thirteen percent increases for psychiatric per diem rates and bariatric case rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-024 is approved effective January 1, 2010. We are enclosing the HCFA-179 and the amended pages.

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

Sincerely,

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-001 A (P&I)**

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
Jan. 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $ ~~130,689,880~~ ~~78,538,271~~ **(P&I) $49,442,651(P&I)**
b. FFY 2011 $ ~~165,481,751~~ ~~98,377,568~~ **(P&I) $74,703,659(P&I)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Part 1, pages 4 -11, 16, 30, 39, 44
~~Attachment 4.19-B page 16~~ **(P&I)**

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

Attachment 4.19-A Part 1, pages 4 -11, 16, 30, 39, 44
~~Attachment 4.19-B page 16~~ **(P&I)**

10. SUBJECT OF AMENDMENT:

~~Hospital Assessment~~ **Hospital Rates (P&I)**

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: Susan N. Dreyfus 3/31/10

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **MARCH 31 2010**

18. DATE APPROVED: **SEP 2 2 2010**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL **JAN 0 1 2010**

20. SIGNATURE OF REGIONAL OFFICIAL: Barbara Richards

21. TYPED NAME: BARBARA K. RICHARDS

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

23. REMARKS:

3/31/2010 State authorized pen and ink changes in boxes 1, 7, 8 & 9.

9/17/2010 State authorized pen and ink changes in boxes 7 & 10.

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

B. DEFINITIONS

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

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

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

Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)
ADATSA is a program that provides a continuum of care to persons who are indigent and considered unemployable as a result of alcoholism and/or other drug addiction.

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

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

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

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

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.

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.

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.

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.

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.

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.

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.)

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 is 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.

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.)

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

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

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

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.)

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

Long Term Acute Care
Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have 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.

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.)

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;
- Medical education costs are the expenses of a formally organized graduate medical education program;
- 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.

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).

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

B. DEFINITIONS (cont.)

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

Present on admission (POA) indicator
Present on admission (POA) indicator is a status code the hospital uses on an inpatient hospital claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that develops during an outpatient encounter. (Outpatient encounters include, but are not limited to, emergency department visits, diagnosis testing, observation, and outpatient surgery.)

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

B. DEFINITIONS (cont.)

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" in effect as of January 1, 2010 (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and chapter 70.170 RCW "HEALTH DATA AND CHARITY CARE" in effect as of January 1, 2010 (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 (cont.)

7. DRG Exempt Hospitals (cont.)

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

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

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

In addition, services for clients in the 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

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

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

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

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

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

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

Effective for dates of admission on or after February 1, 2010, DRG rates for prospective payment system hospitals will be increased by thirteen percent.

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.

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.

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

Exceptions in the determination of psychiatric per diem rates:

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

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.

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