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

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

MAR 07 2013

MaryAnne Lindeblad, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 12-019

Dear Ms. Lindeblad:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-019. This amendment updates the State plan by implementing a one percent quality incentive payment for non-critical hospitals that meet measurable quality standards. To receive this payment, a hospital must submit a strategic plan, to be reviewed and approved by the State, for reducing unnecessary emergency room visits.

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) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process, the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A. Based upon your assurances, Medicaid state plan amendment 12-019 is approved effective July 1, 2012. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

Cindy Mann,
Director
Center for Medicaid and CHIP Services

cc
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: **12-019**

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, 2012

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $853,339
b. FFY 2013 $3,525,201

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

~~Att. 4.19-B Part 1 pp. 11, 26~~
Att. 4.19-A Part 1 pp. 11, 26, and 26a (new) (P&I)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

~~Att. 4.19-B Part 1 pp. 11, 26~~
Att. 4.19-A Part 1 pp. 11, 26

10. SUBJECT OF AMENDMENT:

Hospital Quality Incentive Payments

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:
MaryAnne Lindeblad

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
DIRECTOR

15. DATE SUBMITTED:
8-28-12

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **August 28, 2012**

18. DATE APPROVED: MAR 07 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

08/29/12 - Pen and Ink (P&I) changes authorized by State to blocks 8 and 9.
01/24/13 - Pen and Ink (P&I) changes authorized by State to block 8.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

B. DEFINITIONS (cont.)

Quality Incentive Payment
An additional one percent increase in inpatient hospital rates added to inpatient hospital payments for all qualifying non-critical access hospital providers in accordance with RCW 74.60.130.

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 is calculated by dividing adjusted operating expense by adjusted patient charges. If a hospital's costs exceed charges, a hospital's RCC is limited to 100 percent.

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

19. Base Community Psychiatric Hospitalization Payment Rate

Under the DRG, RCC and "full cost" methods, and only for dates of admission between July 1, 2005 and August 1, 2007, a base community psychiatric hospital payment rate may apply for psychiatric claims submitted by an in-state hospital that has already treated a patient covered under the state's Involuntary Treatment Act (ITA) in an ITA-certified bed. The base community psychiatric hospital payment rate is a per diem rate. The base community psychiatric hospitalization payment rate is used in conjunction with the DRG, RCC and "full cost" methods to determine the final allowable to be paid on qualifying claims.

20. Quality Incentive Payments

A quality incentive payment of "an additional one percent increase in inpatient hospital rates" will be added to inpatient hospital payments for all qualifying non-critical access hospital providers in accordance with RCW 74.60.130. In order to qualify, hospitals must score an average of five points or greater in five quality measurements. Hospitals may score in some or all of the following categories:

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

(d) Reduce preventable emergency room (ER) visits. Hospitals will develop and submit a plan to the agency addressing five sections of possible ER intervention, community partnerships, data reporting, strategic plan for prevention of visits, ER visit follow-up, and participation in continuing education. Each section may be approved or not approved by the agency. A hospital will be awarded 10 points for all five sections begin approved, five points for four sections, three points for three sections, no points for two sections or less. Psychiatric, rehabilitation, and cancer hospitals are not included in this measurement.

(e) Patient discharges with prescriptions for multiple antipsychotic medications. Documentation must appear in the medical record with appropriate justification for discharging the patient with two or more routine antipsychotic medication prescriptions. A hospital will be awarded 10 points for 31% or greater medical records with appropriate justifications, five points for 21-30%, three points for 11-20%, and no points for 10% or less. Hospitals that do not have behavioral health units are not included in this measurement.

D. DRG COST-BASED RATE METHOD

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

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

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

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

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