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## **Table of Contents**

**State/Territory Name: Washington**

**State Plan Amendment (SPA) #: 19-0028**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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



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**Financial Management Group**

December 3, 2019

Susan Birch, Director  
MaryAnne Lindeblad, Medicaid Director  
Health Care Authority  
626 8<sup>th</sup> Avenue SE  
Post Office Box 45502  
Olympia, Washington 98504-5502

RE: State Plan Amendment (SPA) WA-19-0028

Dear Ms. Birch and Ms. Lindeblad:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 19-0028. This amendment clarifies that the per case reimbursement methodology for inpatient hospital services was eliminated upon CMS approval of the diagnosis-related group (DRG) reimbursement methodology through SPA WA 18-0029 (approved December 14, 2018).

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 19-0028 is approved effective as of October 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Tom Couch at (208) 861-9838.

Sincerely,



Kristin Fan  
Director

cc:  
Hamilton Johns  
James Moreth  
Tom Couch

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**19-0028**

2. STATE  
Washington

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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  
October 1, 2019

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:  
1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:  
a. FFY 2020 \$0  
b. FFY 2021 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Attachment 4.19-A Part 1, page 3, 4, 15, 20, 23, 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
Attachment 4.19-A Part 1, page 3, 4, 15, 20, 23, 24

10. SUBJECT OF AMENDMENT:

Update References to the Per Case Rate

11. GOVERNOR'S REVIEW (Check One):

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

16. RETURN TO:  
Ann Myers  
Rules and Publications  
Division of Legal Services  
Health Care Authority  
626 8<sup>th</sup> Ave SE MS: 42716  
Olympia, WA 98504-2716

13. TYPED NAME:  
MaryAnne Lindeblad

14. TITLE:  
Director

15. DATE SUBMITTED:  
11-13-19

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:  
**DEC 03 2019**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
OCT 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

## A. INTRODUCTION (cont.)

Other payment methods used include fixed per diem, cost settlement, per case rate (effective August 1, 2017, through September 30, 2018, only for Medicaid agency-approved bariatric surgery), disproportionate share hospital (DSH), and proportionate share hospital. All are prospective payment methods except the cost settlement payment method used to reimburse critical access hospitals. The DRG, "full cost," per diem, and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement provides reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly.

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

Effective for admissions on and after July 1, 2005, participating public hospitals located in the State of Washington that are not Agency-approved and DOH-certified as CAH, are paid using the "full cost" payment method for inpatient covered services as determined through the Medicare Cost Report, using the Agency's Medicaid RCC to determine cost. Each public hospital district, for its respective non-CAH participating public hospital district hospital(s), the Harborview Medical Center, and the University of Washington Medical Center, provide certified public expenditures which represent the costs of the patients' medically necessary care.

A hospital may opt-out of the inpatient "Full Cost" Payment Program if the hospital meets the criteria for the inpatient rate enhancement under Washington Administrative Code (WAC) 182-550-3830 or is not eligible for public hospital disproportionate share hospital (PHDSH) payments under WAC 182-550-5400. To opt-out, the hospital must submit a written request to opt-out to the agency's Chief Financial Officer by July 1<sup>st</sup> in order to be effective for January 1<sup>st</sup> of the following year.

Hospitals and services exempt from the DRG payment methods are reimbursed under the per diem; per case rate (effective August 1, 2017, through September 30, 2018, only); RCC, "full cost"; cost settlement; or fixed per diem payment method for dates of admission on or after August 1, 2007. For dates of admission before August 1, 2007, reimbursement is under RCC, "full cost" methods, and a base community psychiatric hospitalization payment rate used to determine the allowable for certain psychiatric claims.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**METHODS AND STANDARDS FOR ESTABLISHING  
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)****B. DEFINITIONS**

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 Agency-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.

*Adverse Events*

Adverse events (also known as "adverse health events" or "never events" and effective July 1, 2011, known for Medicaid claims as "other provider preventable conditions") are the events that must be reported to the Washington State Department of Health (DOH) under WAC 246-320-146 in effect as of January 1, 2010. These serious reportable events are clearly identifiable, preventable, and serious in their consequences for patients, and frequently their occurrence is influenced by the policies and procedures of the healthcare organization.

*Agency*

Agency refers to the State Medicaid Agency.

*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 Agency to provide bariatric surgery related services to an eligible medical assistance client for those services (effective August 1, 2017, through September 30, 2018, only).

*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.

## 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.)

## 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.

## 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 (effective August 1, 2017, through September 30, 2018, only), 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 (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 the Agency, 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.

For claims with admission dates on and after January 1, 2010, which qualify under the per diem payment method, the state does not pay for days of service beyond the average length of stay (LOS) attributable to Health Care-Acquired Conditions (HCAC) and are coded with Present on Admission Indicator codes "N" or "U".

For claims with admission dates on and after January 1, 2010, which qualify under the CAH payment method which uses the Departmental weighted costs to charges (DWCC) rates to calculate payments, under the Ratio of Cost to Charges (RCC) payment method, and under the per case payment method (effective August 1, 2017, through September 30, 2018, only), the state does not pay for services attributable to the HCAC.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

## C. GENERAL REIMBURSEMENT POLICIES (cont.)

## 8. DRG Exempt Services (cont.)

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

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

For dates of admission on and after August 1, 2007, services provided in DRGs that do not have an Agency relative weight assigned, are paid using one of the other payment methods (e.g. RCC, per diem, per case rate (effective August 1, 2017, through September 30, 2018 only), "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 receive additional reimbursement from the trauma care fund established by the State of Washington in 1997 to improve the compensation to designated trauma facilities for care to Medicaid trauma patients. The supplemental payment to designated hospitals is in the form of lump-sum payments made quarterly.

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

The payment an eligible hospital receives from the quarterly payment pool is determined by first summing each hospital's qualifying payments for trauma cases from the beginning of the service year and expressing this amount as a percentage of total payments made by the Agency to all Level I, II, and III hospitals for qualifying services provided during the service year to date. The beginning of the service year is defined as July 1 – the state fiscal year – for which legislative appropriation is made. Each eligible hospital's payment percentage for the service year-to-date is multiplied by the trauma supplemental funds available for the service year-to-date, and then the Agency subtracts previous quarterly payments made to the individual hospital for the service year-to-date to determine that hospital's portion of the current quarterly payment pool.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

## C. GENERAL REIMBURSEMENT POLICIES (cont.)

## 12. Inpatient vs. Outpatient Stay Policy

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

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

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

## 13. Medicare Related Policies

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For clients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider cannot exceed the Agency's rates or fee schedule as if they were paid solely by Medicaid using the payment method that would have applied had the claim been paid by Medicaid (i.e. DRG, RCC, per diem, or per case rate [effective August 1, 2017, through September 30, 2018, only]).

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

The state applies the following rules for HCAC claims:

(a) If Medicare denies payment for a claim at a higher rate for the increased costs of care under its HCAC or POA indicator policies:

- (i) The state limits payment to the maximum allowed by Medicare.
- (ii) The state does not pay for care considered non-allowable by Medicare; and
- (iii) The client cannot be held liable for payment.

(b) If Medicare denies payment for a claim under its National Coverage Determination authority from Section 1862(a)(1)(A) of the Social Security Act (42 U.S.C. 1935) for an adverse health event:

- (i) The state does not pay the claim, any Medicare deductible, and/or any co-insurance related to the inpatient hospital services; and
- (ii) The client cannot be held liable for payment.

## 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.)****14. Fixed Per Diem Rate**

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

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

**15. Third-Party Liability Policy**

For DRG cases involving third party liability (TPL), a hospital will be reimbursed the lesser of the billed amount minus the TPL payment and other appropriate deductible amounts, or the applicable allowed amount (basic payment) for the case minus the TPL payment and other appropriate deductible amounts. For RCC, per diem, per case rate (effective August 1, 2017, through September 30, 2018, only), and CAH cases involving TPL, a hospital will be reimbursed the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For "full cost" cases involving TPL, a hospital will be reimbursed the federal match portion of the allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts.

**16. Day Outliers**

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

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

- a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.
- b. The patient payment is DRG methodology.
- c. The charge for the patient stay is under \$33,000 (cost outlier threshold).
- d. Patient length of stay is over the day outlier threshold for the applicable DRG.