

Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) # WA 21-0030

This file contains the following documents in the order listed:

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

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



Financial Management Group

April 5, 2022

Dr. Charissa Fotinos, Acting Medicaid Director

Health Care Authority

PO Box 45502

Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) 21-0030

Dear Ms. Fontinos:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 21-0030 effective for services on or after October 1, 2021. Purpose of this amendment will allow the state to pay up to the higher allowed payment for services provided for psychiatric long-term civil commitments when the claim is for an allowed service(s) and paid for by both Medicare and Medicaid..

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 regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 21-0030 is approved effective October 1, 2021. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

A handwritten signature in cursive script that reads "Rory Howe".

Rory Howe
Director

Enclosure

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

1. TRANSMITTAL NUMBER:
21-0030

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, 2021

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 2021 \$481,155.73
b. FFY 2022 \$481,155.73

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Part I, Pages 23 – 23a; 23b (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
Attachment 4.19-A, Part I, Pages 23 – 23a

10. SUBJECT OF AMENDMENT:

Psychiatric Long-Term Civil Commitment Payments

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:

Charissa Fotinos MD, MSc

13. TYPED NAME:

Charissa Fotinos, MD, MSc

14. TITLE:

Acting Medicaid Director

15. DATE SUBMITTED:

10/8/2021

16. RETURN TO:

Ann Myers
Rules and Publications
Division of Legal Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 8, 2021

18. DATE APPROVED:
April 5, 2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:

Rory Howe

21. TYPED NAME:

Rory Howe

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.)**

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]).

Specific to psychiatric long-term civil commitments, the state pays up to the higher amount when the claim is an allowed service paid by both Medicare and Medicaid. Total Medicare and Medicaid payments cannot exceed the Agency's rates or fee schedules for Medicaid payments, using the per diem payment method that would have applied if the claim had been paid by Medicaid alone.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

(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.

[Back to TOC](#)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Category 1

- ✓ Foreign Object Retained After Surgery
- ✓ Air Embolism
- ✓ Blood Incompatibility
- ✓ Stage III and IV Pressure Ulcers
- ✓ Falls and Trauma; including Fractures, Dislocations, Intracranial Injuries , Crushing Injuries, Burns, Electric Shock
- ✓ Catheter-Associated Urinary Tract Infection (UTI)
- ✓ Vascular Catheter-Associated Infection
- ✓ Manifestations of Poor Glycemic Control; including:Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
- ✓ Surgical Site Infection Following:
- ✓ Coronary Artery Bypass Graft (CABG) - Mediastinitis
- ✓ Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery
- ✓ Orthopedic Procedures; including Spine, Neck, Shoulder, Elbow
- ✓ Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below: