# Medicaid State Plan – Payment for Services

*Attachment 4*

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## Contents


4.11-A Standards for Certain Facilities

4.14-B Utilization Review Plan for Nursing Facilities (NF) and Intermediate Care Facility-Mentally Retarded (ICF-MR)

4.16-A Description of Agreements Between the State Department of Health and the State Department of Social and Health Services

4.17-A Liens and Adjustments or Recoveries

**4.18**

Medicaid Premiums and Cost Sharing
- 4.18-B Fees, Premiums, or Similar Charges Imposed on the Medically Needy
- 4.18-D Premiums Imposed on Low Income Pregnant Women and Infants
- 4.18-E Optional Sliding Scale Premiums Imposed on Qualified Working Disabled and Working Individuals
- 4.18-F Premiums Imposed on Families Receiving Extended Benefits

**4.19**

4.19-A Part I Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services

**Supplements to Attachment 4.19-A Part I**

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

4.19-A Part II Methods and Standards for Establishing Payments for Psychiatric Inpatient Services Provided in Hospitals Operated by the State of Washington

**Supplements to Attachment 4.19-A Part II**

1 Disproportionate Share Hospital Payments

4.19-B Policy and Methods Used in Establishing Payment Rates for Other Types of Care or Service

- I. General
- II. Clinic Services
- III. Physician Services
- IV. Pharmacy Services
- V. DME
- VI. Dental Services
- VII. Optometrists Services

VIII. Institutional Services
IX. Other Noninstitutional Services
A. Home Health
B. Personal Care Services
C. Transportation
D. Rehabilitative Services
F. EPSDT
G. Family Planning Services
H. Extended Services for Pregnant Women Through the Sixty Days Postpartum Period
I. Private Duty Nursing Services
J. Physical and Occupational Therapy; Speech, Hearing and Language
K. Hearing Services and Hearing Aids
L. Prosthetics and Orthotics
M. Licensed or Otherwise State-Approved Freestanding Birthing Centers
N. Tobacco Cessation Counseling Services
X. All Other Practitioners
XI. Prepaid Capitation Arrangements
XII. Laboratory and Radiology Services
XIII. Targeted Case Management Services
XIV. Hospice Services
XV. Personal Care Services
XVI. FQHCs
XVIII. Mental Health Services
XIX. Supplemental Payments for Certain Professional Services
XX. Telelmedicine
XXI. First Choice State Plan Option
XXII. Tribal Outpatient Services
XXIII. Medication Assisted Treatment
XXIV. Qualifying Clinical Trials

**Supplements to Attachment 4.19-B**
1 Payment of Medicare Part A and Part B Deductible/Coinsurance
3 Conversion Factors
A Reimbursement for Pharmacy Services
Supplemental Rebate Agreements

4.19-C Discharge or Leave of a Client from a Long-Term Care Facility
Reimbursement for Indian Health Service and Tribal Health Facilities

4.19-D Part I Nursing Facilities and Swing Bed Hospitals

**Supplements to Attachment 4.19-D Part I**
A Proportionate Share Payments

4.19-D Part II Intermediate Care Facilities for the Mentally Retarded Services

**4.22**

4.22-A Third Party Liability – Identifying Liable Resources

4.22-B Third Party Liability – Payment of Claims

4.22-C State Method of Cost Effectiveness of Employer-Based Group Health Plans

4.23 Third Party Liability – Use of Contracts

**4.30** Sanctions for Psychiatric Hospitals

**4.33-A** Method for Issuance of Medical Eligibility Cards to Homeless Individuals

**4.34-A** Requirements for Advance Directives

**4.35-A-H** Enforcement of Compliance for Nursing Facilities

**4.38** Disclosure of Additional Registry Information

4.38-A Collection of Additional Registry Information

**4.39** Definition of Specialized Services

4.39-A Categorical Determinations

**4.40-A-E** Survey and Certification Education Program

**4.42-A** Employee Education Regarding False Claims Recovery

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITIY ACT

State: WASHINGTON

The standards specified in paragraphs (a) and (b) on Page 42 of the Plan are as follows:

A. General Hospitals — Centers for Medicare and Medicaid Services (CMS) State Manual and Mission and Priority Document

Surveys are conducted by the Department of Health (DOH), Health Systems Quality Assurance Division in accordance with the Mission and Priority document published annually by CMS.

At the request of and funded by Medicare as specified in the Mission and Priority document, DOH's Health Systems Quality Assurance Division surveys facilities participating in the Medicare program. The surveys satisfy Medicare requirements as to survey frequency, content, scope, and documentation, and meet the standards and conditions of participation for contracted hospitals in both Medicare and Medicaid programs established by 42 CFR 482.

The Health Systems Quality Assurance Division conducts Medicare qualifying surveys on a schedule that meets criteria established by the Centers for Medicare and Medicaid Services (CMS).

Other agents having deemed status from CMS for performing Medicare hospital surveys, such as the Joint Commission, are deemed agents for Medicare surveys.

| | | | |
|---|---|---|---|
| B. | Skilled Nursing Facilities | Revised Code of Washington | Chapter 74.42 |
| | | and | Chapter 18.51 |
| C. | Intermediate Care Facilities | Revised Code of Washington | Chapter 18.51 |
| | | or | Chapter 18.20 |
| D. | State Hospitals for the Mentally Ill | Revised Code of Washington | Chapter 72.23 |

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE WASHINGTON

Utilization review plan for Nursing Facilities (NF) and Intermediate Care Facility-Mentally Retarded (ICF-MR)

1. Aging and Adult Services Administration (AASA) is responsible for Utilization Review in Nursing Facilities.

2. Developmental Disabilities shall conduct the Utilization Review of Mentally retarded patients in ICF-MR designated facilities.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**Description of Cooperative Agreements between the State Department of Health and the State Department of Social and Health Services**

The Title V grantee is within the Department of Health. Mutual obligations, respective responsibilities and working relationships are defined. The primary objective is improved provision of care for pregnant women, infants and children and maximum utilization of Maternal and Child Health programs using available resources to best advantage. Provision is made for payment for allowable services provided to children eligible under the Title XIX program, and for a liaison committee of representatives from each organization. Services which are provided are enumerated in the agreement. Responsibility for program planning, delegation, and coordination of reporting of services is placed with supervisory staff within the Department of Health. Overall responsibility for administering the Medicaid program remains with the Single State Agency.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**LIENS AND ADJUSTMENTS OR RECOVERIES**

1. The state uses the following processes for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The department's primary determination is:

   - The client's statement of intent to return home;
   - A recommendation from the client's primary physician regarding permanent institutionalization; or
   - Performance of a new medical review.

   The department may make a secondary determination based on an existing determination that the client meets nursing facility or ICF/MR level of care criteria, in conjunction with a review of prior medical records by the state.

   A determination that an individual is not likely to return home, made for purposes of imposing a lien, is entirely separate from and will have no effect or impact on the home's exemption as a resource for eligibility purposes based on the individual's declared intent to return to the home.

   The client has the opportunity to dispute a "no potential for discharge" finding via an administrative hearing, allowing the client/representative to present medical evidence.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

   The department accepts documentation from the client, the client's doctor, visiting nurse, home health provider, clergyman, or other bona fide witness:

   That the client's child lived in the client's home for two years immediately before the institutionalization of the client; and
   Provided care to the client which allowed the client to remain in the client's home.

   A lien may not be placed on an individual's home if any of the following are lawfully residing in the home:

   - ✓ The client's spouse;
   - ✓ A child under 21 or blind or disabled; or
   - ✓ A sibling having equity interest in the home and residing in the home for at least one year before the recipient is institutionalized.

3. The State defines the terms below as follows:

   *Estate* means:

   - All real and personal property and any other assets that pass upon the client's death under the client's will or by intestate succession.
   - An estate also includes:
     For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets, except property passing through a community property agreement; or
     For a client who died after July 27, 1997, nonprobate assets.
     a) The value of the estate will be reduced by any valid liability against the deceased client's property at the time of death.

**LIENS AND ADJUSTMENTS OR RECOVERIES** (cont.)

b) For an individual covered under a long-term care insurance partnership policy issued on or after December 1, 2011, estate does not include assets or resources disregarded for Medicaid eligibility under Attachment 2.6-A, Supplement 8c, or, at the death of the individual, any unused amount of assets that may be disregarded based on the total dollar amount of benefits utilized by the individual under the partnership policy.

c) The individual's personal representative has the burden of proving that assets in the estate of the individual or individual's surviving spouse were assets, portions of assets or proceeds from assets that were disregarded for Medicaid eligibility during the individual's lifetime.

d) The personal representative may designate any unused amount of partnership asset protection to disregard additional assets in the estate up to the amount of benefits utilized by the decedent under the qualifying policy before death.

e) The personal representative has the burden of proving the unused value of partnership asset protection. To determine an individual's unused amount of partnership asset protection remaining at the time of estate recovery, the State uses the following methodology:
   a. Determines the total dollar amount paid out by the long-term care partnership policy during the individual's lifetime;
   b. Subtracts from that amount the value of assets, portions of assets or proceeds of assets retained or possessed by, accessible to or under the control of the individual or the individual's surviving spouse on the date of the individual's death and designated as protected for the purposes of Medicaid eligibility;
   c. Subtracts from that amount the value on the date of transfer of assets, portions of assets or proceeds of assets transferred to a third party during the individual's lifetime by either the individual or the individual's spouse;
   d. The amount remaining may be designated by the personal representative to disregard additional assets in the estate.

*Individual's home* means:

- A person's principal place of residence prior to the person's institutionalization.

*Equity interest in the home* means:

- Fair market value minus encumbrances.

*Residing in the home for at least one or two years on a continuous basis* means:

- The person has lived in the client's home as the principal place of residence for a period of at least one or two years immediately before the date of the client's admission to the institution and has resided there on a continuous basis since that time.

*Lawfully residing* means:

- The person lives in the state and intends to remain indefinitely.

*Discharge from the medical institution and return home means:*

- The person leaves the medical institution, returns home, and intends to remain in the home indefinitely.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

LIENS AND ADJUSTMENTS OR RECOVERIES (cont.)

4. The state defines undue hardship as follows:

The department shall waive recovery when recovery would work an undue hardship. This waiver is 1imited to the period during which undue hardship exists.

Undue hardship exists when:

- The estate subject to adjustment or recovery is the sole income-producing asset of the heirs and income is limited; or
- Recovery would result in the impoverishment of one of the heirs; or
- Recovery would deprive an heir to the property of shelter and the heir lacks the financial means to obtain and maintain alternative shelter.

Undue hardship does not exist when:

- The adjustment or recovery of the client's cost of assistance would merely cause the client's family members inconvenience or restrict the family's lifestyle.
- The heir divests assets to qualify under the undue hardship provision.

The department shall not waive recovery based on undue hardship when a deceased client's assets were disregarded in connection with a long-term care insurance policy or contract.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective.

*Standards*: Same as 4. above

*Procedures*:

During the course of the department's investigation into the assets of the estate, information is provided to the department by heirs and others. When that information indicates the estate may be entitled to an undue hardship waiver, the department issues a written decision which includes a notice to the heirs of the right to contest the department's decision.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

LIENS AND ADJUSTMENTS OR RECOVERIES (cont.)

5. Standards and procedures (con't)

A person who requests the department to waive recovery in whole or in part, and who suffers a loss because the request was not granted, may contest the department's decision in an adjudicative proceeding. The department's decision shall state the requirements for an application for an adjudicative proceeding and state where assistance might be obtained to make an application. An application for an adjudicative proceeding must:

- Be in writing;
- State the basis for contesting the department's denial of the request to waive recovery;
- Be signed by the applicant and state the applicant's address and telephone number;
- Be served on the Office of Financial Recovery within twenty-eight days of the date the applicant received the department's decision denying the request for a waiver. An application filed up to thirty days late may be treated as if timely filed if the applicant shows good cause for filing late; and
- Be served on the Office of Financial Recovery in a manner which shows proof of receipt, such as personal service or certified mail, return receipt requested.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

A total medical assistance payment of $100 or less is waived as not cost-effective. Guidelines used to establish the cost-effectiveness of other cases follow:

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

LIENS AND ADJUSTMENTS OR RECOVERIES (cont.)

6. Cost effectiveness (cont.)

- Because the costs of estate administration may deplete an estate valued at $3,000 or less, each such case is evaluated individually to determine cost-effectiveness.

- After consultation with the Attorney General's Office, claims rejected (disallowed) in probate court are evaluated individually to determine if initiating legal action is cost-effective.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

*Advance Notice Requirement:*

The State will file liens, seek adjustment, or otherwise effect recovery for medical assistance correctly paid on behalf of a client. "Medical assistance" here means long-term care (LTC) services, including nursing facility services, home and community-based services, and related hospital and prescription drug services.

When the State seeks to recover from a client's estate the cost of medical assistance (as defined above) that is provided to the client, prior to filing a lien against the deceased client's real property the State will provide notice to:

- The probate estate's personal representative, if any; or

- Any other person known to have title to the affected property.

Prior to filing a lien against any of the deceased client's property, the State will provide ascertained titled property owners notice and an opportunity for an adjudicative proceeding. The State will serve upon ascertained titled property owners a notice of intent to file lien, which will state:

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

LIENS AND ADJUSTMENTS OR RECOVERIES (cont.)

7. Collection procedures (cont.)

- The deceased client's name, social security number, if known, date of birth, and date of death;
- The amount of medical assistance long-term care correctly paid on behalf of the deceased client the department seeks to recover;
- The department's intent to file a lien against the deceased client's real property to recover the medical assistance long-term care correctly paid on behalf of the deceased client;
- The county in which the property is located; and
- The ascertained titled property owner's right to contest the department's decision to file a lien by filing an application for an adjudicative proceeding with the Office of Financial Recovery; and provide an adjudicative proceeding to determine whether:
    - The amount of medical assistance long-term care correctly paid on behalf of the deceased client alleged by the department's notice of intent to file lien is correct; and
    - The deceased client had legal title to the property at the time of the client's death.

An application for an adjudicative proceeding must:

- Be in writing;
- State the basis for contesting the department's notice of intent to file lien;
- Be signed by the applicant and state the applicant's address and telephone number;
- Be served on the Office of Financial Recovery

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

LIENS AND ADJUSTMENTS OR RECOVERIES (cont.)

7. Collection procedures (cont.)

within twenty-eight days of the date the applicant received the department's notice of intent to file a lien. An application filed up to thirty days late may be treated as timely filed if the applicant shows good cause for filing late; and

- Be served on the Office of Financial Recovery in a manner in which shows proof of receipt, such as personal service or certified mail, return receipt requested.

Upon receipt of an application for an adjudicative proceeding, the department shall provide notice of the proceeding to all other ascertained titled property owners.

If no ascertained titled property owner files an application for the adjudicative proceeding within twenty-eight days of the date the department served a notice of intent to file lien, the department may file a lien against the deceased client's property for the amount of medical assistance long-term care correctly paid on behalf of the deceased client alleged in the notice of intent to file lien.

*Method of Applying for a Waiver, Hearing and Appeals Procedures, and Time Frames Involved:* Same as 4. and 5. ab ove.

8. Tribal Exemptions for Estate Recovery

American Indian/Alaska Native income, resources, and property that were exempt from estate recovery as of April 1, 2003 under Federal instructions in the State Medicaid Manual remain exempt from Medicaid estate recovery according to section 1917(b)(3)(B) of the Act.

Back to TOC

# Medicaid Premiums and Cost Sharing

State Naune: Washington

0MB Control Number: 0938-1148

Transmittal Number: WA - 20 - 0036

| Cost Sharing Requirements | Gl |
|---|---|
| 1916<br>1916A<br>42 CFR 447.50 through 447.57 (excluding 447.55) | |
| The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. | |

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionall left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

The following enrollment fee, premium or similar charge is imposed on the medically needy:

| Gross Family Income (per mo.) | Charge Family Size 1 or 2 | 3 or 5 | 5 or more | Liability Period | Frequency of Charges |
|---|---|---|---|---|---|
| (1) | (2) | (3) | (4) | (5) | (6) |
| $150 or less | | | | | |
| 151 – 200 | | | | | |
| 201 – 250 | | | | | |
| 251 – 300 | | | N/A | | |
| 301 – 350 | | | | | |
| 351 – 400 | | | | | |
| 401 – 450 | | | | | |
| 451 – 500 | | | | | |
| 501 – 550 | | | | | |
| 551 – 600 | | | | | |
| 601 – 650 | | | | | |
| 651 – 700 | | | | | |
| 701 – 750 | | | | | |
| 751 – 800 | | | | | |
| 801 – 850 | | | | | |
| 851 – 900 | | | | | |
| 901 – 950 | | | | | |
| 951 – 1000 | | | | | |
| More than $1000 | | | | | |

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

MEDICALLY NEEDY ENROLLMENT FEES, PREMIUMS (cont.)

Effect on recipient of non-payment of enrollment fee, premium or similar charge:

____ Non-payment does not affect eligibility

____ Effect is as described below:

N/A

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

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Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

This page intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**PREMIUMS IMPOSED ON LOW INCOME PREGNANT WOMEN AND INFANTS**

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

NONE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

NONE

*Description provided on attachment.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PREMIUMS IMPOSED ON LOW INCOME PREGNANT WOMEN AND INFANTS (cont.)**

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes [ ] No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**OPTIONAL SLIDING SCALE PREMIUMS IMPOSED ON QUALIFIED DISABLED AND WORKING INDIVIDUALS**

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

NONE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

NONE

*Description provided on attachment

Back to TOC

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**OPTIONAL SLIDING SCALE PREMIUMS IMPOSED ON QUALIFIED DISABLED AND WORKING INDIVIDUALS (cont.)**

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes [ ] No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PREMIUMS IMPOSED ON FAMILIES RECEIVING EXTENDED BENEFITS DURING A SECOND SIX-MONTH PERIOD**

A. The following method is used to determine the premium imposed during each premium payment period on families receiving extended benefits (Transitional Medicaid or TMA) during the second six-month period under section 1902(a)(52) and section 1925 of the Act:

The premium amount for months seven, eight, and nine are based on the family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative during months one, two and three. The premium amount for months ten, eleven, and twelve are based on the family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative average income less work-related child cares during months four, five, and six.

The family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative is divided by three and multiplied by one percent. This amount is rounded down to the nearest whole dollar for the per person/per month premium. In no case may the amount of the premium exceed three percent of the family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative.

A family whose average gross monthly earnings less work-related child care is equal to or less than one hundred percent of the federal poverty level (FPL) is exempt from the premium requirement. In addition, pregnant women and children are exempt from the premium requirement.

B. A description of the billing method used is as follows (include due date for premium payment and notification of the consequences of nonpayment):

Billing is approximately the fifth of each month for the following month of service. If payment is not received by the end of the month of service, the department reviews individual members of the family to determine if they are eligible for another medical

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PREMIUMS IMPOSED ON FAMILIES RECEIVING EXTENDED BENEFITS DURING A SECOND SIX-MONTH PERIOD (cont.)**

B. Billing description (con't)

program. If a client is not eligible for another program, the receipt of medical will end the end of the month following the month of service for which the client has not paid the premium. The client is given a minimum of ten days advance notice.

C. The criteria for determining good cause for failure to pay such premium on a timely basis are described below:

Reasons for good cause include, but are not limited to:

1. Illness, mental impairment, injury, trauma, or stress;

2. Lack of understanding the premium payment requirement due to a language barrier;

3. Transportation problems;

4. The client did not pay the premium because they expected to be able to meet the family medical needs, but could not; or

5. The client was given incorrect information or did not receive advance and adequate notice about the premium payment requirements.

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**

The State has in place a public process that complies with the requirements of Section 1902(a)(A) of the Social Security Act.

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**

A. INTRODUCTION

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 amounts:

1. Diagnosis-Related Group (DRG);
2. Ratio of cost-to-charges (RCC);
3. Per diem (beginning August 1, 2007); and
4. Full cost (beginning July 1, 2005).

Chapter 182-550 of the Washington Administrative Code (WAC), Revised Code of Washington (RCW) 74.04.050, 74.04.057, 74.08.090, 74.09.500, and any other state or federal laws or regulations, codified or uncodified, as they exist as of July 1, 2011, as may be applicable, are incorporated by reference in Attachment 4.19-A Part I as if fully set forth.

Back to TOC

**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 RCW 74.09.5225 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 1st in order to be effective for January 1st 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.

Back to TOC

**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.

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.)**

*Children's Health Program (CHP)*
The CHP provides medical coverage for non-citizen children under age 19 whose household income is at or less than 300% of the Federal Poverty Level.

*Cost Limit for DSH Payments*
The hospital-specific DSH payment limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations.

*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 Agency-approved and DOH Medicare-certified as a CAH, are reimbursed through a cost settlement method.

*DRG Conversion Factor (DRG rate)*
The DRG conversion factor is a calculated amount based on the statewide-standardized average payment 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 total DSH payments to an eligible hospital may not exceed the hospital-specific cost limit for DSH payments, in accordance with federal regulations. The total DSH payments to all eligible hospitals in a given year are limited to the State allotment for that year.

*DSH One Percent Inpatient Medicaid Utilization Rate*
All hospitals must meet the one percent Medicaid inpatient utilization rate in order to qualify for any of the Agency disproportionate share hospital programs.

Back to TOC

**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 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 prior to July 1, 2014.

For dates of admission before August 1, 2007, the Agency 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 between August 1, 2007, and June 30, 2014, the Agency 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 Agency to pay claims using a non-DRG payment method.

For dates of admission between July 1, 2014, and March 31, 2018, the Agency uses version 31.0 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification software to assign DRGs and Severity of Illness (SOI) indicators.

For dates of admission between April 1, 2018 and June 30, 2022, the Agency uses version 33.0 of the All Patient Refined Diagnosis-Related Group (APR-DRG) classification software to assign DRGs and Severity of Illness (SOI) indicators.

For dates of admission on and after July 1, 2022, the Agency uses version 38.0 of the All Patient Refined Diagnosis-Related Group (APR-DRG) classification software to assign DRGs and Severity of Illness (SOI) indicators.

*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.

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.)

*"Full Cost" Payment Program*
"Full cost" payment program means a hospital payment program for participating public hospitals located in the State of Washington that are operated by public hospital districts and are not Agency-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 RCCs(ratio of costs–to-charges). 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 RCCs 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.

*Health care-acquired condition (HCAC)*
Means a medical condition for which an individual was diagnosed in a Medicaid inpatient hospital setting that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

*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.
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Back to TOC

**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 equaled or exceeded the DRG allowed amount (hospital-specific DRG rate times relative weight for the DRG code on the claim). 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 the Agency. 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.

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.)**

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/MCS*
PII/MCS, as used in Paragraph H.2 and H.3 below, means the Agency Limited Casualty Program Psychiatric Indigent Inpatient (PII) or Medical Care Services (MCS) program. MCS persons are low-income individuals who are not eligible for Title XIX coverage and who are unemployable for at least 90 days due to a medical, mental health, or substance abuse incapacity. MCS was known as General Assistance Unemployable (GAU) through December 31, 2010, and as Disability Lifeline (DL) through October 31, 2011.

Back to TOC

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

B. DEFINITIONS (cont.)

*Per Diem Rate*
The per diem rate is a calculated amount based on the statewide, standardized, average payment 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.)

*Provider Preventable Conditions (PPC)*
PPC are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings and are defined as the full list of Medicare's HAC, with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients, as described in section 1886(d)(4)(D)(IV) of the Social Security Act.

Other Provider Preventable Conditions (OPPC) apply to both inpatient and outpatient settings and are defined in 42 CFR §447.26(b)(i)-(v) as a condition occurring in any health are setting that meets the following criteria:

- 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;
- Has a negative consequence for the beneficiary;
- Is auditable; and
- Includes the Medicare national coverage determinations.

Back to TOC

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

B. DEFINITIONS (cont.)

*Quality Incentive Payment*
Effective for dates of admission on or between July 1, 2012 and June 30, 2013, and dates of admission beginning July 1, 2014, 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 Chapter 74.60 RCW.

*RCC*
RCC means a hospital ratio of costs-to-charges (RCC) calculated annually using the most recently filed 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.

Note: Through December 30, 2014, the Centers for Medicare and Medicaid Services (CMS) applied the definition on an "individual-specific" basis (i.e., does an individual have coverage).

Effective December 31, 2014, CMS began applying the definition on a "service-specific" basis, (i.e., the services furnished to the individual during the year). This allows the cost of inpatient and outpatient hospital services provided to Medicaid patients who have exhausted applicable state coverage limits to be included in the DSH calculation. Additionally, the cost of uncompensated care provided to hospital patients who have exhausted private insurance benefits or lifetime insurance limits may now be counted as uninsured costs in calculation the hospital- specific DSH limit.

Back to TOC

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, the agency uses Medicare cost report data from the Healthcare Cost Report Information System (HCRIS), CMS form 2552-10, or successor federal cost reporting forms or data sources to determine the cost of providing hospital services. 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.

Effective dates of admission on and after January 1, 2010, the State does not pay for adverse events which became termed as Other Provider-Preventable Conditions (OPPCs) effective July 1, 2011. Some Health Care-Acquired Conditions (HCACs) can become an OPPC if the patient dies or is seriously disabled, or level of severity is great, such as the patient develops level three or level four pressure ulcers.

Effective for dates of admission on and after January 1, 2016, the state does not pay for an early elective delivery unless it is medically necessary. An early elective delivery is any non-medically necessary induction or cesarean section before 39 weeks of gestation. 39 weeks of gestation is greater than 38 weeks and 6 days.

If the State reduces or recoups the payment, the client cannot be held liable for payment.

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.

For claims with dates of admission on and after January 1, 2010, the State does not make additional payments for services on inpatient hospital claims that are attributable to Health Care Acquired Conditions (HCAC) and are coded with Present on Admission Indicator codes “N” or “U”. For HAC claims which fall under the DRG payment basis, the State does not make additional payments for complications and comorbidities (CC) and major complications and comorbidities (MCC).

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

2. DRG Relative Weights

For dates of admission prior to July 1, 2014, 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 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 Medicaid 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 between August 1, 2007, and June 30, 2014, 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.

For dates of admission between July 1, 2014, and March 31, 2018, the Agency uses the APR-DRG version 31.0 standard national relative weights established by the 3M Corporation. Due to the usage of national relative weights the Agency does not pay per-diem for any DRG classifications previously considered unstable.

For dates of admission between April 1, 2018 and June 30, 2022, the Agency uses the APR-DRG version 33.0 standard national relative weights established by the 3M Corporation. Due to the usage of national relative weights, the Agency does not pay per-diem for any DRG classifications previously considered unstable.

For dates of admission on and after July 1, 2022, the Agency uses version 38.0 of the All Patient Refined Diagnosis-Related Group (APR-DRG) classification software to assign DRGs and Severity of Illness (SOI) indicators.

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 between August 1, 2007, and June 30, 2014, the Agency allows a high outlier payment for claims that meet high outlier qualifying criteria. To qualify, the claim's estimated cost must exceed a fixed outlier cost threshold of $50,000 and an outlier threshold factor (a multiplier times the inlier). Only DRG and specific per diem claims (medical, surgical, burn and neonatal) qualify for outlier payments. If a claim qualifies, the outlier payment is the costs in excess of the outlier factor threshold multiplied by an outlier adjustment factor. Total payment is outlier plus inlier. (The inlier is the hospital's specific DRG rate times the relative weight or for per diem claims, the hospital's specific per diem rate times allowed days).

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

a) Estimated Cost. The cost of a claim is estimated by multiplying the hospital's Ratio of Cost to Charges (RCC) by the billed charges.

b) Outlier Threshold Factor. The inlier is multiplied by a date specific factor to determine the threshold that must be met in order to qualify for an outlier payment. This factor is referred to as the outlier threshold factor. For dates of admission August 1, 2007, through July 31, 2012, the outlier threshold factor is 1.50 for pediatric services and pediatric hospitals, and 1.75 for all other services. For dates of admission on or after August 1, 2012, the outlier threshold factor is 1.429 for pediatric services and pediatric hospitals, and 1.667 for all other services. For dates of admission on or after July 1, 2013, the outlier threshold factor is 1.563 for pediatric services and pediatric hospitals, and 1.823 for all other services.

c) Outlier Adjustment Factor. The costs that exceed the outlier threshold are multiplied by a date specific factor to determine the outlier payment. This factor is referred to as the outlier adjustment factor. For dates of admission August 1, 2007 through July 31, 2012, the outlier adjustment factor is 0.95 for pediatric services and pediatric hospitals, 0.90 for burn DRGs, and 0.85 for all other services. For dates of admission on or after August 1, 2012, the outlier adjustment factor is 0.998 for pediatric services and pediatric hospitals, 0.945 for burn DRGs, and 0.893 for all other services. For dates of admission on or after July 1, 2013, the outlier adjustment factor is 0.912 for pediatric services and pediatric hospitals, 0.864 for burn DRGs, and 0.816 for all other services.

For dates of admission on or after July 1, 2014, the Agency allows a high outlier payment for claims that meet high outlier qualifying criteria. To qualify, the claims' estimated cost must be in excess of the DRG inlier + $40,000.

Only DRG claims qualify for outlier payments. If a claim qualifies, the outlier payment is the costs in excess of the outlier threshold factor multiplied by an outlier adjustment factor. Total payment is outlier plus inlier. (The inlier is the hospital's specific DRG rate multiplied by the relative weight).

a) Estimated Cost. The cost of a claim is estimated by multiplying the hospital's Ratio of Cost to Charges (RCC) by the billed charges.

b) Outlier Threshold Factor. The inlier is multiplied by a date specific factor to determine the threshold that must be met in order to qualify for an outlier payment. This factor is referred to as the outlier threshold factor. For dates of admission on or after July 1, 2014, the factor is $40,000.

c) Outlier Adjustment Factor. The costs that exceed the outlier threshold are multiplied by a date specific factor to determine the outlier payment. This factor is referred to as the outlier adjustment factor. The outlier adjustment factor is 0.80 for claims grouping to severity of illness (SOI) 1 and 2 and 0.95 for SOI 3 and 4.

Back to TOC

**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.

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.)**

C. GENERAL REIMBURSEMENT POLICIES (cont.)

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.

*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 Agency's 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)* Agency-approved and Medicare-designated CAHs receive Medicaid prospective payment based on Agency/Department 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 based on the weighted average of RCCs for in-state hospitals.

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.)**

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

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

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

*g. Public Hospitals Located In the State of Washington*

Beginning on July 1, 2005, for participating public hospitals located in the State of Washington that are operated by public hospital districts and are not Agency-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, Medicaid and MCSDSH 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.

Back to TOC

**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.

For dates of admission between July 1, 2014, and March 31, 2018, the Agency uses the APR-DRG version 31.0 standard national relative weights established by the 3M Corporation. Due to the usage of national relative weights the Agency does not pay per-diem for any DRG classifications previously considered unstable.

For dates of admission between April 1, 2018 and June 30, 2022, the Agency uses the APR-DRG version 33.0 standard national relative weights established by the 3M Corporation. Due to the usage of national relative weights the Agency does not pay per-diem for any DRG classifications previously considered unstable.

For dates of admission on and after July 1, 2022, the Agency uses version 38.0 of the All Patient Refined Diagnosis-Related Group (APR-DRG) classification software to assign DRGs and Severity of Illness (SOI) indicators.

*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.

Back to TOC

**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 method. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient. Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

Back to TOC

**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.

Back to TOC

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

*h. Trauma Center Services (cont.)*

Effective with dates of service on and after July 1, 2013, the supplemental payments proportion a Level I, II, or III hospital receives will be calculated using the aggregate qualifying trauma care services provided in both fee for service and managed care. Payments for inpatient Medicaid services are not to exceed the upper payment limit (UPL) for federal financial participation for fee for service.

A trauma case qualifies a Level I, II, or III hospital for supplemental trauma payment if the Injury Severity Score (ISS) is 13 or greater for an adult patient or 9 or greater for a pediatric patient (through age 14 only). A transferred trauma case qualifies the receiving hospital for supplemental payment regardless of ISS.

The qualifying ISS for adult and pediatric patients are evaluated periodically and may be adjusted based on the Washington State Department of Health's Trauma Registry data and changes to the Abbreviated Injury Scale (AIS) coding system.

Level IV and V trauma centers receive a trauma care grant from the Department of Health using only state funds.

*i. Inpatient Pain Center Services*

Services in Agency-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 or a facility with sub-acute medical services, 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.

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.)**

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

Effective January 1, 2016 through December 31, 2017, the agency adjusts the payment rate to a hospital with an excessive number of potentially preventable readmissions (PPRs) using specific criteria. A PPR is an inpatient readmission within 30 days after discharge that is clinically related to the initial admission and is potentially preventable through appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period. The first readmission is within thirty days after the initial admission, and the thirty-day timeframe begins again at the discharge of the most recent readmission to the same or to any other hospital.

The methodology to determine excess readmissions is an analysis based on the 3M™ Health Information Systems Potentially Preventable Readmissions Classification System under standard settings currently used by the agency. The software excludes certain types of readmissions from the PPR analysis prior to processing the claims.

The agency will prospectively apply a readmission reduction factor to inpatient rates based on a PPR analysis consisting of fee-for-service and managed care claims data. A readmission reduction factor for each hospital is based on the hospital's excess readmission payments divided by the total hospital inpatient payments in the PPR analysis. The agency will annually update the readmission reduction factors on January 1 using updated claims data from the prior state fiscal year (July 1 - June 30).

The agency calculates the number of excess PPRs using a risk-adjusted comparison between the actual and expected number of PPRs attributable to a hospital and prospectively reduces the payment. Payment reductions do not apply to critical access hospitals; however, critical access hospital claims are included in the PPR analysis.

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)**

C. GENERAL REIMBURSEMENT POLICIES (cont.)

10. Readmission Policy (cont)

Effective January 1, 2018, readmissions occurring within 14 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.

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.

When a hospital admission is solely for a stay until an appropriate sub-acute placement can be made or for a postpartum parent rooming with an infant being monitored for NAS/NOWS, 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.

**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.

(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:

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.

Back to TOC

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

The Level I, II, and III trauma center supplemental payment is based on 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 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. 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.

Effective with dates of service on and after July 1, 2013, the supplemental payments proportion a Level I, II, or III hospital receives will be calculated using the aggregate qualifying trauma care services provided in both fee for service and managed care. Payments for inpatient Medicaid services are not to exceed the upper payment limit (UPL) for federal financial participation for fee for service.

Level IV and V trauma centers receive a trauma care grant from the Department of Health using only state funds.

A trauma case qualifies a Level I, II, or III hospital for supplemental trauma payment if the Injury Severity Score (ISS) is 13 or greater for an adult patient or 9 or greater for a pediatric patient (through age 14 only). A transferred trauma case qualifies the receiving hospital for supplemental payment regardless of ISS.

The qualifying ISS for adult and pediatric patients are evaluated periodically and may be adjusted based on the Washington State Department of Health's Trauma Registry data and changes to the Abbreviated Injury Scale (AIS) coding system.

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.)

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.

**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

Effective for dates of admission on or between July 1, 2012 and June 30, 2013, 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 Chapter 74.60 RCW. 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.

Back to TOC

**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.

For dates of admission July 1, 2014, and after, 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 Chapter 74.60 RCW.

Effective July 1, 2014, quality measures for the quality incentive payment for inpatient hospitals are listed at http://www.hca.wa.gov/medicaid/hospitalpymt/Pages/inpatient.aspx

21. Rate enhancement for Sole Community Hospitals

For Sole Community Hospitals' rate enhancements, the agency multiplies an in-state hospital's specific conversion factor and per diem rates by a multiplier if the hospital meets all of the following criteria:

- Be certified by CMS as a sole community hospital as of January 1, 2013
- Have a level III adult trauma service designation from the Washington State Department of Health as of January 1, 2014
- Have less than one hundred fifty acute care licensed beds in fiscal year 2011
- Be owned and operated by the state or a political subdivision
- Not participate in the full cost payment through certified public expenditures (CPE) program

As of July 1, 2021, an additional increase may be applied for hospitals that accept single bed certifications.

| **Enhancement Multipliers** | | | | |
|---|---|---|---|---|
| **Hospital category** | **Effective Dates** | | | |
| | 7/1/2015 – 6/39/2018 | 7/1/2018 – 6/30/2021 | 7/1/2021 – 6/30/2022 | 7/1/2022 – 6/30/2022 |
| Sole Community Hospital | 1.25 | 1.5 | 1.0 | 1.25 |
| Sole Community Hospital accepting single bed certification per RCW 71.05.745 | NA | NA | 1.5 | 1.5 |

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

22. Rate Enhancement for low volume, small rural hospitals

Effective July 1, 2020, through June 30, 2021, the agency multiplies an in-state hospital's specific conversion factor and per diem rate by 1.50 if the hospital meets all of the following criteria:

(a) Has less than seventy (70) available acute care beds, as reported in the hospitals 2018 DOH year-end report;
(b) Is not currently designated as a critical access hospital;
(c) Does not meet the current federal eligibility requirements for designation as a critical access hospital;
(d) Is not participating in the certified public expenditure full cost reimbursement program; and
(e) Has combined Medicare and Medicaid inpatient days greater that eighty (80) percent of total days as reported in the hospital's 2018 cost report.

Effective July 1, 2021, the agency will revert to the payment level and methodology for low volume, small rural hospitals' that was in place as of June 30, 2020.

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.

Back to TOC

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

D. DRG COST-BASED RATE METHOD 2

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 Agency 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 Agency 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

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.)**

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 RCCs 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 Agency adjusted both accommodation and ancillary costs for inflation. The Agency 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 Agency 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

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.)**

D. DRG COST-BASED RATE METHOD (cont)

8. Conversion Factor Determination
For dates of admission between August 1, 2007, and June 30, 2014, 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 Agency 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.

Back to TOC

**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 hospitals paid under the prospective payment system (PPS) method were increased by thirteen percent (13.0%) from the rates that were established for dates of admission on and after July 1, 2009. This rate adjustment was in accordance with RCW 74.60.080.

Effective for dates of admission on or after July 7, 2011, DRG rates for hospitals paid under the PPS method were decreased by eight percent (8.0%) from that rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with RCW 74.60.090, as amended by the Legislature in 2011. The July 7, 2011, rates will be three and ninety-six one hundredths percent (3.96%) higher than the July 1, 2009, rates.

Effective for dates of admission between July 1, 2013, and June 30, 2014, DRG rates for hospitals paid under the PPS method will decrease by seven and sixty-six one hundredths percent (7.66%) from the rates that were established for dates of admission on and after July 7, 2011. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be four percent (4.00%) lower than the July 1, 2009, rates

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

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

Effective for dates of admission on or after July 1, 2014, the Agency changed the inpatient prospective payment system from AP-DRG to APR-DRG. The base conversion factor for APR-DRG payments was calculated so that aggregate inpatient payments would remain constant between AP-DRG and APR-DRG payment methods. This calculation included a shift of $3,500,000 from DRG to specialty psychiatric services.

c. Supplemental payments

Effective for dates of admission on or after July 1, 2013, supplemental payments will be paid for inpatient Medicaid services not to exceed the upper payment limit as determined by available federal financial participation for fee-for-service claims. The supplemental payment is based on the distribution amount mandated by the legislature to the following hospital categories as defined in RCW 74.60.010:

- Prospective payment hospitals other than psychiatric or rehabilitation hospitals,
- Psychiatric hospitals
- Rehabilitation hospitals, and
- Border hospitals.

For hospitals designated as prospective payment system (PPS) hospitals, $59,785,000 per state fiscal year. For hospitals designated as freestanding psychiatric specialty hospitals, $1,750,000 per state fiscal year. For hospitals designated as freestanding rehabilitation specialty hospitals, $450,000 per state fiscal year. For hospitals designated as out-of-state border area hospitals, $500,000 per state fiscal year.

The payment is calculated by applying the Medicaid fee-for-service rates to each hospital's Medicaid and CHIP inpatient fee-for-service claims and Medicaid and CHIP managed care encounter data for the base year as defined in RCW 74.60.010. This sum is divided by the aggregate total of all hospitals within each category to determine the individual hospital pro rata share percentage. The individual hospital payment is the pro rata percentage multiplied by the amount mandated to be distributed by the Legislature within each hospital category.

The payment will be made quarterly, by dividing the total annual disbursement amount by four to calculate the quarterly amount.

d. 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 Agency as critical border hospitals is the lowest hospital specific conversion factor for a hospital located instate.

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

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

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.

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, the Agency 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, the Agency 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 PAYMENT 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 between August 1, 2007, and June 30, 2014, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

1. Per diem rate (cont)

The Agency 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 Agency 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 Agency 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.

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.)**

E. PER DIEM, PER CASE, AND RCC PAYMENT 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 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 Agency adjusted both accommodation and ancillary costs for inflation. The Agency 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 Agency 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.

Back to TOC

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

E. PER DIEM, PER CASE, AND RCC PAYMENT 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

For dates of admission on and between August 1, 2007, and June 30, 2014, 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 Agency 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.

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.)**

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

Back to TOC

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

E. PER DIEM, PER CASE, AND RCC PAYMENT 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 20 07 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.

Effective for dates of admission on or after July 1, 2013, per diem rates for non specialty services will decrease by seven and sixty-six one hundredths percent (7.66%) from the rates that were established for dates of admission on and after July 7, 2011. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013 rates will be four percent (4.00%) lower than the July 1, 2009 rates.

For dates of admission after July 1, 2014, Washington State Medicaid no longer pays for unstable DRGs under the per diem method.

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 and APR-DRG classifications identified as specialty services are grouped into:

- Psychiatric Services. Psychiatric claims are claims with a psychiatric diagnosis (i.e., assigned to a psychiatric DRG classification).
- Rehabilitation Services. Rehabilitation claims are claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation DRG classification).
- Detoxification Services. Detoxification claims are claims from freestanding detoxification hospitals, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification DRG classification).
- 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.

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.)**

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

1. Per diem rate (cont.)

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

The Agency 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.

Back to TOC

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

E. PER DIEM, PER CASE, AND RCC PAYMENT 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 are 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 is multiplied by the Medicare wage index. This factor may be updated on an annual basis in July of each year, using the most recently available Medicare wage index.

  To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs are multiplied by the Medicare indirect medical factor. This factor may be updated on an annual basis in July of each year, using the most recently available Medicare indirect medical education 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.

Back to TOC

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

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

Effective for dates of admission on or after July 1, 2013, per diem rates for non-specialty services will decrease by seven and sixty-six one hundredths percent (7.66%) from the rates that were established for dates of admission on and after July 7, 2011. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013 rates will be four percent (4.00%) lower than the July 1, 2009 rates.

For dates of admission after July 1, 2014, Washington State Medicaid no longer pays for unstable DRGs under the per diem method.

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 and APR-DRG classifications identified as specialty services are grouped into:

- Psychiatric Services. Psychiatric claims are claims with a psychiatric diagnosis (i.e., assigned to a psychiatric DRG classification).
- Rehabilitation Services. Rehabilitation claims are claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation DRG classification).
- Detoxification Services. Detoxification claims are claims from freestanding detoxification hospitals, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification DRG classification).
- 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.
- Long-term psychiatric commitments. Long-term psychiatric commitments are psychiatric claims for 90 or more days with a psychiatric diagnosis and a legal commitment

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

1. i. PER DIEM RATE (cont.)

- ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.

- ✓ Effective for dates of admission on or after July 1, 2014, psychiatric rates were rebased at cost using the same methods as described above, based on cost information for hospital fiscal years ending in 2013. The Agency applied a budget adjuster so that aggregate inpatient payments would remain constant after the rebased costs were determined. The Agency increased funding by psychiatric services by $3,500,000.

- ✓ Effective for dates of admission on and after October 1, 2017, psychiatric per diem rates were increased as directed by the legislature. The increase was applied to any hospital with 200 or more psychiatric bed days. The increase was prioritized for hospitals not currently paid based on provider-specific costs using a similar methodology to set rates for existing inpatient facilities utilizing cost report information for hospital fiscal years ending in 2016. To distribute the funds for each fiscal year, free-standing psychiatric hospitals were given 68.15% of the statewide average cost per day. All other hospitals were given the greater of 78.41% of their provider-specific cost, or their current Medicaid psychiatric per diem rate. Rate increases for providers were set so as not to exceed the amounts provided by the legislature. The agency will conduct annual reviews for updated cost information to determine whether new and/or existing providers meet the 200+ bed criteria. The agency will apply the same cost percentage criteria for future rebasing of the psychiatric per diem rates.

- ✓ Effective for dates of admission beginning May 8, 2019 through June 30, 2019, psychiatric per diem rates were increased to $1,050.00 as directed by the legislature. The increase was applied to any hospital that is designated as a rural hospital by the Department of Health (DOH), has less than fifty staffed acute care beds as reported by DOH, is not participating in the certified public expenditure full cost reimbursement program, and has combined Medicare and Medicaid inpatient days greater than fifty percent of total days. The agency set the rate increases for qualifying providers so as not to exceed the amounts provided by the legislature.

- ✓ Effective for dates of admission beginning July 31, 2019, through June 30, 2020, long-term psychiatric per diems were set at $1,171 or the hospital-specific psychiatric per diem rate, whichever is greater as directed by the Legislature. The increase is applied to any hospital that accepts patients committed to a psychiatric facility for a period of 90 days or greater. The Agency set the rate so as not to exceed the amounts provided by the Legislature.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

1. i. PER DIEM RATE (cont.)

✓ Effective for dates of admission beginning July 1, 2020, Hospitals that have a 12-month Medicare cost report on file, their psychiatric per diem will be the greater of their costs or $940. If the hospital does not have a 12-month cost report available, their long-term psychiatric per diem rate will be set at the greater of either the average of all in-state provider-specific long-term psychiatric per diem rates or their current short-term psychiatric per diem. The increase is applied to any hospital that accepts patients committed to a psychiatric facility for a period of 90 days or greater. The Agency set the rate so as not to exceed the amounts provided by the Legislature.

✓ Effective for dates of admission beginning July 1, 2021

Acute Care Hospitals with distinct psychiatric units

- Hospitals that have a 12-month Medicare cost report on file with at least 200 psychiatric bed days, will receive a long term psychiatric per diem rate equivalent to their costs documented on their Medicare cost report on file with the agency.
- Hospitals that do not have a 12-month cost report with at least 200 bed days, will receive a long-term psychiatric per diem rate equivalent to the greater of either the average of all acute care hospital's providing long term psychiatric services in-state provider-specific long-term psychiatric per diem rates or their current short-term psychiatric per diem. The increase is applied to any hospital that accepts patients committed to a psychiatric facility for a period of 90 days or greater. The Agency set the rate so as not to exceed the amounts provided by the Legislature.

Free Standing Psychiatric hospitals

- Hospitals without an existing long-term Rate, will receive a per diem rate equivalent to either the greater of their short-term rate or the statewide average long term psychiatric rate for free standing psychiatric hospitals.
- Hospitals that have an existing long term per diem will continue to receive the $940 established for July 1, 2021. In addition to the $940 per diem rate, the hospital may submit supplemental cost data with their cost reports to the authority for consideration. If approved, the appropriate adjustments to the Medicaid inpatient psychiatric per diem payment rate of the hospital will be made. Adjustment of costs may include any of the following:
  - Costs associated with professional services and fees not accounted for in the hospital's Medicare cost report or reimbursed separately.
  - Costs associated with the hospital providing the long-term psychiatric patient access to involuntary treatment court services that are not reimbursed separately.
  - Other costs associated with caring for long-term psychiatric patients that are not reimbursed separately.

The Agency sets the rate so as not to exceed the amounts provided by the Legislature.

- For non-distinct psychiatric unit hospitals with less than 200 psychiatric days:
  - ✓ 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.
  - ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.
  - ✓ Effective for dates of admission on or after July 1, 2014, the statewide-standardized average cost was recalculated using the same methods as described above, based on cost information for hospital fiscal years ending in 2013. The Agency applied a budget adjuster so that aggregate inpatient payments would remain constant after the rebased costs were determined.

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, the Agency 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, the Agency 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

The per case rate methodology is effective August 1, 2017, through September 30, 2018, only; effective October 1, 2018, the per case rate methodology is obsolete.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

3. RCC PAYMENT METHOD

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

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.

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.)**

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

3. RCC PAYMENT METHOD (cont)

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

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.

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 RCCs are used to determine "full cost" for those hospitals.

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

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.)**

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

3. RCC PAYMENT 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 sub-providers 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 participating public hospitals located in the State of Washington that are operated by public hospital districts and are not Agency-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 to determine costs for covered medically necessary services. The payment method pays only the federal match portion of the allowable costs on fee for service inpatient Medicaid claims. Recipient responsibility (spend-down) and third-party liability as identified on the billing invoice or by the Agency 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 Agency claim will be the allowed federal match on the amount of the related certified public expenditures. The Agency 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.

Back to TOC

**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 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 HOSPITAL 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 hospital payment, a hospital must meet the minimum requirement of a one-percent Medicaid inpatient utilization rate. A hospital will be considered for one or all of the disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility criteria for that respective DSH program and has met the State DSH application requirements explained in WAC 182-550-4900 through 182-550-5400.

The total of all DSH payments will not exceed the State's DSH allotment. To accomplish this goal, the Agency intends to distribute DSH payments to ensure costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by federal rules.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed the uncompensated cost of furnishing hospital services to Medicaid-eligible individuals and individuals with no insurance or any creditable third party coverage for the services provided.

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.)**

H. DISPROPORTIONATE SHARE PAYMENTS (cont)

The Agency 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 Agency DSH program payments are prospective payments, and these programs are: LIDSH, PIIDSH, CHPDSH, MCSDSH, SCDSH, SRDSH, SRIADSH, NRIADSH, and PHDSH. DSH is available only to acute care hospitals with the exception of IMDDSH, which is distributed to the state-owned institutions for Mental Disease (IMD) The IMDDSH is appropriated separately to the Division of Behavioral Health and Recovery.

The following DSH programs are supplemental payments: PHDSH, LIDSH, SRDSH, SCDSH, SRIADSH, and NRIADSH. Three DSH programs are paid on a per claim basis: CHPDSH, MCSDSH and PIIDSH. Institutions for Mental Disease are not eligible for any of these programs.

If an individual hospital has been overpaid by a specified amount, the Agency will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

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

Beginning in state fiscal year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, hospitals are required to return overpayments to the Agency for redistribution to qualifying hospitals as an integral part of the audit process. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital’s share of the particular DSH program. Only the recouped payments are redistributed

Back to TOC

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont)

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

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

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

b. 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

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

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

e. The hospital is not a Certified Public Expenditure (CPE) hospital.

Hospitals considered eligible under the above criteria will receive DSH payment amounts that in total will equal the annual appropriation 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 Agency divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals, and then multiplies the result by the hospital's most recent Medicaid case mix index (CMI), and then multiplies the result by the hospital's base year Title XIX discharges. The Agency 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 its paid Medicaid DRG claims during the state fiscal year used as the base year for the DSH application.

Each hospital's total DSH payments will not exceed its DSH limit. The hospital-specific DSH payment limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations.

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

Total funding to the LIDSH program equals $17,204,000 in state fiscal year (SFY) 2010, $16,204,000 in SFY 2011, and $8,522,000 in SFY 2012 and thereafter.

Back to TOC

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

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

Effective January 1, 2014, the PII DSH program was repealed. This is because many of the individuals for whom the hospitals benefited under PII DSH Program are now considered “Newly Eligible” under the Affordable Care Act, which took effect January 1, 2014. Therefore the need for PII DSH no longer exists, and the program officially closed effective July 1, 2016.

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 for inpatient claims.

For all hospitals, except hospitals participating in the “full cost” payment program through certified public expenditures, the inpatient payments made are at a rate lower than the Medicaid rate and are based on published, non-Medicaid rates. The hospital claims are processed through the Provider One (MMIS) system where the PII clients are identified based upon their assigned Recipient Aid Category (RAC) code. If a hospital does not qualify for DSH payments, these claims are paid with State funds.

The total of each hospital’s claims-based PIIDSH payments will not exceed its hospital-specific DSH cap. The hospital-specific DSH cap limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations

For the excepted hospitals, the payment equals “full cost” using the Medicaid RCCs to determine cost for the medically necessary care.

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.)**

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

3. Medical Care Services Disproportionate Share Hospital (MCSDSH) Payment

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

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

b. The hospital provides services to low-income, Medical Care Services (MCS) patients. MCS persons are low-income individuals who are not eligible for Title XIX coverage and who are unemployable for at least 90 days due to a medical, mental health, or substance abuse incapacity; and

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

Hospitals qualifying for MCSDSH payments will receive a per claim payment for inpatient claims. For all hospitals, except hospitals participating in the “full cost” payment program through certified public expenditures, the inpatient payments made are at a rate lower than the Medicaid rate and are based on published, non-Medicaid rates. The hospital claims are processed through the Provider One (MMIS) system where the MCS clients are identified based upon their assigned Recipient Aid Category (RAC) code. If the hospital does not qualify for DSH, these claims are paid with State funds.

The total of each hospital’s claims-based MCSDSH payments will not exceed its hospital-specific DSH cap. The hospital-specific DSH cap limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations.

For the excepted hospitals, the payment equals “full cost” using the Medicaid RCCs to determine cost for the medically necessary care

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.)**

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

4. Small Rural Disproportionate Share Hospital (SRDSH) Payment

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 is a small, rural hospital, defined as a hospital with fewer than 75 acute beds and located in a city or town with a non-student population of no more than 17,806 in calendar year 2008, as determined by population data reported by the Washington State Office of Financial Management population of cities, towns, and counties used for the allocation of state revenues. This non-student population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the non-student population is increased by two percent;

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

d. The hospital is not a Certified Public Expenditure (CPE) hospital.

Each hospital's SRDSH payment is based on the hospital's Medicaid 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 subject to hospital-specific DSH limits.

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 percent of actual payments. A hospital is determined to have a low profitability margin when their profitability margin is less than 110 percent of the average profitability margin for qualifying hospitals.

The Agency will calculate each hospital's net operating margin based on the hospital's base year data and audited financial statements from the hospital.

Back to TOC

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

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

Each hospital's total DSH payments will not exceed its DSH limit. The hospital-specific DSH payment limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations.

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.

Total funding to the SRDSH program equals $3,818,000 per state fiscal year (SFY) beginning SFY 2021.

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 is a small, rural hospital, defined as a hospital with fewer than 75 acute beds and located in a city or town with a non-student population of no more than 17,806 in calendar year 2008, as determined by population data reported by the Washington State Office of Financial Management population of cities, towns, and counties used for the allocation of state revenues. This non-student population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the non-student population is increased by two percent;

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

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

e. The hospital is not a Certified Public Expenditure (CPE) hospital.

Back to TOC

**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)

Hospitals qualifying for SRIADSH payments are paid from a legislatively appropriated pool. Beginning July 1, 2007, the apportionment formulas 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, subject to hospital-specific DSH limits.

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 percent of calculated charity costs. A hospital is determined to have a low profitability margin when their profitability margin is less than 110 percent of the average profitability margin for qualifying hospitals. The Agency will calculate each hospital's net operating margin based on the hospital's base year data ant audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed its DSH limit. The hospital-specific DSH payment limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations.

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.

Total funding to the SRIADSH program equals $1,294,000 in state fiscal year (SFY) 2011 and $1,330,000 in SFY 2012. This program was not funded in SFY 2010.nor has this program received any funding beyond SFY 2012.

Back to TOC

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

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

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

c. The hospital is not a Certified Public Expenditure (CPE) hospital; and

d. 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 Agency 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. A hospital is determined to have a low profitability margin when their profitability margin is less than 110 percent of the average profitability margin for qualifying hospitals. The Agency will calculate each hospital's net operating margin~~s~~ based on the hospital's base year data and audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed its DSH limit. The hospital-specific DSH payment limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations.

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.

Total funding to the NRIADSH program equals $11,506,000 in state fiscal year (SFY) 2011 and $11,810,000 in SFY 2012. This program was not funded in SFY2010 nor has this program received any funding beyond SFY 2012.

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.)**

H. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (cont.)

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 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 operated by public hospital districts);
b. The hospital qualifies under section 1923 (d) of the Social Security Act; and the hospital participates in the "full cost" inpatient payment program through certified public expenditures

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.

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

The PHDSH payments for the Certified Public Expenditures (CPE) program are cost settled on an interim and final basis per Supplement 3 to Attachment 4.19A Part 1.

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

Effctive July1, 2011, hospitals will be considered eligible for a CHPDSH payment if:

a. The hospital is an in-state (Washington) or border area hospital;
b. The hospital provides services to low-income, Children's Health Program patients who, because of their citizenship status, are not eligible for Medicaid health coverage and who are encountering a medical condition; and
c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

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.)**

H. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (cont.)

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

For all hospitals, except hospitals participating in the "full cost" payment program through certified public expenditures, the inpatient payments made are at a rate lower than the Medicaid rate and are based on published, non-Medicaid rates. The hospital claims are processed through the Provider One (MMIS) system where the eligible clients are identified based upon their assigned Recipient Aid Category (RAC) code. If the hospital is not eligible for DSH funds, these claims are paid with State Funds.

The total of each hospital's claims based CHPDSH payments will not exceed its hospital specific DSH cap. The hospital-specific DSH cap limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no insurance or any other creditable third-party coverage, in accordance with federal regulations

Hospitals qualifying for CHPDSH payments will receive a per claim payment for inpatient and outpatient claims at the equivalent Medicaid rate.

For the excepted hospitals, the inpatient payment equals "full cost" using the Medicaid RCCs to determine cost for the medically necessary care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

H. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (cont.)

9. Sole Community Hospital Disproportionate Share Hospital (SCDSH) Payments

Effective July 23, 2013, a hospital will be considered eligible for a SCDSH payment if:

a. The hospital is an in-state (Washington) hospital;
b. The hospital is a rural hospital certified by the Centers for Medicare and Medicaid Services (CMS) as a sole community hospital as of January 1, 2013;
c. The hospital has less than one hundred and fifty acute care licensed beds in fiscal year 2011;
d. The hospital qualifies under Section 1923(d) of the Social Security Act; and
e. The hospital is not a certified public expenditure (CPE) hospital.

Hospitals qualifying for SCDSH payments are paid from a legislatively appropriated pool. This distribution is based on the hospital's Medicaid payments. To determine the hospital's SCDSH payments the agency:

a. Identifies the sum of the Medicaid payments to the individual hospital during the state fiscal year (SFY) two years prior to the current SFY for which DSH application is being made. These Medicaid payment amounts:
   (i) Are based on historical data;
   (ii) Include payments from the agency; and
   (iii) Include payments reported on the encounter data supplied by the managed care plans.

b. Divides the total Medicaid payments made to each SCDSH hospital (as identified above) during the most currently available state fiscal year by the sum of the Medicaid payments amounts for all qualifying hospitals during the same period to determine the hospital's percentage. The percentage is then applied to the total dollars in the pool to determine each hospital's payment subject to hospital-specific DSH limits.

Each hospital's total DSH payments will not exceed its DSH limit. The hospital-specific DSH payment limit is defined as the uncompensated cost of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no insurance or any other creditable third party coverage, in accordance with federal regulations.

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

Total funding to the SCDSH program is $800,000 for state fiscal year (SFY) 2014. For SFY 2015, total funding for the SCDSH program will be $600,000. For the period January 1, 2015 through June 30, 2015, $200,000 of this SFY amount is only available to rural hospitals located in Lewis County that meet the requirements in 9 a through e in this section. The Medicaid agency will discontinue SCDSH payments after June 30, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**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.

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.)**

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.

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.)**

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 may be periodically audited.

Hospital billings and other financial and statistical records will be periodically audited by the agency.

4. Rebasing & Recalibration

The Medicaid 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.

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.)**

K. TRIBAL INPATIENT HOSPITAL SERVICES

Inpatient hospital services provided by or through facilities of the Indian Health Service (IHS) that include, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act (also known as Tribal 638 facilities), are paid for each Medicaid beneficiary inpatient stay at the applicable per diem rate published in the Federal Register or Federal Register Notices by IHS. Inpatient hospital services exclude professional services a patient receives in the inpatient setting, which are paid in accordance with the applicable practitioner payment methodologies described in Attachment 4.19-B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**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.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**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:

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**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.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**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

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**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

Back to TOC

**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

Back to TOC

**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.

Back to TOC

**CPE Protocol (cont)**

**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

Back to TOC

**CPE Protocol (cont)**

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.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON**

STATE PSYCHIATRIC HOSPITALS FOR PATIENTS UNDER AGE 21 AND OVER AGE 65

The State of Washington's Department of Social and Health Services (Department) through its Mental Health Division (Division) established systems for reimbursement of Medicaid inpatient psychiatric hospital services provided to eligible Medicaid patients under age 21 and over age 65 in state operated psychiatric hospitals.

The state-operated psychiatric hospitals provide inpatient acute psychiatric services and special hospital services addressing a variety of post-acute psychiatric inpatient acuity levels for patients admitted to geriatric, forensic, and adult units. Special hospital programs addressing various acuity levels may include, but are not limited to inpatient restorative / habilitative / rehabilitative, intense psychosocial, transition or hospital outpatient services. A separate cost entity, or distinct program cost center is established within each state hospital geriatric, forensic and adult units for each of these special hospital programs. Acute psychiatric and special programs are services as described by Medicare.

The state hospitals are JCAHO accredited and Medicare certified inpatient acute psychiatric hospitals including the forensic units. The special hospital programs are established with the hospital surveys for accreditation and certification.

In order to meet changing demand for services, the division may add special programs by submitting a state plan amendment specifying the covered service and method and standards for payment to the state psychiatric hospitals.

This part describes the reimbursement system for payment for these services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

STATE PSYCHIATRIC HOSPITALS FOR PATIENTS UNDER AGE 21 AND OVER AGE 65
(cont)

INTERIM RATE SETTING

At least annually, the division will establish a Medicaid per diem rate and ancillary fee schedules for each state psychiatric hospital.

Interim payments are made to the state psychiatric hospitals based on charges to the general public for services delivered by the state hospitals. Recipient patient participation identified at eligibility determination is subtracted from aggregate monthly hospital charges and the reduced sum is paid to the hospitals.

PER DIEM

Computation of per diem payment rates for each of the adult psychiatric hospitals require the collection and preparation of the following data elements:

A. First ten months of the current fiscal years expenditures for each hospital reported in the State's financial records. The first ten months expenditures are annualized to form the base line hospital costs. A spreadsheet is developed to cross walk the hospital cost centers from the state accounting records to the cost centers used to calculate the annual Medicare cost report.

B. The baseline expenditure level is adjusted, based on the State's appropriated budget ensuing fiscal year. Add on adjustments are:

   1. Salaries and Benefits increase as appropriated by the State's legislators.

   2. All costs used to set the hospitals' room and board rates will be adjusted for economic trends and conditions. Those costs specifically addressed in the biennial appropriations act will be adjusted by the factor or factors used to set allotments. Costs not addressed in the biennial appropriations act will be adjusted by the most current annual unadjusted percent change in the Consumer Price Index for All Urban Consumers (CPI-U) as published by the United States Department of Labor, Bureau of Labor and Statistics. CPI-U will be applied to costs by

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

STATE PSYCHIATRIC HOSPITALS FOR PATIENTS UNDER 21 AND OVER AGE 65 (cont)

PER DIEM (cont)

the appropriate expenditure category, commodity or service group factor. http://stats.bls.gov/news.release/cpi.t01.htm

- Some cost center maybe adjusted above the general inflation factor based on consistently higher inflation indicators (i.e., Medical, pharmacy and utility costs).

3. Budgeted legislative changes for program, and other legislative adjustments.

4. The department accounting records provide capital depreciation, interest expenditure data and moveable equipment depreciation, which are added to the baseline work sheet.

C. The adjusted baseline expenditure level is entered into the prior years Medicare cost report (HCFA 2552-96) software. The Medicare cost report worksheets A-6, reclassifications, A-8, adjustment to expenditures, A-8-1, related organization including department wide cost allocations (home office cost), A-8-2, provider based physician adjustment and B-1, cost allocation-statistical basis are all updated with the most current data available. If current data is not available the statistics are used from the prior years Medicare cost report.

D. The hospital patient census for the first ten months of the current fiscal year is annualized.

E. The cost report is calculated. The appropriate program cost center is divided by the patient census related to the program to arrive at the per diem rate.

Payment is based on a single daily room & board Per Diem Rate for acute psychiatric and special hospital services in the state hospitals.

Title XIX patient days include therapeutic leave days, which are a planned and medically authorized period of absence from the hospital not exceeding 7 consecutive days.

Ancillary fee schedules are established from either available state Medicaid fee schedules or HCFA schedules and adjusted to reflect each hospital cost of

Back to TOC

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

STATE PSYCHIATRIC HOSPITALS FOR PATIENTS UNDER 21 AND OVER AGE 65 (cont)

PER DIEM (cont)

operating each ancillary department. Ancillary schedules are developed where service volume is high enough is to warrant a separate department. Remaining ancillary services are bundled in the per diem rate. The mix of ancillary services included or distinct from the per diem cost may be different at each hospital.

RETROSPECTIVE SETTLEMENT

This section describes the methodology used for retrospective settlement for state psychiatric hospitals services for Medicaid per diem reimbursement.

Interim settlements are made upon the provider's completion of the Medicare cost report for each fiscal year for each state hospital. Interim settlement is
made by comparing total interim payments to total allowable cost computed from the Medicare cost report. If total allowable cost exceeds total interim payments, additional payment is made to the hospital. If total interim payments exceed total allowable cost, recovery of excess interim payments is made.

Final Settlements are made upon the Medicare intermediary's determination of total allowable Medicare costs. If total allowable cost exceeds total interim payments additional payment is made to the hospital. If total interim payments exceed total allowable cost, recovery of excess interim payments is made. Final settlement will be adjusted for all prior interim settlements and all subsequent adjustments made due to successful appeals to Medicare Intermediary determinations.

DISPROPORTIONATE SHARE PAYMENTS

The Medicaid reimbursement system takes into account hospitals serving a disproportionate number of low-income patients with special needs by making payment adjustments for eligible hospitals.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

STATE PSYCHIATRIC HOSPITALS FOR PATIENTS UNDER 21 AND OVER AGE 65 (cont)

DISPROPORTIONATE SHARE PAYMENTS (cont)

1. A state psychiatric hospital will be deemed eligible for disproportionate share hospital (DSH) payment adjustment if its Medicaid Inpatient day utilization is at least one percent and if:

   a. The hospital's Medicaid inpatient utilization rate ( as defined by Section 1923 (b)(1)(A)) is at least one standard deviation above the mean state Medicaid inpatient utilization rate; or
   b. The hospital's low-income utilization rate (as defined by Section 1923 (b)(1)(B) exceeds 25 percent.

2. The DSH payment for each qualifying hospital is based on its annual net costs of uncompensated services delivered to uninsured indigent patients determined as follows:

   Annual costs of acute psychiatric and special hospital services, as described above, delivered to uninsured indigent adult, geriatric and forensic patients by each hospital in the most recent state fiscal year are determined by applying aggregate hospital per diem costs to total annual inpatient days attributable to uninsured indigent individuals. Aggregate hospital per diem costs are the quotient of dividing total operating expenses by total inpatient days reported in the Medicare cost report. Identification of uninsured indigent patients is determined from statistical sampling of department records.

   Annual net costs for uncompensated services of the qualifying state psychiatric hospital are the residual of total aggregate annual cost as defined above, reduced by total revenue received from or on behalf of such patients. This revenue is total revenue from all sources, but excluding regular Medicaid revenue, receipts of adjustments and Washington State general fund subsidies.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

STATE PSYCHIATRIC HOSPITALS FOR PATIENTS UNDER 21 AND OVER AGE 65 (cont)

DISPROPORTIONATE SHARE PAYMENTS (cont)

3. The DSH payment adjustments shall be made as described below:

a. An initial payment will be made during the second quarter of each Federal Fiscal year at 95 percent of the cost of net uncompensated services to uninsured indigent patients as defined in 2 above for the state fiscal year which ended prior to the beginning of the FFY.

b. The final payment will be made within 120 days after the end of the FFY, and will be the lessor of the residual of costs of uncompensated services delivered after subtraction of the initial payment, or;

c. The residual of the remaining balance in the Federal limit for payment adjustments to institutions for mental diseases (IMD's) for the fiscal year, after subtracting the initial installment payments paid under "a" above. In the event the final installment adjustment payment is limited by the federal IMD limit, the payment will be apportioned between the facilities based on the ratio of the facilities' initial installment payment.

JCAHO-ACCREDITED PSYCHIATRIC SERVICES FOR CHILDREN AND ADOLESCENTS AGE 17 AND UNDER

INTRODUCTION

This section applies to the Washington State Child Study and Treatment Center (CSTC), a psychiatric hospital providing inpatient and day treatment services for children/adolescents age 17 and under. The hospital is accredited by JCAHO to provide inpatient psychiatric hospital and day treatment psychiatric services.

This hospital operates in conjunction with a full time school located at the hospital. School costs are not included in the hospital reimbursement.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

JCAHO-ACCREDITED PSYCHIATRIC SERVICES FOR CHILDREN AND ADOLESCENTS AGE 17 AND UNDER (cont)

RATE SETTING – CHILD STUDY AND TREATMENT CENTER

Annually, the division will establish a prospective Medicaid per diem rate for CSTC. The rate is all inclusive of routine, physician and ancillary costs for inpatient psychiatric services.

Payments are made to CSTC based on charges to the general public for services delivered by CSTC. Recipient patient participation identified at eligibility determination is subtracted from aggregate monthly hospital charges and the reduced sum is paid to the provider.

PER DIEM

Computation of per diem payment rates for CSTC hospitals require the collection and preparation of the following data elements:

A. First ten months of the current fiscal years expenditures for each hospital reported in the State's financial records. The first ten months expenditures are annualized to form the base line hospital costs. A spreadsheet is developed to cross walk the hospital cost centers from the state accounting records to the cost centers used to calculate the annual Medicare cost report.

B. The baseline expenditure level is adjusted, based on the State's appropriated budget ensuing fiscal year. Add on adjustments are:

1. Salaries and Benefits increase as appropriated by the State's legislators.

2. All costs used to set the hospitals' room and board rates will be adjusted for economic trends and conditions. Those costs specifically addressed in the biennial appropriations act will be adjusted by the factor or factors used to set allotments. Costs not addressed in the biennial appropriations act will be adjusted by the most current annual unadjusted percent change in the Consumer Price Index for All Urban Consumers (CPI-U) as published by the United States Department of Labor, Bureau of Labor and Statistics. CPI-U will be applied to costs by

Back to TOC

**PART II – METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS FOR PSYCHIATRIC INPATIENT SERVICES PROVIDED IN HOSPITALS OPERATED BY THE STATE OF WASHINGTON (cont)**

JCAHO-ACCREDITED PSYCHIATRIC SERVICES FOR CHILDREN AND ADOLESCENTS AGE 17 AND UNDER (cont)

PER DIEM (cont)

the appropriate expenditure category, commodity or service group factor. http://stats.bls.gov/news.release/cpi.t01.htm

- Some cost center maybe adjusted above the general inflation factor based on consistently higher inflation indicators (i.e., Medical, pharmacy and utility costs).

3. Budgeted legislative changes for pension rate, L&I rate, workers compensation, social security, work load changes, program changes, and other legislative adjustments.
4. The department accounting records provide capital depreciation, interest expenditure data and moveable equipment depreciation, which are added to the baseline work sheet. The adjusted baseline expenditure level is entered into the prior years Medicare cost report (HCFA 2552-96) software. The Medicare cost report worksheets A-6, reclassifications, A-8, adjustment to expenditures, A-8-1, related organization including department wide cost allocations (home office cost), A-8-2, provider based physician adjustment and B-1, cost allocation-statistical basis are all updated with the most current data available. If current data is not available the statistics are used from the prior years Medicare cost report.

C. The hospital patient census for the first ten months of the current fiscal year is annualized.

The cost report is calculated. The appropriate program cost center is divided by the patient census related to the program to arrive at the per diem rate.

COST SETTLEMENT

Rates established are prospective; no settlement is made for Medicaid payments.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN**

**Purpose**: Using statistical means described in this sampling plan the Mental Health Division (MHD) will measure the net uncompensated costs of services delivered to uninsured indigent patients of state owned psychiatric hospitals. The resulting value will be paid as Medicaid Disproportionate Share Hospital payments to the hospitals.

**Sampling Theory:** Variables Estimation Sampling as implemented with computer software devised by U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services. This software is named "RAT-STATS."

A thorough discussion of Variables Estimation Sampling is found in Sampling Methods for Auditors, an Advanced Treatment; by Herbert Arkin 1982, McGraw-Hill.

**Definitions**

*Institutions of Universe:*
Eastern and Western-State Hospitals are the topic of the sampled universe and will be treated as individual estimation entities under this sampling plan.

*Potentially Uninsured Patients (PUP):*
PUP are all patients in the psychiatric hospitals between the ages of 21 and 65. Patients in other age groups are considered to be potentially insured through operation of the federal medical programs of Medicare and Medicaid.

*Sample period:*
Each fiscal year beginning on July 1 and ending on the subsequent June 30 of the following year is a separate sample period.

*Sample unit:*
Each separate psychiatric hospital inpatient day of PUP is the sample unit. The sample unit is abbreviated as PUPD. The cost of each PUPD is the per diem computed by dividing total days into total costs. The net cost of a PUPD is the per diem minus all revenue attributable to that day.

*Hospital stay:*
All the PUPD are confined within PUP hospital stays. A hospital stay is defined as one or more consecutive inpatient days (count day of admission but not day of release). The stay begins with the first day of the fiscal year if the patient was in residence on the last day of the prior fiscal year, or it begins with the first day the patient becomes age 22 if the patient was in residence on the last day they were age 21 or it begins with the day of admission.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN (cont.)**

Definitions (cont.)

The stay ends with the last day of the fiscal year if the patient was in residence on the first day of the following fiscal year, or it ends with the last day the patient was aged 64 if they were in residence on the first day they became aged 65, or it ends when the patient is released for any reason and is not in residence at the midnight census.

*Sample Population (also Sample Universe):*
The sample universe or population is the total of PUPDs in each hospital for a fiscal year.

*Population Array:*
The purpose of the population array is to arrange the universe in such a fashion that any natural biases are removed. To this end the array will be fashioned in a two-step process. In step one, each PUP stay will be arranged in an ascending hierarchy by three orders of sort. The first sort level will be the PUP stay date of admission for the stay, the next sort criteria will be the date of release (if patient still in residence when population is identified the date of computer run will be last day for array purposes), and the final sort will the alphabetical sort of PUP names. In the second step, each day in each stay beginning with the first day of the first stay arranged in step 1 and ending with the last day of the last stay will be assigned a consecutive population number, beginning with number 1. As test of accuracy the total days in the stays listed in step 1 will be compared to the final population day consecutive number in step 2. They should be the same.

*Sample Selection:*
Samples will be selected randomly with FIAT-STATS random number generator.

*Sample size:*
Samples will be selected to a 95% confidence level with RAT-STATS.

*Countable revenue:*
Countable revenue will be all revenue received from or on behalf of each PUPD. In event revenue is received that is not identified to specific days, it will be prorated by the number of days in the stay. If payments are encountered that cover more than one stay it will be prorated over the days reported in the payment document.

**Sampling Process:**

The universe will be devised with computer capabilities from MHD database of all PUP having hospital stays in each hospital. The universe will be arrayed and numbered with sample numbers as described in definitions above. RAT-STATS random number generator will be used to select 500 samples.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN (cont.)**

Sampling Process (cont.)

A pre-sample will be the first 50 random selections. The pre-sample will be reviewed for PUPD net uncompensated costs as defined below and is results will be processed through RAT-STATS to compute a standard deviation. The pre-sample standard deviation will be used in RAT-STATS to identify a sample size at the 95o confidence level. Additional samples will be selected from the 500 random samples in sequential order from the pre-sample end point to be added to the pre-sample to reach the computed 95% sample size. The added samples will be reviewed as described below. Each sample will show:

| | | | |
|---|---|---|---|
| a. | Sample number | b. | Sample service date (sample unit) |
| c. | Patient record number | d. | Patient name |
| e. | Admission date | f. | Release date |
| g. | Stay from date | h. | Stay to date |
| i. | Days of stay | | |

**Review process:**

All selected samples will be reviewed for patient revenue by OFR and revenue will be reported for each sampled PUPD as either i. insurance proceeds or ii. all other revenue.

**Estimation computation:**

Costs for each selected sample unit (PUPD) will be the per diem for the hospital attributable to the reimbursement year. The total countable revenue for each PUPD will be subtracted from the per diem to compute net uncompensated costs of each PUPD.

The net uncompensated costs of all sampled PUPDs will be accumulated and divided by the total units or the sample to compute the mean PUPD sample value of net uncompensated costs of services to uninsured patients. The mean hospital PUPD sample value will be multiplied by the grand total of PUPD in the universe to compute mid-point of the estimation range.

**Estimation evaluation:**

The detail of estimation computation will be examined by RAT-STATS to compute upper and lower estimation amounts at the 95% confidence level. If the resulting estimation precision is greater than 10% of the mid-point, additional samples will be selected and reviewed in 25% increments of the 95% confidence level sample size until the original sample size has been doubled. If at that point, the estimation precision remains above 10%, the mid-point of the estimate will become the final value for purposes of the goal.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**DISPROPORTIONATE SHARE HOSPITAL PAYMENTS - STATE PSYCHIATRIC HOSPITALS, STATISTICAL SAMPLING PLAN (cont.)**

Estimation Evaluation (cont.)

The net costs of uncompensated services delivered to uninsured patients at Western State Hospital (WSH) is predicted to be $75 million and Eastern State Hospital (ESH) is assumed to be about 1/3 of Western's value.

Both hospitals have average occupancy of over 90%.

The average length of stay in each hospital will be over 90 days.

WSH is predicted to have about 150,000 PUPDs (sample units) and ESH is predicted to have 65000 PUPDs.

ESH and WSH are separate Medicaid providers, with different per diem rates, necessitating separate sample entities.

The federal Medicaid DSH allotment for F/Y 95 will be low enough that the 200% transition factor will cause costs to exceed the limit, thus some of the transition costs and sample estimation at midpoint will not be needed to achieve the federal ceiling.

Patients in rare cases receive large payments (tort recoveries, retroactive insurance payments, estate settlements, etc.) that will exceed the cost of the stay being sampled. The value above 100% of the costs of the sample PUPD will be assumed to belong to stays and days outside the sample and excluded from the estimation computations.

Crude estimates predict that about 60% of PUP have no insurance or other resources, about 30% of the PUP have minor insurance coverage, about 2% have significant insurance resources, and the remainder require review of patient documentation on an individual basis to determine insurance status.

The federal medical programs of Medicare and Medicaid operate to fully cover costs of patients eligible for both. Patients eligible for only Medicare will be fully insured to the extent that they have not reached a spell of illness limit or lifetime inpatient psychiatric limits. Most Medicare only patients have achieved one of these limits due to the nature of their illness as reflected in the extended average length of stay.

If the PUPD revenue records are reviewed 6 months or more after the end of the sample period, it can be assumed that no significant revenue receivables exist, and that no significant revenue reversals remain unprocessed.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN.**

I. General

1. The state Medicaid agency, the Health Care Authority (the agency), will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus cost of materials.

2. The agency maintains data indicating the allowed charges for claims made by providers. Such data will be made available to the Secretary of Health and Human Services upon request.

3. Payment methods are identified in the various sections of Attachment 4.19-B, and are established and designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population. Payment for extraordinary items or services under exception to policy is based upon agency approval and determination of medical necessity.

4. Participation in the program is limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee structure.

5. State payment will not exceed upper limits as described in regulations found in 42 CFR 447.300 through 447.371. Any increase in a payment structure that applies to individual practitioner services is documented in accordance with the requirements of 42.CFR 447.203.

6. Providers, including public and private practitioners, are paid the same rate for the same service, except when otherwise specified in the State Plan.

7. Agency fee schedules are published on the agency's website at http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx

8. In the case of a governor-declared state of emergency and when the agency determines it is appropriate, the agency may cover professional services provided via telephone services and/or online digital evaluation and management services at the same rates for professional services provided face-to-face or via telemedicine, to support the delivery of health care services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

II. Clinic Services

A. Unless otherwise specified in this section, Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state.
Specialized clinics are reimbursed only for services the clinic is approved to provide.

B. Unless otherwise specified in this section, Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state. Specialized clinics are reimbursed only for services the clinic is approved to provide.

Dialysis Services: Reimbursement for Hemodialysis, Intermittent Peritoneal Dialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cycling Peritoneal Dialysis (CCPD) is provided under a statewide composite rate. The composite rate includes all standard equipment, supplies, and services necessary for dialysis. Drugs covered on the Kidney Center Services fee schedule are paid according to Medicare's Average Sales Price (ASP) methodology. Payment limits on the drugs are updated quarterly based on the ASP pricing file located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html?redirect=/McrPartBDrugAvgSalesPrice/.

See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

Dialysis services provided by freestanding facilities are clinic services and are reimbursed according to the provisions of 42 CFR 447.321.

C. Rural Health Clinics

Effective January 1, 2001, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under BIPA 2000, all RHCs that provide services on or after January 1, 2001 and each succeeding year are reimbursed on a prospective payment system (PPS) or an accepted alternative methodology.

BIPA 2000 allows for payment to an RHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the clinic that is at least equal to the PPS payment rate.

This alternative methodology must be agreed to by the State and the RHC, and documentation of each clinic's agreement must be kept on file by the State. If an individual RHC does not agree to be reimbursed under this alternative methodology, the RHC will be paid under the BIPA PPS methodology.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)**

II. Clinic services (cont.)

Effective January 1, 2001, through December 31, 2008, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 1902(bb) of the Social Security Act (SSA). As set forth in Section 1902(bb)(2) and (3), all RHCs that provide services on January 1, 2001 and through December 31, 2008 are reimbursed on a prospective payment system (PPS). The first reconciliation was for payments made in calendar year 2009 and was done starting in calendar year 2010. Thereafter, a reconciliation will be done for each calendar year in the following calendar year.

Effective January 1, 2009, fee-for-service (FFS) and managed care organization (MCO) payments to RHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. Those RHCs that do not choose the APM will continue to be paid under the PPS.

For the period beginning January 1, 2009, the PPS and APM will utilize the clinics' base encounter rates, using the PPS methodology in place at the time. The base rates were calculated as illustrated by the following formula:

$$\frac{(1999\ \text{Rate} * 1999\ \text{Encounters}) + (2000\ \text{Rate} * 2000\ \text{Encounters})}{(1999\ \text{Encounters} + 2000\ \text{Encounters})}$$

For clinics receiving their initial RHC designation after 2001, their base rates were established using the first available Medicare-audited cost report.

Effective January 1, 2009, and each January 1 thereafter, PPS rates will be increased by the percentage change in the Medicare Economic Index (MEI) for that period.

Effective January 1, 2009, and each January 1 thereafter, APM rates will be increased by a Washington-specific health care index developed by IHS Global Insight. To ensure that the APM pays an amount at least equal to the PPS, the greater of the Washington-specific index or the MEI will be used. The greater of the Washington-specific index or the MEI will also be applied retroactively to the clinics' base encounter rates.

For services provided on and after July 7, 2011, each center will have the choice of receiving either (1) its PPS rate, as determined under the method described above or (2) a rate determined under a revised APM. The revised APM will be as follows: for centers that rebased their rate effective January 1, 2010, their 2008 allowed cost per visit inflated by the cumulative percentage increase in the MEI between 2009 and 2011. For centers that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year to the extent the 2002 rate was updated to account for the addition of a new site or type of service) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2009 through 2011. The rates will be inflated by MEI effective January 1, 2012 and each January 1 thereafter. The State will compare each year's APM rate to the rate that would have been paid under PPS to ensur the APM payments are at least equal to the payments that would have been made under PPS.

The State will periodically rebase the RHC encounter rates using the RHC cost reports and other relevant data. Rebasing will be done only for clinics that chose the APM.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)**

II. Clinic Services (cont.)

RHCs receiving their initial designation after January 1, 2001, are paid an average encounter rate of other clinics located in the same or adjacent area with a similar case load, on an interim basis until the clinic's first Medicare-audited cost report is available.

Once the audited report for the clinic's first year is available, the new clinic's encounter rate is set at 100 percent of its costs as defined in the cost report. The new RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available, and will receive annual increases thereafter consistent with the payment methodology (PPS or APM) chosen by the clinic.

An adjustment will be made to a clinic's encounter rate if the clinic can show that it has experienced a valid change in scope of service.

An RHC may file a change in scope of services rate adjustment application only when:

- The cost to the RHC of providing covered healthcare services to eligible clients has increased or decreased due to change in the type, intensity (total quantity of labor and materials consumed by an individual client during an average encounter), duration (length of an average encounter), and/or amount of services; and
- The cost change equals or exceeds an increase of 1.75% in the rate per encounter over one year; a decrease of 2.5% in the rate per encounter over one year; or a cumulative increase or decrease of 5% in the rate per encounter as compared to the current year's cost per encounter; and
- The costs reported to the State to support the proposed change in scope rate adjustment are reasonable under OMB circular A-122 or its successor and other applicable state and federal law; and
- The service meets the definition of RHC service as defined in section 1905(a)(2)(B) of the Social Security Act; and
- The service is included as a covered Medicaid service as described in the State Plan.

An RHC may apply for a prospective or retrospective change in scope rate adjustment.

For prospective change in scope, an RHC submits projected costs sufficient to establish an interim rate. Once the clinic can demonstrate its true costs of providing the services, it must submit required documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary and adjust the interim rate by the final rate within 90 days of receiving complete information from the clinic. The final rate will take effect on the date the State issues the adjustment.

For retrospective change in scope, an RHC submits actual data of twelve months documenting the cost change caused by the qualifying event. A retrospective change in scope is a change that took place in the past and the RHC is seeking to adjust its rate based on that change. If approved, a retrospective rate adjustment takes effect on the date the RHC filed the application with the State. The State will notify the clinic of a decision within 90 days of receiving completed application.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)**

II. Clinic Services (cont.)

For clients enrolled with a managed care contractor, and effective April 1, 2014, the State anticipates that the managed care contractor will pay each clinic an encounter rate that is at least equal to the PPS rate specific to each clinic.

To ensure that the appropriate amounts are being paid to each clinic, the State will perform an analysis of the managed care contractor's data at least quarterly and verify that the payments made by the managed care contractor in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to clinics reimbursed under the APM rate methodology and to clinics reimbursed under the PPS rate methodology.

At no time will a managed care organization be at risk for or have any claim to the supplemental payment portion of the rate which will be reconciled to ensure accurate payment of the obligated funds.

Covered services for Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

Encounters are limited to one per client per day, except when:

- The client needs to be seen by different practitioners with different specialities; or
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

D. Non-hospital-owned Freestanding Ambulatory Surgery Centers

Freestanding ambulatory surgery centers (ASCs) are reimbursed in a manner similar to Medicare's ASC reimbursement model in effect prior to January 1, 2008. All ASC procedure codes are fit into one of nine payment groups, with each group having its own payment rate. New procedure codes are associated with the appropriate payment group based on their weights, which are set by CMS under its payment methodology in effect from January 1, 2008, forward. Any new procedure code is put into the payment group containing weights with which it is most similar. The agency pays for the first billed procedure code at 100%, the second at 50% and the third and subsequent procedure codes at zero.

Implantable devices are paid separately. For devices, the ASC bills the agency the amount the facility paid for the device, based on a manufacturer's invoice. The agency pays the invoiced amount.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The agency's rates were set as of October 1, 2022, and are effective for dates of services on and after that date.

See 4.19-B I, General #G, for the agency's website where the fee schedules are published.

Back to TOC

III. Physician Services

A. Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under WAC 182-531-1850, the agency uses CMS-established relative value units (RVU) multiplied by both the Geographic Practice Cost Indices (GPCI) for Washington State (supplied by the Federal Register) and the conversion factors specific to Washington. The agency's conversion factor that is annually adjusted based on utilization and budget neutrality from year-to-year. For the current conversion factor, and further description, see Supplement 3 to Attachment 4.19-B.

B. When no MFSDB RVU exists, some of the codes are reimbursed using flat fee (based upon market value, other state's fees, budget impacts, etc.), acquisition cost (the cost of the actual item being billed), Medicare Laboratory Fee Schedule, ASP (106% of ASP), and/or Point of Sale (POS) actual acquisition cost (AAC).

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of physician services. See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

III. Physician Services (continued)

D. Trauma Center Physician Services - Trauma Centers are designated by the State of Washington Department of Health (DOH).

Trauma center physician services are paid 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. Currently, the fund is providing reimbursements at an increased percentage of the base Medicaid rate for physician services provided under fee-for-service to trauma patients with an Injury Severity Score (ISS) that meets or exceeds the threshold set by the department. The additional payment is paid as the claim for the case is paid, and is not a lump-sum supplemental payment. The percentage enhancement is reviewed and adjusted annually based on the amount of trauma care funds available and the volume of trauma cases eligible for the higher reimbursement.

E. Out-of-State Physician-related Care.

For medically necessary treatment of emergencies that occur while a client is out-of-state, DSHS pays the lesser of the usual and customary charge or a fee based on a published department fee schedule.

For physician related services in those instances when DSHS makes referrals to out-of-state hospitals, after MAA's Medical Director or designee approved an Exception to Rule for the care not available instate:

1. In absence of a contract, DSHS pays the lesser of the usual and customary charge or a fee based on a published department fee schedule.

2. When DSHS is successful negotiating a contract for such services, the services are paid using a negotiated contract rate. DSHS first negotiates for the rate mentioned above, then for the lesser of the usual or customary charge or the other state's Medicaid or Medicare rate, and finally for the best rate possible beyond the other tiers.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

III. Physicians Services (continued)

F. Critical Care

1. More than one physician may be reimbursed if the services are distinctly separate services (i.e., involve multiple organ systems (unrelated diagnosis)).

2. In the emergency room, only one physician is reimbursed.

3. For inpatient critical care, only the attending physician(s) who assume(s) responsibility for care of the client during a life-threatening episode is/are reimbursed.

4. Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under WAC 182-531-1850, the agency uses CMS-established relative value units (RVU) multiplied by both the Geographic Practice Cost Indices (GPCI) for Washington State (supplied by the Federal Register) and the conversion factors specific to Washington. The agency's conversion factor that is annually adjusted based on utilization and budget neutrality from year-to-year. For the current conversion factor, and further description, see Supplement 3 to Attachment 4.19-B.

5. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of critical care services.

G. Early Elective Deliveries

1. An early elective delivery is any non-medically necessary induction or cesarean section before 39 weeks of gestation. 39 weeks of gestation is greater than 38 weeks and 6 days.
2. Effective for dates of admission on and after January 1, 2016, the state does not pay for an early elective delivery unless it is medically necessary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES.**

III. Physician Services (cont)

H. Pediatric Vaccine Administration and Evaluation and Management

The Medicaid agency pays an enhanced rate for pediatric vaccine administration codes and evaluation and management (E&M) codes for services provided on and after October 1, 2018, for clients age 18 and younger. The agency determines the base rates according to the RBRVS methodology described in Supplement 3 to Attachment 4.19-B. The enhanced rate is a calculated flat percentage increase over the base rates and is subject to funding appropriated by the state legislature. See 4.19-B.I. General, #G, for the agency's website where the fee schedules are published.

I. Enhanced payments for Medication for Opioid Use Disorder (MOUD) (formerly lnown as Medication Assisted Treatment (MAT))

1. Effective October 1, 2018, the Medicaid agency pays an enhanced rate to qualified providers for selected evaluation and management (E/M) codes when Medication for Opioid Use Disorder (MOUD) is part of the visit. The enhanced rate is the Medicare rate for the selected codes.
2. The agency does not pay the enhanced rate when the service is billed on the same date as a separately billable opioid treatment billed by any Opioid Treatment Program licensed by the Department of Health.
3. The agency pays one enhanced payment per day per client.

J. Adult Evaluation and Management

The Medicaid agency pays an enhanced rate for adult vaccine administration codes and evaluation and management (E&M) codes for services provided on and after October 1, 2021, for clients age 19 and above. The agency determines the base rates according to the RBRVS methodology described in Supplement 3 to Attachment 4.19-B. The enhanced rate is a calculated flat percentage increase over the base rates and is subject to funding appropriated by the state legislature. See 4.19-B.I. General, #G, for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

IV. Pharmacy Services

A. General Information:

1. The department reimburses only for prescription drugs provided by manufacturers that have a signed drug rebate agreement with the Department of Health and Human Services (HHS).

   Prescriptions for drugs may be filled and refilled at the discretion of the prescriber. For those drugs specified by the department, prior approval is required.

2. Payment for drugs purchased in bulk by a public agency is made in accordance with governmental statutes and regulations governing such purchases.

3. Each Medical Assistance client is granted the freedom to choose his or her source of medications, except when the client is covered under a managed care plan that includes the drug benefit.

Back to TOC

IV. Pharmacy Services (cont.)

B. General Information

1. Total reimbursement for a covered outpatient drug does not exceed the lesser of actual acquisition cost (AAC), plus a professional dispensing fee or the provider's usual and customary charge. The AAC is calculated as the lowest of:

   a. National Average Drug Acquisition Cost (NADAC);
   b. Maximum allowable cost (MAC);
   c. Federal Upper Limit (FUL); or
   d. The provider's usual and customary (U&C) charge to the non-Medicaid population.

   e. Where NADAC does not exist, Wholesale Acquisition Cost (WAC) or an established MAC will be used as the basis for the reimbursement.

   f. When requested by a provider, and with submittal of proof of invoice cost, the Agency may adjust a provider claim in order to cover the provider's actual acquisition cost (AAC). The provider is requested to contact the NADAC Help Desk to contribute their cost information to the NADAC survey.

2. The Agency reimburses specialty drugs in accordance with the methodology listed in Section (B)(1).

3. The Agency reimburses nominally priced drugs at the provider's actual acquisition cost (AAC), plus a professional dispensing fee.

4. The Agency reimburses drugs dispensed by the Indian Health Services (IHS), which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or III of the Indian Self Determination and Education Assistance Act, to an IHS-eligible Medicaid beneficiary at the outpatient per visit encounter rate published in the Federal Register, plus a professional dispensing fee.

5. The Agency reimburses drugs purchased through the Federal Supply Schedule (FSS) at the provider's actual acquisition cost, plus a professional dispensing fee, unless the provider is paid via an encounter rate.

6. The Agency reimburses for 340B discounted drugs at the provider's 340B actual acquisition cost, plus a professional dispensing fee, and only when the billing provider is a federally qualified PHS-entity billing with a National Provider Identifier (NPI) or National Council for Prescription Drug Programs (NCPDP) number listed on the Office of Pharmacy Affairs national Medicaid exclusion file.

7. The Agency does not cover 340B discounted drugs dispensed by contract pharmacies.

8. The Agency does not cover investigational drugs. Investigational drugs are not a covered service under Washington's Medicaid pharmacy program.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

IV. Pharmacy Services (cont.)

C. Professional Dispensing Fees

1. The Agency sets pharmacy professional dispensing fees based on periodic review and examination of market research and other reliable data. The research and data must be sufficient to establish the adequacy of ingredient cost reimbursement and professional dispensing fees, independently and in the aggregate.

2. The current professional dispensing fee payment system is multi-tiered. The professional dispensing fee paid to a pharmacy depends upon that pharmacy's total annual prescription volume (both Medicaid and non-Medicaid), as reported to the Agency on the annual prescription count survey distributed to pharmacies.
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3. Pharmacies providing unit dose delivery service are paid the Agency's highest allowable professional dispensing fee for unit dose prescriptions dispensed. All other prescriptions filled by these pharmacies are paid at the professional dispensing fee level applicable to their annual prescription volume.

4. A professional dispensing fee is paid for each ingredient in a compound prescription.

5. Listed below are the professional dispensing fees paid to pharmacies for each drug ingredient in compounded and non-compounded prescriptions.

- High-volume pharmacies (over 35,000 Rxs/yr) $4.24/Rx
- Mid-volume pharmacies (15,001-35,000 Rxs/yr) $4.56/Rx
- Low volume pharmacies (15,000 Rxs/yr and under) $5.25/Rx
- Unit Dose Systems $5.25/Rx

D. Reimbursement for Other Pharmacy Services

1. The Agency reimburses drugs administered in the provider's office, and billed using the drug-specific HCPCS code and the product-specific NDC, at the rates showing on Medicare's drug pricing files (ASP plus 6 percent). Exceptions to this methodology:

   a. Drugs without published ASP rates are paid at a fee equal to the POS rate at the beginning of the most recent calendar quarter. The POS rate is calculated by the methodology listed under A above (NADAC, MAC, FUL, U&C).
   b. Drugs without assigned HCPCS are paid at the POS rate or based on submitted invoice cost; whichever is less.
   c. Anti-hemophilia drugs are paid based on Medicare's drug pricing file without the clotting factor furnishing fee or based on submitted invoice cost.
   d. Contraceptive drugs dispensed from family planning clinics are paid at an Agency researched MAC rate.
   e. Contraceptive drugs dispensed from family planning clinics participating with Medicaid in the 340B drug program are reimbursed at 340B AAC. A 340B family planning dispensing fee, based on a 340B shared-savings model, is paid when contraceptive pills, patches, rings or emergency contraception products are dispensed from the participating 340B family planning clinics

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

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**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN**

V. Medically Necessary Durable Medical Equipment and Supplies, and Medically Necessary Non-Durable Medical Equipment and Supplies

Qualified providers are paid for covered medically necessary durable medical equipment and supplies (DME) and medically necessary non-durable medical equipment and supplies (Non-DME), repairs, and related services provided to eligible clients. The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule.

Effective January 1, 2018, DME equipment codes subject to the FFP limitation are reimbursed at the lesser of Medicare's prevailing payment rates in the DMEPOS Fee Schedule or Competitive Bid Area (CBA) rate. For power wheelchairs (K0813 through K0864), the purchase rate is determined by the Medicare rental rate divided by 0.15. For all other items where Medicare provides a rental rate but the agency only covers purchase, the rate is determined by taking the Medicare rental rate multiplied by 10.

For all other items, the agency may use the CMS DMEPOS Fee Schedule, flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

Certain healthcare services which include treatment, equipment, related supplies, and drugs require prior authorization (PA) as a precondition for provider reimbursement. The agency evaluates a request for an authorization of a health care service on a case-by-case basis. Providers must obtain prior authorization (PA) when required before delivering the item to the client. The item must be delivered to the client before the provider bills the agency.

Items not included on the state fee schedule are not covered. Requests for non-covered items will be reviewed according to the agency's "Exception to Rule" process.

The agency does not pay DME providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

The agency's reimbursement for covered DME includes any adjustments or modifications to the equipment that are required within three months of the date of delivery (not to include adjustments related to a change in the client's medical condition), fitting and set-up, and instruction to the client or client's caregiver in the appropriate use of the equipment and/or supplies.

See 4.19-B, I, General #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)**

VI. Dental Services and Dentures

A. The Medicaid agency pays directly to the specific provider the lesser of the usual and customary charge or a fee based on an agency fee schedule for dentures and dental services that are provided within their specific scope of practice by dentists, dental hygienists, and denturists throughout the state. There are no geographical or other variations in the fee schedule.

B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, or denturist to private patients (e.g., that provider's usual fee) and which fee is within the range of usual fees charged by dentists, dental hygienists, or denturists of similar training and experience.

C. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of dentures, dental services and dental hygiene.

See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

The agency's fee schedule rate was set as of January 1, 2023, and is effective for services provided on or after that date.

D. Under the Oral Health Connections pilot program, eligible dental providers are paid an enhanced rate to provide up to three additional periodontal treatments (for a total of four) per calendar year to adult Medicaid clients who have diabetes or who are pregnant. The Oral Health Connections pilot program is effective for dates of service on or after January 1, 2019.

E. Eligible dental providers are paid an enhanced rate to provide additional dental services to eligible clients age 5 and under as described in Attachment 3.1-A and 3.1-B section 10.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

**POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont)**

VII. Optometrists Services (Vision Care Services and Eyeglasses)

A. Ophthalmologists, optometrists, and opticians

Ophthalmologists, optometrists, and opticians are authorized to provide vision care services within their scope of practice.

The agencypays the lesser of the usual and customary charge or a fee based on an agencyfee schedule for authorized medically necessary vision care services.

The fees for the codes under Vision Care Services are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the agency uses CMS-established relative value units (RVUs) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factor, service descriptions, and their effective dates are found in Supplement 3 to Attachment 4.19-B.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

B. Frames, lenses and contact lenses

Frames, lenses and contact lenses must be ordered from the agency's contractor.

The amount paid for authorized medically necessary frames, lenses and contact lenses is the agency's contracted price with the contractor.

Competitive bid: Frames, lenses, and contact lens services are based on a contract price established through competitive bidding in accordance with section 1915(a)(1)(B) of the Act and regulations at 42 CFR 431.54(d).

Reimbursement rates are based on cost plus mark-up negotiated with the contractor. The rates are included in the contract. The contract is published on the state's contracts website at
https://fortress.wa.gov/ga/apps/ContractSearch/ContractSummary.aspx?c=12303

Back to TOC

VIII. Institutional Services

A. Outpatient hospital services

**Outpatient Prospective Payment System (OPPS)**

Duplicate payment for services does not occur. Non-Critical Access Hospital (CAH) outpatient hospital services are reimbursed using the Medicaid agency's Outpatient Prospective Payment System (OPPS). Under OPPS, services are reimbursed using one of the following payment methods:

1. Payment Grouping
   a. Ambulatory Patient Classifications
   b. Enhanced Ambulatory Patient Groups
   c. Supplemental Payments
2. Fee schedule
3. Hospital Outpatient Rate

1. Payment Grouping
   a. For dates of service prior to July 1, 2014, the agency uses the Ambulatory Patient Classifications (APC) to classify OPPS services.

      Effective for dates of service on or after July 1, 2013, payments for services reimbursed using the APC method at Prospective Payment System hospitals (as defined in Attachment 4.19-A, Part 1) will decrease by twenty-four and fifty-five hundredths percent (24.55%) from the rates that were established for dates of admission on and after July 7, 2011. This adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be four percent (4.00%) lower than the July 1, 2009, rates.

   b. Effective July 1, 2014, the agency uses the Enhanced Ambulatory Patient Groups (EAPG) to classify OPPS services. Under the EAPG system, the reimbursement of outpatient hospital services will include packaging of like services into groups with similar resource use.

      For a significant procedure, the EAPG payment formula is as follows:
      EAPG Relative Weight (RW) multiplied by the Hospital-Specific Conversion Factor multiplied by the Pricing Discount (if applicable) multiplied by the Policy Adjustor (if applicable)

      To pay outpatient services under EAPG, the agency:
      i. Uses the national standard RWs developed by the 3M Corporation for determining relative resource intensity within the EAPG system. The relative weights are changed when grouper versions are changed. The relative weights effective July 1, 2020 are published on the agency's website. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.
      ii. Calculates a conversion factor for each hospital. Each conversion factor is based on a statewide standardized rate. The statewide standardized rate is determined at the time of rebasing as the maximum amount which can be used to ensure that aggregate outpatient reimbursement levels remain consistent. The statewide standardized rate is adjusted by a hospital-specific wage index and medical education component. See 4.19-B, I. General #G for the website where the fee schedules are published.

         The formula for determining a hospital's specific conversion factor is: Statewide Standardized Rate x ((0.6 x WageIndex) + 0.4) / (1 – (DMECost/TotalCost))-

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

iii. Uses the wage index information established and published by the Centers for Medicare and Medicaid Services (CMS) at the time the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.

iv. Calculates the hospital-specific graduate medical education (GME) by dividing the direct GME cost reported on worksheet B, part 1, of the CMS cost report by the adjusted total costs from the CMS cost report.

v. Uses the EAPG software to determine the following discounts:

- Multiple Surgery/Significant Procedure – 50%
- Bilateral Pricing – 150%
- Repeat Ancillary Procedures – 50%
- Terminated Procedures – 50%

vi. Establishes a policy adjustor of 1.35 for services to clients age 17 and under, and establishes a policy adjustor of 1.10 for chemotherapy and combined chemotherapy/pharmacotherapy groups. These policy adjustors are not exclusive.

The statewide standardized conversion factor and all hospital-specific adjustments are effective July 1, 2022. See 4.19-B, I, General, #G for the agency's website where the fee schedule and conversion factors are published.

c. Effective for dates of admission on or after July 1, 2013, supplemental payments will be paid for outpatient Medicaid services not to exceed the upper payment limit as determined by the available federal financial participation for fee-for-service claims. The supplemental payment is based on the distribution amount mandated by the legislature to the following hospital categories as defined in RCW 74.60.010:

- Prospective Payment hospitals other than psychiatric or rehabilitation hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Border hospitals.

For hospitals designated as prospective payment system (PPS) hospitals, $60,000,000 per state fiscal year. For hospitals designated as out-of-state border area hospitals, $500,000 per state fiscal year.

The payment is calculated by applying the Medicaid fee-for-service rates in effect on July 1, 2009, to each hospital's Medicaid and CHIP outpatient fee-for-service claims and Medicaid and CHIP managed care encounter data for the base year as defined in RCW 74.60.010. This sum is divided by the aggregate total of all hospitals within each category to determine the individual hospital pro rata share percentage. The individual hospital payment is the pro rata percentage multiplied by the amount mandated to be distributed by the Legislature within each hospital category.

The payment will be made quarterly, by dividing the total annual disbursement amount by four (4) to calculate the quarterly amount.

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

**Rate enhancement for Sole Community Hospitals**
The agency multiples the in-state hospital's specific EAPG conversion factor by a multiplier if the hospital meets all of the following criteria:

- Be certified by CMS as a sole community hospital as of January 1, 2013
- Have a level III adult trauma service designation from the Washington State Department of Health as of January 1, 2014
- Have less than one hundred fifty acute care licensed beds in fiscal year 2011
- Be owned and operated by the state or a political subdivision

As of July 1, 2021, an additional increase may be applied for hospitals that accept single bed certifications.

| **Enhancement Multipliers** | | | | |
|---|---|---|---|---|
| **Hospital category** | **Effective Dates** | | | |
| | 7/1/2015–6/30/2018 | 7/1/2018–6/30/2021 | 7/1/2021–6/30/2022 | 7/1/2022–6/30/2023 |
| Sole Community Hospital | 1.25 | 1.5 | 1.0 | 1.25 |
| Sole Community Hospital accepting single bed certification | NA | NA | 1.5 | 1.5 |

**Rate enhancement for low volume, small rural hospitals**

Effective October 2, 2020, through June 30, 2021, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.50 if the hospital meets all of the following criteria:

(a) Has less than seventy (70) available acute care beds, as reported in the hospitals 2018 DOH year-end report;

(b) Is not currently designated as a critical access hospital;

(c) Does not meet the current federal eligibility requirements for designation as a critical access hospital;

(d) Is not participating in the full cost payment through certified public expenditures CPE) program; and

(e) Has combined Medicare and Medicaid inpatient days greater that eighty (80) percent of total days as reported in the hospital's 2018 cost report.

Effective July 1, 2021, the agency will revert to the payment level and methodology for low volume, small rural hospitals' that was in place as of September 30, 2020.

Back to TOC

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

2. Fee Schedule

For non-CAH hospitals and covered services not paid using the OPPS or the “hospital outpatient rate”, the agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for covered procedures.

Services paid using the agency’s fee schedule include, but are not limited to, physical therapy, occupational therapy, speech/language therapy, corneal transplants, and other hospital services as identified and published by the agency.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency’s outpatient fee schedule is effective for services provided on and after July 1, 2022. The fee schedule is updated quarterly in a budget neutral manner. See 4.19-B, I, General, #G for the agency’s website where the fee schedules are published.

Back to TOC

A. Outpatient hospital services (cont)

3. Hospital Outpatient Rate

The “hospital outpatient rate” is a hospital-specific rate having as its base the hospital’s inpatient ratio of costs-to-charges (RCC) adjusted by an outpatient adjustment factor that factors annual cost and charge level changes into the rate. The “hospital outpatient rate” is used to reimburse under OPPS as explained earlier in this subsection, or for non-CAH hospitals exempt from the agency’s OPPS, for all other covered outpatient services (those not mentioned in the previous paragraphs as covered by fee schedule) on the hospital’s outpatient claim.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency’s outpatient fee schedule is effective for services provided on and after January 1, 2023. See 4.19-B, I, General, #G for the agency’s website where the fee schedules are published.

VIII. Institutional Services (cont.)

**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 1, the highest level of trauma care, through Level V, the most basic trauma care.

Level of designation is determined by specific 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 hospitals for care to Medicaid trauma patients.

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

The trauma care fund provides additional reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly. The supplemental payment each designated trauma hospital receives is proportional to the hospital's percentage share of the value of qualifying trauma care services provided to Medicaid clients by all Level I, II, and III trauma centers for the service year to date. Effective July 1, 2013, the supplemental payments proportion will be calculated using the aggregate trauma care cases provided in both fee for service and managed care. Payments for outpatient Medicaid services are not to exceed the upper payment limit for federal financial participation for fee for service.

A trauma case qualifies for supplemental payment if its Injury Severity Score (ISS) meets or exceeds the specified threshold.

Level IV and V trauma centers receive a trauma care grant from the Department of Health using only state funds.

Back to TOC

VIII. Institutionnel Services (cont.)

B. Ambulatory surgery centers that are hospital-owned facilities.

Ambulatory surgery centers (ASC) that are hospital-owned (hospital-based) will be reimbursed as part of the hospital, using the payment methods used to pay hospital outpatient claims.

C. 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.

VIII. Institutional Services (cont.)

D. Critical Access Hospital (CAH) Program

1. Critical Access Hospital (CAH) program means a Title XIX and state inpatient and outpatient hospital reimbursement program through which hospitals approved by the department for the CAH program, that meet the Medicare qualifications for CAH designation, and are approved by the Department of Health as critical access hospitals, are reimbursed by the department for Title XIX and state program services through a cost settlement method.

2. Through this cost settlement payment method, department-approved hospitals participating in the state's Title XIX CAH program receive prospective payment for outpatient hospital services based on an Outpatient Departmental Weighted Cost-to- Charge (ODWCC) ratio.

Post-period cost settlement is then performed for fee-for-service covered services subsequent to the hospital fiscal year (HFY) end, using HFY claims data and data from the CMS 2552 Medicare Cost Report. Settlements are performed using the initially submitted CMS 2552 Medicare Cost Report and the finalized CMS 2552 Medicare Cost Report.

Healthy Options services are reimbursed using rates negotiated between the hospitals and the Healthy Options managed care plans. Healthy Options managed care plans receive premiums from the state that are actuarially developed to cover these payments rates. No cost settlement is performed on Healthy Options services.

E. Medicare-Related Policies for Outpatient Hospital Payments

For payment methods related to the Medicare Part A, Part B, and Part C deductibles, coinsurance, and/or co-pays, please refer to Supplement 1 to Attachment 4.19-B, as updated. Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medicaid. For these clients, the state considers the Medicare Part B Outpatient Hospital payments to be payment in full. The state will pay the Medicare deductible and co-insurance related to a Medicaid clients' Medicare Part B outpatient hospital claim only up to the maximum payment level calculated using the Medicaid "hospital outpatient rate" described in subsection VIII. A. above, and Supplement 1 to Attachment 4.19-B. However, the maximum payment level will exclude any trauma enhanced payment amount.

If the Medicare Part B covered charges and payments are combined with the Medicare Part A inpatient covered charges and payments on a Medicare claim, obscuring the Part B charges and payment amounts, the total Medicaid payment to a Medicaid provider will be calculated as described in Attachment 4.19-A for Medicare crossovers, and Supplement 1 to Attachment 4.19-B, for Medicare Part A services. The total Medicaid payment to a Medicaid provider for Medicare Part C outpatient hospital-related care provided to a Medicaid client will be calculated as described in Supplement 1 to Attachment 4.19-B.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE:_____WASHINGTON_____

VIII. Institutional 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.

**Other Provider-Preventable Conditions**

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) 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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services

A. Home Health

1. Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

   Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Rate changes made through the Vendor Rate Increase (VRI) may be made only through the legislative process. Selected rates may also be adjusted through a special appropriation directed by the Washington State Legislature. The agency may set rates outside of the legislative process if the agency determines such actions are necessary to maintain access to critical services. The Washington State Legislature approved a $10.00 per hour rate increase for skilled nursing services provided in a home setting, effective for services provided on and after July 1, 2016.

   The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for these services.

   Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The fee schedule is effective for services provided on and after January 1, 2023. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

2. Other Supplies and Services used in the home and other setting

   The agency's reimbursement rates include:
   a) Any adjustments or modifications to the equipment that are either required within three months of the delivery date, or are covered under the manufacturer's warranty
   b) Pick-up, delivery, or associated costs such as mileage, travel time, or gas
   c) Telephone calls
   d) Shipping, handling, and postage
   e) Fitting and setting up
   f) Maintanence of rented equipment
   g) Instructions to the client or client's caregiver about the safe and proper use of the equipment and supplies

   The equipment, supplies, and services for parenteral nutrition, home infusion therapy, oxygen, and respiratory care are reimbursed using the CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services that are not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

   Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services and supplies. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

B. The Medicaid agency makes payment for transportation to and from medically necessary services covered by a client's medical assistance program as specifically listed below.

1. Ambulance services for emergency situations are paid as an optional medical service through direct vendor payments based on fee-for-service.

2. All non-emergency transportation services, to assure clients have access to and from covered services, are provided using either administrative matched dollars or medical match dollars in accordance with Section 42 CFR 431.53 and Attachment 3.1-C.

3. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of transportation services. The agency's fee schedule rate was set as of October 1, 2021, and is effective for services provided on or after that date. See 4.19-B I, General, #G, for the agency's website where the fee schedules are published.

4. In the case of a governor-declared state of emergency and when the agency determines it is appropriate, the agency may elect to make supplemental payments for transportation services provided in connection with the emergency.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. C. Other Noninstitutional Services (cont.)

Eligible air ambulance providers will be cost reconciled to equal the cost of services provided during the fiscal period beginning July 1, 2010 through June 30, 2011, and for subsequent 12 month fiscal periods. Eligible providers are:

1. Operated by or affiliated with a public entity; and
2. "Major Air Ambulance Providers" whose service area covers all counties in the State of Washington. Cost will be determined by the Medicaid agency using a CMS-approved cost identification process in accordance with Medicare cost allocation principles. Cost for each Major Air Ambulance Provider will be identified and compared to the direct vendor payments based on fee-for-service. Based on this comparison, additional payment or recovery of payment will be made to assure that the total of payment equals cost.

(a) Annual Cost Report Process

During the state fiscal year, each Major Air Ambulance Provider must complete an annual Major Air Ambulance Provider cost report. The cost report will document the provider's total CMS-approved, Medicaid-allowable, direct and indirect costs of delivering Medicaid coverable services using a CMS-approved cost-allocation methodology. Reported personnel costs including wages, salaries, and fringe benefits must be exclusively attributable to air ambulance services provided. Total direct and indirect costs will be divided by the number of total transports to determine an average cost per trip. The average cost per trip will be multiplied by the number of paid Medicaid trips for the cost reporting year to determine Medicaid's allocable air ambulance costs.

(b) Cost Reconciliation Process

Annual direct vendor payments based on fee-for-service will be reconciled to total CMS-approved Medicaid-allowable costs calculated on page 20a section C(a). The total Medicaid-allowable scope of costs are compared to the direct vendor payments based on fee-for-service paid to the Major Air Ambulance Provider as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

(c) Cost Settlement Process

- Each Major Air Ambulance Provider will receive payments in an amount equal to the greater of (i) direct vendor payments based on fee-for-service, or (ii) total CMS-approved Medicaid-allowable costs for air ambulance services calculated in accordance with page 20a section C(a).
- If a Major Air Ambulance Provider's direct vendor payments based on fee-for-service exceed the provider's certified cost for air ambulance services provided to Medicaid clients, no cost settlement will be finalized and the direct vendor payments will be the final payments.
- If the certified cost of a Major Air Ambulance Provider exceeds the direct vendor payments based on fee-for-service, the Medicaid agency will pay the difference to the provider.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of air ambulance services. The fee schedule and any annual/periodic adjustments to the fee schedule are published at http://hrsa.dshs.wa.gov/rbrvs/ The Medicaid agency's fee schedule rate was set as of October 1, 2021, and is effective for services provided on or after that date

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS

The Ground Emergency Medical Transportation (GEMT) program is a voluntary program that makes supplemental payments to eligible GEMT providers who furnish qualifying emergency ground ambulance services to Medicaid clients. The supplemental payments are funded using the certified public expenditures (CPE) payment method.

Using the CMS-approved cost report, eligible GEMT providers must certify to the State the total expenditures incurred for providing the GEMT services that will be used to determine the supplemental payments. The Agency makes supplemental payments only for the uncompensated and allowable direct and indirect costs incurred while providing GEMT services to Medicaid clients. The supplemental payment covers the gap between the provider's total allowable costs for providing GEMT services as reported on the CMS-approved cost report and the amount of the base payment, mileage, and all other sources of reimbursement.

The Agency makes supplemental payments only up to the amount uncompensated by all other sources of reimbursement. Total reimbursements from Medicaid including the supplemental payment do not exceed one hundred percent of actual costs.

The Agency does not consider these payments to be an individual increase to current FFS reimbursement rates.

The GEMT program must be implemented without any additional expenditure from the state general fund. As a condition of participation under this program, an eligible provider must agree to reimburse the Agency for any costs associated with implementing the GEMT program.

This supplemental payment applies only to GEMT services rendered to Washington Medicaid beneficiaries by eligible GEMT providers on or after June 2, 2016.

A. Definitions

1. "Agency" means the Washington State Health Care Authority.

2. "Advanced life support (ALS)" means special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

3. "Allowable costs" means an expenditure which meets the test of the appropriate Executive Office of the President of the United States' Office of Management and Budget Circular (OMB).

4. "Basic life support (BLS)" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

5. "Cognizant agency" is the Federal agency with the largest dollar value of direct Federal awards with a governmental unit or component.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

6.. "Cost Allocation Plan (CAP)" is a document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The document also identifies the allocation methods used for distribution to cost objectives, on the basis of relative benefits received. For GEMT purposes, the fire departments/districts must use their local government's approved CAP.

7. Direct costs" are those costs that are identified by 45 CFR 75.413 that:

   1) Can be identified specifically with a particular final cost objective (to meet emergency medical transportation requirements), such as a federal award, or other internally or externally funded activity; orCan be directly assigned to such activities relatively easily with a high degree of accuracy.

8. "Direct federal award" means an award that is being paid directly from the federal government. GEMT is not a direct award as it is being paid through the Washington State Health Care Authority or the agency.

9. "Dry run" means GEMT services (basic, limited-advanced, and advanced life support services) provided by an eligible GEMT provider to an individual who is released on the scene without transportation by ambulance to a medical facility.

10. "Federal financial participation (FFP)" means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the State Plan for medical assistance. Clients under Title XIX are eligible for FFP.

11. "GEMT Services" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by GEMT providers before or during the act of transportation.

12. "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.

13. "Limited advanced life support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services.

14. "Publicly owned or operated" means a unit of government which is a state, a city, a county, a special purpose district, or other governmental unit in the state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act.

15. "Service period" means July 1 through June 30 of each Washington State fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS

15. "Shift" means a standard period of time assigned for a complete cycle of work, as set by each eligible GEMT provider. The number of hours in a shift may vary by GEMT provider, but will be consistent to each GEMT provider.

B. To qualify for supplemental payments, GEMT providers must meet all of the following:

1. Be enrolled as a Medicaid provider for the period being claimed on their annual cost report.
2. Provide ground emergency medical transport services to Medicaid enrollees.
3. Be organizations owned or operated by the state, city, county, fire protection district, community services district, health care district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50.

C. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and OMB Circular A-87, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.

2. Medicaid base payments to the GEMT providers for providing GEMT services are derived from the ground ambulance fee-for-service (FFS) fee schedule established for reimbursements payable by the Medicaid program by procedure code. The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursements is the Washington Medicaid Management Information System (MMIS) also called ProviderOne. The number of paid Medicaid FFS GEMT transports is derived from and supported by the ProviderOne reports for services during the applicable service period.

3. The total uncompensated care costs of each eligible GEMT provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each eligible GEMT provider providing GEMT services to Washington Medicaid beneficiaries, net of the amounts received and payable from the Washington Medicaid program and all other sources of reimbursement for such services provided to Washington Medicaid beneficiaries. If the eligible GEMT providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

D. Cost Determination Protocols

1. An eligible GEMT provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

2. Direct costs for providing medical transport services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.

3. Indirect costs

   A. Fire Departments/Districts which are direct recipients of federal awards:

      i. Fire departments/districts that receive more than $35 million in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the fire department/district does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.

      ii. Fire departments/ districts that receive less than $35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, fire departments/districts may use methods originating from a CAP to identify its indirect cost. If the fire department does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.

   B. Fire Departments/Districts which receive $0 federal award

      i. Fire departments/districts which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
         - A CAP with its local government
         - An indirect rate negotiated with its local government
         - Direct identification through use of a cost report

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

i. If the fire department/districts never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.

4. Cost incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect cost. Essentially, any cost incurred by a fire department/district which includes both cost incurred applicable to firefighting as well Emergency Medical Transportation (EMT) services must be consistently direct or indirect in its entirety.

5. The GEMT provider-specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs of the specific provider by the total number of medical transports provided by the provider for the applicable service period.

6. “Dry run” as defined in Section A is a covered service. Costs applicable to EMT services that do not result in a transport should be included in the total allowable costs.

E. Interim Supplemental Payment

1. Each eligible GEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section D) and must submit the completed annual as-filed cost report, to the Agency within five (5) months after the close of the State’s Fiscal Year (SFY).

2. The Agency will make annual interim supplemental payments to eligible GEMT providers. The interim supplemental payments for each provider is based on the provider’s completed annual cost report in the format prescribed by the Agency and approved by CMS for the applicable cost reporting year.

3. To determine the interim GEMT payment rate, the Agency must use the most recently filed cost reports of all qualifying providers. The Agency will then determine an average cost per transport which will vary between the qualifying providers.

F. Cost Settlement Process

1. The GEMT Washington Medicaid payments and the number of transport data reported in the as-filed cost report will be reconciled to the ProviderOne reports generated for the cost reporting period within two (2) years of receipt of the as-filed cost report. The Agency will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved ProviderOne report.

2. Each provider will receive payments in an amount equal to the greater of the interim payment or the total CMS-approved Medicaid-allowable costs for GEMT services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

3. If, at the end of the final reconciliation, it is determined that the GEMT provider has been overpaid, the provider will return the overpayment to the Agency and the Agency will return the overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If an underpayment is determined, then the GEMT provider will receive a supplemental payment in the amount of the underpayment

G. Eligible GEMT Provider Reporting Requirements

A GEMT-eligible provider must:

1. Report and certify total computable allowable costs annually on an Agency- and CMS-approved cost report. Eligible providers will submit cost reports no later than five (5) months after the close of the SFY, unless a provider has made a written request for an extension and such request is granted by the Agency.

2. Provide supporting documentation to serve as evidence supporting information on the cost report and the cost determination as specified by the Agency.

3. Keep, maintain, and have readily retrievable, such records as specified by the Agency to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS.

4. Comply with the allowable cost requirements provided in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87, and Medicaid non-institutional reimbursement policy.

E. Agency Responsibilities

1. The Agency will submit to CMS claims based on total computable certified expenditures for GEMT services provided, that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.

2. The Agency will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law.

3. The Agency will complete the audit and reconciliation process of the interim payments for the service period within three years of the postmark date of the cost report and conduct on-site audits as necessary.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**Ambulance Transportation Quality Assurance Fee**

This program provides increased reimbursement to eligible ground emergency medical transport providers by application of an add-on rate to Apple Health fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on applies to eligible Current Procedural Terminology (CPT) Codes, as described below, effective July 1, 2021, through June 30, 2024. The base rates for emergency medical transportation services remain unchanged.

“Eligible providers” means an ambulance transportation provider that bills and receives patient care revenue from the provision of ground emergency ambulance transports. "Ambulance transport provider" does not include a provider that is owned or operated by the state, cities, counties, fire protection districts, regional fire protection service authorities, port districts, public hospital districts, health care districts, federally recognized Indian tribes, or any unit of government as defined in 42 C.F.R. Sec.12433.50.13

“Emergency medical transport” means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429 BLS Emergency, A0427 ALS Emergency, A0433 ALS2, and A0434 Specialty Care Transport. An “emergency medical transport” does not occur when, following evaluation of a patient, a transport is not provided.

**Methodology**

For State Fiscal Year (SFY) 2022-SFY 2024, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the fee-for-service (FFS) fee schedule base rate, excluding any declared disaster adjustments, for SFY 2019-2020 and the add-on amount for the CPT code. The resulting total payment amount is published on the agency’s web site. The add-on payment is paid for each eligible CPT code on a per-claim basis.

D. Rehabilitative Services

1. Payment for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders is described in Section IX. J.

2. Behavior Rehabilitative Services (BRS)

Payment for behavioral rehabilitative services is on a fee-for-service basis. Services are authorized by month; claims are pro-rated to pay for the actual number of days of service provided within that month. The State assures that only BRS is claimed; maintenance is not claimed. Documentation is recorded by all providers and by the State which provides the elements necessary for claiming Title XIX funding: name of person who received the service, name of provider of the service, provider identification number, date the service was provided, location of the service provided, and the nature and scope of the service.

Rates are tiered based upon the level of the intensity, duration, and severity of behavioral dysfunction experienced by the child being served; the levels range from moderate to extreme.

Behavioral rehabilitative services and the practitioners who can provide and bill for these services are described in Attachments 3.1-A and 3.1-B, Section 13.d.9.

The State requires BRS providers to participate in a time study and submit cost reports that address the service components described in Attachments 3.1-A and 3.1-B, Section 13.d.9. The system of time studying and cost reporting provides an accurate representation of the time spent in Title XIX allowable activities and the costs associated with them. The time study and cost reports also expressly exclude the room and board component in BRS and direct it to Title IV-E.

Based on documentation from the provider, the State's automated payment system captures the elements necessary for Title XIX claiming, (i.e., who received the service, who provided the service, where the service was provided, when the service was provided, and the nature and scope of the service). The State reviews data and provides oversight with respect to all providers' activities and reporting.

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Behavior Rehabilitation Services. The State's rates were set as of October 1, 2019, and are effective for services rendered on or after that date. The fee schedule is published at https://www.dcyf.wa.gov/sites/default/files/pdf/Fee_BRS.pdf.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

D. Rehabilitative Services

3. Alcohol/Drug Treatment and Detoxification Services

Payment for detoxification services provided in freestanding Medicaid Agency-approved alcohol/drug treatment centers is on a fee-for-service basis, with one day being the unit of service. The Medicaid Agency pays the lesser of the usual and customary charge or a fee based on an Agency fee schedule. The per diem rate on the Agency fee schedule for secure withdrawal management and stabilization is set at a flat fee based upon market value, other states' fees, and budget impacts.

There is no room and board paid for these services.

Payment for alcohol/drug treatment services is provided to certified facilities on a fee-for-services basis for specific services. The Medicaid Agency pays the lesser of the usual and customary charge or a fee based on a Medicaid Agency fee schedule. There is no room and board paid for these services. Licensed chemical dependency professionals who are paid by the facility, provide services

Except as otherwise noted in the plan, payment for these services is based on fee schedule rates, which are the same for both governmental and private providers of alcohol/drug treatment and detoxification services. The Agency's rates were set as of July 1, 2020, and are effective for services rendered on or after that date. See 4.19-B I, General, #G, for the agency's website where the fee schedules are published.

A. Tribal Residential Substance Use Disorder Treatment Facilities

Payment to residential substance use disorder treatment facilities of the Indian Health Service (IHS), which includes, at the option of the tribe, residential substance use disorder treatment facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act (also known as tribal residential substance use disorder treatment facilities), will be at a per patient, per day facility-specific rate for residential substance use disorder treatment services (including intensive residential treatment, withdrawal management, and recovery house services as applicable for the facility) for youth and adult patients, each rate negotiated with the respective tribe(s) or tribal organization for a base calendar year. During the negotiations, the state and the tribe or tribal organization may agree for the tribal facility to be responsible for the state share of financial participation in accordance with 42 C.F.R. § 433.51. The rate negotiated for a base calendar year will be adjusted annually thereafter, based on the percentage increase or decrease of the inpatient hospital per diem rate published each year in the Federal Register by the U.S. Department of Health and Human Services' Indian Health Service, under the authority of Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. § 1601 et seq.).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

F. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of EPSDT services. The Medicaid agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule.

EPSDT fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code (WAC) chapter 182-531, the agency uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost indices (GPCI) and the conversion factors, both of which are specific to Washington. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations do not apply other than based on medical necessity. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B. Washington's Medicaid State Plan may be found at http://www.hca.wa.gov/medicaid/medicaidsp/Pages/index.aspx

The agency pays providers an enhanced rate or the allowed amount, whichever is higher, per EPSDT health screening examination for children in foster care. The enhanced is a flat fee for these services, which is based on market value, other states' fees, historical pricing, and comparable services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

School-based healthcare services

The fees for the codes under School-based Healthcare Services are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the agency uses CMS-established relative value units (RVUs) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factor, service descriptions, and their effective dates are found in Supplement 3 to Attachment 4.19-B. Washington's Medicaid State Plan may be found at http://www.hca.wa.gov/medicaid/medicaidsp/Pages/index.aspx

Codes not valued under the RVU methodology are reimbursed using flat rate. These fees are based upon market value, other states' fees, budget impacts, etc.

Except as otherwise noted in the plan, fee schedule rates for school-based healthcare services are the same as the rates paid to similar providers within the community outside of the school setting. See 4.19-B I, General, #G, for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

G. Family Planning Services

The agency pays the lesser of the usual and customary charge, or a fee based on an agency fee schedule for covered family planning services. See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

The agency pays providers an enhanced rate for codes directly related to implant or insertion of Long-Acting Reversible Contraceptives (LARCs). The enhanced rate is a flat fee added to the RBRVS values obtained as described in Supplement 3 to Attachment 4.19-B.

The agency's enhanced rates related to implant or insertion of LARCs is effective September 1, 2015.

The legislature approved an increase in rates for Department of Health's Sexual Reproductive Health Program providers as of October 1, 2021. These rates are either a percentage increase above RBRVS methodology as described in Supplement 3 to Attachment 4.19-B, or at Medicare rates.

H. Extended Services For Pregnant Women Through the Sixty Days Postpartum Period

Services include maternity support services, outpatient alcohol and drug treatment, rehabilitation alcohol and drug treatment services, genetic counseling, and smoking cessation counseling. The agency pays the lesser of the usual and customary charge, or a fee based on an agency fee schedule.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

I. Private Duty Nursing Services

Private duty nursing services consist of four or more hours of continuous skilled nursing services provided in the home to eligible clients who are 17 years of age or younger with complex medical needs that cannot be managed within the scope of intermittent home health services. The agency will authorize private duty nursing services up to a maximum of 16 hours per day, restricted to the least costly, equally effective amount of care. Nursing rates for services provided in the home setting are flat rates and based on comparable nursing rates.

Rate changes made through the Vendor Rate Increase (VRI) may be made only through the legislative process. Selected rate changes may also be adjusted through a special appropriation directed by the Washington State Legislature. The agency may set rates outside of the legislative process if the agency determines such actions are necessary to maintain access to critical services. The Washington State Legislature approved a 10% rate increase to the hourly rate and the daily rate for skilled nursing services provided in a home setting, effective for services provided on and after January 1, 2020.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The fee schedule is effective for services provided on and after July 1, 2020. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

J. Physical therapy, occupational therapy, and services for Individuals with speech, hearing and language disorders

The agency does not pay separately for therapy services that are included as part of payment for other treatments or programs.

The Medicaid Agency pays the lesser of the usual and customary charge or a fee based on a Medicaid Agency fee schedule for these services. Maximum allowable fees are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated using the RBRVS methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

IX. Other Noninstitutional Services (cont.)

K. Hearing Hardware

Payment for purchased hearing aids includes all of the following: a prefitting evaluation; an ear mold; and a minimum of three post-fitting consultations

The agency sets rate for hearing hardware using CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services not listed on CMS DMEPOS Fee Schedule, the Medicaid agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published

L. Prosthetics and Orthotics

The agency does not pay providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

Prosthetics and orthotics are reimbursed using CMS DMEPOS Fee Schedule less a specified percentage. In April 2012, this specific percentage reduction was established at 3.5 percent as a result of a negotiated agreement with providers. For those items and services not listed on CMS DMEPOS Fee Schedule, the agency uses flat fee (based upon market value, other state's fees, budget impacts, etc.) or by-report methodology (based on a percentage of billed charges).

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

IX. Other Noninstitutional Services (cont)

M. Licensed or Otherwise State-Approved Freestanding Birthing Centers

The fees for the majority of codes under freestanding birthing centers are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under WAC 182-531-1850, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factor descriptions are found in Supplement 3 to Attachment 4.19-B.

Codes not valued under the RVU methodology, are reimbursed using CMS DMEPOS Fee Schedule, flat fee (based upon market value, other state's fees, budget impacts, etc.), acquisition cost (the cost of the actual item being billed). Drugs administered at the birthing center are reimbursed according to Medicare's Average Sales Price (ASP) methodology except when no ASP rate is available. When no Medicare drug file rate is available, the drug is paid at the same actual acquisition cost (AAC) methodology as would be applied if the drug were dispensed through a pharmacy and paid through Point-Of-Sale (POS) system.

The birthing center facility fee is consistent across birthing centers. This facility fee is based on 90% of the average hospital facility rate for a non-complicated delivery with a one day inpatient stay. Facility fee payments are made only when the delivery is performed in a facility licensed as a childbirth center by the Washington State Department of Health and approved by the agency. The facility fee includes all room charges for mother and baby, equipment, supplies, anesthesia administration, and paid medication. The facility fee does not include other drugs, professional services, lab charges, ultrasound, other x-rays, blood draws, or injections.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

IX. Other Noninstitutional Services (cont)

N. Tobacco Cessation Counseling Services

The Medicaid agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for these services. Maximum allowable fees are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated using the RBRVS methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code, chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

X. All Other Practitioners

1. "All other practitioners" refers to other practitioners as described in section 6.d of Attachments 3.1-A and 3.1-B.

2. The agency pays the lesser of the usual and customary charge, or a fee based on an agency fee schedule.

3. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services and the fee schedule and any annual/periodic adjustments to the fee schedule(s).

4. The facility fees used to calculate the payment rates for intensive behavior services (Applied Behavior Analysis (ABA) services) in facility settings will be calculated using methods that are consistent with Medicaid State Plan attachment 4.19-B sections II and VIII. A Outpatient hospital services. Outpatient hospitals and clinics rendering intensive behavior services as a day program do not receive a facility fee in addition to the per diem rate identified on the state's ABA Services fee schedule.

   The agency's fee schedule rate was set as of July 1, 2022, and is effective for dates of services provided on or after that date. See 4.19-B, I. General #G for the agency's website where the fee schedules are published.

5. Collaborative care services are delivered under the Collaborative Care Model (CoCM). Payment rates for CoCM are based on the 2016 Medicare rates for Integrated Behavioral Health Services and are effective for dates of service on and after July 4, 2018.

   Under CoCM, a medical care provider bills for the services provided by the collaborative care team. Only state-licensed physicians and state-licensed advanced registered nurse practitioners are eligible to be a medical care billing provider.

6. Community Assistance Referral and Education Services (CARES) programs include Treat and Refer services which are provided when clients' medical needs do not require ambulance transport to an emergency department. The rate was set as of July 1, 2019, and is effective for dates of services provided on or after that date. See 4.19-B, I. General #G for the agency's website where the rates are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XI. Prepaid Capitation Arrangements

The cost of providing a given scope of services to a given number of individuals under a capitation arrangement will not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XII. Laboratory and Radiology Services

1. Payments for laboratory and pathology services are made at a percentage of Medicare's clinical laboratory fee schedule.

2. The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule for radiology services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

XIII. Targeted Case Management Services

A. Clients Manifesting Pathology with Human Immunodeficiency Virus (HIV).

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the targeted case management services.

Payment is made through fee-for-service as billed by the provider.

1. The agency's case management fee was set as of July 4, 2018 and is effective for dates of service on and after that date.

2. See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

3. TCM for clients manifesting pathology with HIV will be billed in weekly increments.

Examples of the types of expenditures that are considered in the computation of the fee schedule rate are:

Targeted case management staff salary and personnel benefit expenses;
Other administrative and programmatic expenses in support of TCM services; and
Other indirect expenses (e.g., insurance, utilities, etc.)

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

XIII. Targeted Case Management Services (cont)

B. Infant Case Management (ICM)

The agency provides infant case management services to Medicaid infants and their parent(s) for the direct benefit of the eligible infant from the time the infant is three months of age through the month of the infant's first birthday.

For the purpose of this program, the State defines a parent(s) as a person who resides with an infant, provides the day-to-day care, is authorized to make health care decisions, and is:

The infant's natural or adoptive parent(s);

A person other than a foster parent who has been granted legal custody of the infant; or

A person who is legally obligated to support the infant.

Payment for Title XIX targeted case management services may not duplicate payments made to public agencies or private entities under other programs for this same purpose. If the eligible infant and family are involved in services for another targeted group, ICM is closed and case management for the other targeted group is initiated.

Targeted case management for ICM is billed on a per-visit basis, with each visit based on time increments of 15 minutes equaling one unit. Unit limitations are described in agency billing instructions.

Computation of the per-unit rate takes the following into consideration:

- Relative value of targeted case management services provided by similar professionals in different settings;
- Historical expenditures for ICM services; and
- Other expenses related to provision of targeted case management services (e.g., travel time and associated travel costs, charting/documentation time, etc.)

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. The agency's case management fee was set as of August 6, 2015, and is effective for dates of service on and after that date. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

XIII. Targeted Case Management Services (cont)

D. All children under age 21 who have been removed, or are at risk of such removal, from his/her home into publicly funded care or supervision due to family crisis or dysfunction, and their caretakers (parents of such children or persons serving in a parental capacity, excluding paid foster parents). Assistance to caretakers is provided for the direct benefit of the child.

Qualifications for contracted and governmental providers are described in Supplement D to Attachment 3.1-A.

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

As noted below, state-developed fee schedule rates are not the same for governmental and private providers of the targeted case management services.

Contracted providers: payment is on a fee-for-service basis. The payment for services provided on a fee-for-service basis is based on a rate negotiated by the state Medicaid Agency.

The Agency's fee schedule rate was set as of Oct. 1, 2009 and is effective for dates of services provided on and after that date. All rates are published on the Agency's fee schedule website at http://www.dshs.wa.gov/ca/partners/contractRates.asp

The Agency requests providers to bill on a monthly basis using a daily rate. The billing must validate the total number of daily units of service provided during the month.

Examples of the types of expenditures that are considered in the computation of the fee schedule rate are:

Targeted case management staff salary and other personnel expenses;
Supervisory salary and other personnel expenses in support of TCM services; and
Indirect expenses (general government service charges, worker's compensation, property insurance, etc.)

Governmental providers (state staff): payment is based on the actual statewide expenditures for the service.

Expenditures include;
Targeted case management staff salary and other personnel expenses;
Supervisory salary and other personnel expenses in support of TCM services; and
Proportional indirect overhead expense.

Cost for TCM provided by governmental providers (state staff) are accumulated and recognized after expenses are incurred. These costs are accumulated and allocated based on a CMS approved Random Moment Time Study (RMTS). As the cost recognition process is based on an allocation of employee salaries and actual expenditures for overhead expenses, there is no need for any interim payments nor reconciliation.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XIV. Hospice Services

A. Payment for hospice services is made to a designated hospice provider using the CMS annually published Medicaid hospice rates that are effective from October 1 of each year through Sept. 30 of the following year. With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one of the following four pre-determined daily rates. The rates are contingent on the type of service provided that day. The rates are based on the Medicaid guidelines and are wage adjusted. The Medicaid agency uses the Hospice Wage Index published by CMS. The pre-determined daily rates are:

1. Routine Home Care (RHC): Hospice providers are paid one of two levels of RHC for dates of service on and after January 1, 2016. This two-rate payment methodology will result in a higher RHC rate based on payment for days one (1) through sixty (60) of hospice care and a lower RHC rate for days sixty-one (61) or later. A minimum of sixty (60) day's gap in hospice services is required to reset the counter that determines which payment category a participant is qualified for.

2. Continuous Home Care (CHC)

3. Inpatient Respite Care (IRC)

4. General inpatient hospice care

B. Service Intensity Add-On

Effective for hospice services with dates of service on and after January 1, 2016, hospice services are eligible for an end-of-life service intensity add-on payment when the following criteria are met:

1. The day on which the services are provided is an RHC level of care;
2. The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;
3. The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and
4. The service is not provided by the social worker via telephone.

C. Hospice Care Furnished to an Individual In a Nursing Facility

The agency pays a hospice nursing facility room and board if the client is admitted to a nursing facility or a hospice care center and is not receiving general inpatient care or inpatient respite care. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility ), must equal at least 95% of the per diem rate that DSHS would have paid to the nursing facility for that individual in that facility under the State Plan.

The room and board rates are set by the Department of Social and Health Services (DSHS) and published on the DSHS website at http://www.aasa.dshs.wa.gov/professional/rates/reports/

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XIV. Hospice Services (cont)

D. The agency reimburses hospice claims through the use of revenue codes used to bill for room and board and revenue codes used to bill for the hospice daily rate.

E. The agency does not pay for face-to-face encounters to recertify a hospice client.

F. The agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for the professional service provided for pediatric palliative care and for authorized medically necessary concurrent care services. The pediatric palliative care (PPC) revenue code is adjusted only through a Vendor Rate Increase (VRI) that has been appropriated by the Washington State Legislature.

G. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XV. Personal Care Services

State-developed fee schedule rates are the same for both governmental and private providers of the same service. See 419-B.I, General, for the agency's website where the fee schedules are published.

A. Payment for services

Services are provided by these provider types:

- State-licensed agencies providing personal care services, consisting of licensed home-care agencies. Home health agencies providing personal care services do not require Medicare certification;
- Adult residential care providers who are licensed by Department of Social and Health Services (DSHS ) according to DSHS Revised Code of Washington (RCW) and Washington Administrative Code (WAC) as follows:
  - Assisted Living Facilities – chapter 18.20 RCW and chapter 388-78A WAC. Must be licensed as an assisted living facility. Care givers must be at least 18 years of age, have cleared initial background checks as required by state law and remain free of disqualifying crimes or negative actions, complete training requirements outlined in chapter 388-112 WAC and be authorized to work in the United States.
  - Adult family home – chapter 70.128 RCW and chapter 388-76 WAC. Must be licensed as an adult family home. Provider/resident manager must be at least 21 years of age and have a high school diploma or general education development certificate. Care givers must be at least 18 years of age. Provider/resident manager and care givers must clear initial background checks as required by state law and remain free of disqualifying crimes and/or negative actions, maintain current CPR and first aid certificate, complete training requirements outlined in chapter 388-112 WAC, and be authorized to work in the United States.

- Individual providers of personal care employed by the Consumer Directed Employer (CDE). The CDE must certify individual providers:
  - Are age 18 or older;
  - Are authorized to work in the United States;
  - Have cleared the initial state background checks and remain free of disqualifying crimes and/or negative actions; and
  - Complete training and certification requirements outlined in chapter 388-71 WAC

Payment for services provided by agency and individual providers employed by the CDE are reimbursed at an hourly unit rate, and payment for residential-based services is reimbursed at a daily rate. All providers will submit claims in the state MMIS system for personal care services.

No payment is made for services beyond the scope of the program or hours of service exceeding the Medicaid Agency's authorization. Payments to residential providers are for personal care services only, and do not include room and board services that are provided. Payment is made only for the services described in Attachment 3.1-A, section 26.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XV. Personal Care Services (cont)

B. Service Rates

The fee schedule was set as of July 1, 2022, to be effective for dates of service on and after July 1, 2022.

Effective Jan. 1, 2008, the standard hourly rate for individual-provided personal care is based on comparable service units and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing the workers. The rate for personal care services provided by individual providers consists of wages, industrial insurance, paid time off, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and other such benefits needed to ensure a stable, high performing workforce. The agreed-upon negotiated rates schedule is used for all bargaining members.

The rate for personal care services provided by agencies is based on an hourly unit. The agency rate determination corresponds to the rate for individual providers with an additional amount for employer functions performed by the agency.

The rate for personal care provided in assisted living facilities is based on a per day unit. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. The rates are based on components for provider staff, operations, and capital costs. The rate paid to residential providers does not include room and board.

The rate for personal care provided in an adult family home is based on a per day unit and is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVI. Federally Qualified Health Centers

Effective January 1, 2001, through December 31, 2008, the payment methodology for Federally Qualified Health Centers (FQHCs) conforms to Section 1902(bb) of the Social Security Act (SSA). As set forth in Section 1902(bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reimbursed on a prospective payment system (PPS). The reconciliation for calendar year 2009 will be done starting in calendar year 2010 and every year thereafter.

Effective January 1, 2009, fee-for-service (FFS) and managed care organization (MCO) payments to FQHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. Those FQHCs that do not choose the APM will continue to be paid under the PPS.

For the period beginning January 1, 2009, the PPS and APM will utilize the centers' base encounter rates, using the PPS methodology in place at the time. Because the FQHC cost reports reflected the centers' fiscal year, the base rates were adjusted to a calendar year, as illustrated by the following formula (the example reflects a center with a fiscal year ending March 31):

$$\frac{(((FY99\ R*FY99\ E)/12)*3)+(FY00\ R*FY00\ E)+(((FY01\ R*FY01\ E)/12)*9)}{((FY99\ E/12)*3)+(FY00\ E)+((FY01\ E/12)*9)}$$

R = Rate
E = Encounters

For FQHCs receiving their initial designation after January 1, 2001, their base rates were established using an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis until their permanent rates were determined.

Effective January 1, 2009, and each January 1 thereafter, PPS rates will be increased by the percentage change in the Medicare Economic Index (MEI) for that period.

Effective January 1, 2009, and each January 1 thereafter, APM rates will be increased by a Washington-specific health care index developed by IHS Global Insight. To ensure that the APM pays an amount at least equal to the PPS, the greater of the Washington-specific index or the MEI will be used. The greater of the Washington-specific index or the MEI will also be applied retroactively to the centers' base encounter rates.

For services provided on and after July 7, 2011, each center will have the choice of receiving either (1) its PPS rate, as determined under the method described above or (2) a rate determined under a revised APM. The revised APM will be as follows: for centers that rebased their rate effective January 1, 2010, their 2008 allowed cost per visit inflated by the cumulative percentage increase in the MEI between 2009 and 2011. For centers that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year to the extent the 2002 rate was updated to account for the addition of a new site or type of service) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2009 through 2011. The rates will be inflated by MEI effective January 1, 2012 and each January 1 thereafter. The State will compare each year's APM rate to the rate that would have been paid under PPS to ensure the APM payments are at least equal to the payments that would have been made under PPS.Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVI. Federally Qualified Health Centers (continued)

The State will periodically rebase the FQHC encounter rates using the FQHC cost reports and other relevant data. Rebasing will be done only for centers that choose the APM.

FQHCs receiving their initial designation after January 1, 2001, will be paid an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis. Within two years of receiving its initial designation, the FQHC must demonstrate its true costs using standard cost reporting methods, to establish its base encounter rate. The State will audit the new center's cost report to ensure the costs are reasonable and necessary.

The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive annual increases thereafter consistent with the payment methodology (PPS or APM) chosen by the center.

If two or more FQHCs merge, a weighted average of the centers' encounter rates is used as the encounter rate for the new center.

An adjustment will be made to a center's encounter rate if the center can show that it has experienced a valid change in scope of service. An FQHC may file a change in scope of services rate adjustment application only when:

The cost to the FQHC of providing covered healthcare services to eligible clients has increased or decreased due to the following: change in the type, intensity (total quantity of labor and materials consumed by an individual client during an average encounter), duration (length of an average encounter) and/or amount of services; and
The cost change equals or exceeds an increase of 1.75% in the rate per encounter over one year; a decrease of 2.5% in the rate per encounter over one year; or a cumulative increase or decrease of 5% in the rate per encounter as compared to the current year's cost per encounter; and
The costs reported to the State to support the proposed change in scope rate adjustment are reasonable under OMB circular A-122 or its successor,and other applicable state and federal law; and
The service meets the definition of an FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and
The service is included as a covered Medicaid service as defined in the State Plan.

An FQHC may apply for a prospective or retrospective change in scope rate adjustment.

For prospective change in scope, an FQHC submits projected costs sufficient to establish an interim rate. Once the center can demonstrate its true costs of providing the services, it must submit required documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the final rate within 90 days of receiving complete information from the center. The final rate will take effect on the date the State issues the adjustment.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVI. Federally Qualified Health Centers (continued)

For retrospective change in scope, an FQHC submits actual data of twelve months documenting the cost change caused by the qualifying event. A retrospective change in scope is a change that took place in the past and the FQHC is seeking to adjust its rate based on that change. If approved, a retrospective rate adjustment takes effect on the date the FQHC filed the application with the agency. The State will notify the center of a decision within 90 days of receiving completed application.

For clients enrolled with a managed care contractor, and effective April 1, 2014, the State anticipates that the managed care contractor will pay each center an encounter rate that is at least equal to the PPS rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the managed care contractor's data at least quarterly and verify that the payments made by the managed care contractor in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers reimbursed under the APM rate methodology and to centers reimbursed under the PPS rate methodology.

At no time will a managed care organization be at risk for or have any claim to the supplemental payment portion of the rate which will be reconciled to ensure accurate payment of the obligated funds.

Covered services provided to Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19-B, pages 1, 2, and 3.

Encounters are limited to one per client per day, except when:

- The client needs to be seen by different practitioners with different specialties; or
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: _____WASHINGTON_____

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVIII. Mental Health Services

There are two circumstances in which the Medicaid agency will reimburse eligible behavioral health providers under the fee-for-service system. The first circumstance is when a Medicaid population is not eligible for services under the state's Section 1915(b) waiver. The second circumstance is when a contract between the state and a managed care entity that had provided behavioral health services is discontinued. Mental health fee-for-service rates are developed using the methodology below.

When possible, rates are developed using the RBRVS methodology. Rates are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under Washington Administrative Code chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B. When providers serve an individual who meets medical necessity for specialized mental health services based on statewide access standards, the provider will receive an enhanced rate. To increase availability of behavioral health service and incentivize adoption of the primary care behavioral health model, the legislature may increase rates for certain codes. These increases will be a percentage increase to the RBRVS methodology as described above.

If Medicare does not cover a particular approved State Plan service, and thus no RVU exists, codes are reimbursed using a flat fee based upon market value, service rate schedules from other states, budget impacts, historical pricing, and/or comparable services..

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of these services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE WASHINGTON

XIX. Supplemental Payments for Certain Professional Services

A. Notwithstanding other provisions of this section, effective July 1, 2009, supplemental payments will be paid according to this subsection for professional services performed by qualified licensed professionals. The exceptions to this are:

- Trauma center professional services, which will continue to be paid as described in subsection III.D above; and
- Services paid at an enhanced rate through a separate provision or regulation.

The purpose of the supplemental payments is to ensure access to essential professional services for Medicaid beneficiaries through the care provided by the University of Washington Medicine and the University of Washington School of Medicine, and at public hospitals or other public entities.

Qualified licensed professionals include physicians, physician assistants, advanced nurse practitioners, certified registered nurse anesthetists, nurse midwives, psychiatrists, psychologists, speech-language pathologists, physical therapists, occupational therapists, podiatrists, optometrists, social workers, dentists, audiologists, chemical dependency counselors, mental health professionals, opticians, and nutritionists who are eligible to receive payment for professional services under the state's approved Medicaid program, who are:

1. Licensed by the State of Washington, where applicable;

2. Enrolled as a State of Washington Medicaid provider; and

3. Either:

   (a) Employed by the University of Washington and/or a member of its affiliated physician practice plans; or

   (b) Employed by a public hospital or other public entity, when the public entity elects to participate.

B. A supplemental payment will be made for services provided by qualified licensed professionals and billed by a component or affiliate of the University of Washington or another public entity, including a public hospital, equal to the difference between the Medicaid payments otherwise made for the services and payments at the Average Commercial Rate. Only the professional component of a procedure is eligible for a supplemental payment. Payment will be made quarterly and will not be made prior to the delivery of services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

XIX. Supplemental Payments for Certain Professional Services (cont)

C. The Average Commercial Rate to be paid to qualified licensed professionals is determined as follows:

a. Compute Average Commercial Fee Schedule: For the most recently completed state fiscal year, compute the average commercial allowed amount per procedure code, including patient share amounts, for all commercial third party payers with negotiated fee schedules.

b. Calculate the Average Commercial Payment Ceiling: For each quarter of the current state fiscal year, multiply the Average Commercial Fee Schedule as determined in subsection III.F.3.a by the number of times each procedure code was paid to qualified licensed professionals on behalf of Medicaid beneficiaries as reported from the Medicaid Management Information System (MMIS). The sum of the product for all procedure codes subject to enhanced payment represents the Average Commercial Payment Ceiling.

D. The Medicaid Supplemental Payment to Qualified Licensed Professionals equals the difference between the Average Commercial Payment Ceiling for the quarter and the total Medicaid payments for the applicable procedure codes paid to qualified licensed professionals in the quarter on behalf of Medicaid beneficiaries, as reported from the MMIS. Medicaid volume and payments includes all available payments and adjustments.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

XX. Telemedicine services

Payment for telemedicine/telehealth services is made as follows:

Originating sites (the physical location of the client at the time the service is provided) are paid a facility fee per completed transmission, according to the fee schedule.

Distant sites (the physical location of the practitioner providing the service) are paid the current fee schedule amount for the service provided.

Hospitals billing for audio only telemedicine/telehealth are not paid a facility fee for originating or distance fees.

Maximum allowable fees are developed using the Resource Based Relative Value Scale (RBRVS) methodology. Rates are established and updated using the RBRVS methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB), or flat fee (based upon market value, other state's fee, budget impacts, etc.).. In the RBRVSis methodology, under Washington Administrative Code, chapter 182-531, the State uses CMS-established relative value units (RVU) multiplied by the Geographic Practice Cost Indices (GPCI) and the conversion factors, both of which are specific to Washington. Current conversion factors and descriptions are found in Supplement 3 to Attachment 4.19-B.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of telemedicine/telehealth services. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Washington
Community First Choice State Plan Option

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option

State-developed fee schedule rates are the same for both governmental and private providers of the same service. The fee schedule is published at https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.xls. Rates for Personal Care and Nurse Delegation provided under 1915(k) are the same as the payment rates for Personal Care and Nurse Delegation services listed in Attachment 4.19-B, XV Personal Care Services. Rates for Nurse Delegators provided under 1915(k) are the same as the payment rates for Nurse Delegators under Attachment 4.19-B, XV Personal Care Services. Payment rates for 1915(k) services will be updated whenever the fee schedule is updated on the corresponding State Plan page under the existing Personal Care Services benefit.

A. PERSONAL CARE

Personal care service providers:

1. Individual providers employed by the Consumer Directed Employer (CDE)
2. State-licensed home-care agencies
3. Residential service providers which include:
   a. Assisted living providers
   b. Adult family homes

Personal care service provider rates:

1. Individual providers employed by the CDE
   The rate paid to the CDE for providing personal care by individual providers is an hourly rate which covers the individual provider service hours and employer functions performed by the CDE, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the State legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, paid time off, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies
   The rate paid to home care agencies for providing personal care is an hourly rate that consists of home care worker compensation, benefits, and taxes, as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. Residential service providers
   The rate paid to adult family homes and assisted living facilities for providing personal care is paid at a daily rate. Each participant is assigned to a classification group based on the State's assessment of their personal care needs. The daily rate varies depending on the individual's classification group. Rates are based on wages, benefits, and administrative expenses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

The rate for personal care provided in an adult family home is determined by the State legislature, based on negotiations between the Governor's Office and the union representing Adult Family Homes. The agreed upon negotiated rates schedule is used for all bargaining members.

The rate paid to residential providers does not include room and board.

No payment is made for services beyond the scope of the program or hours of service exceeding the Medicaid Agency's authorization. The State uses the following classification levels as the basis for daily rates paid to adult family homes and assisted living providers and to allocate the number of personal care hours for which a home care agency or individual provider may be reimbursed.

E-Group
Individuals meet criteria for exceptional care due to very high ADLs need, turning & repositioning; Bowel Program, Catheter Care or Total assist in Toileting; and assistance with Range of Motion exercises. There are two subgroups within E; E-Med and E-High.

D-Group
Individual meets criteria for Clinical Complexity and have significant or severe cognitive impairment. There are four sub-groups within D; D, D-Med, D-Med-High and, D-High.

C-Group
Individuals meet criteria for Clinical Complexity, having a qualifying condition, diagnosis, or indicator coupled with a minimum ADL. There are four sub-groups within C; C-Low, C-Med, C-Med-High and, C-High.

B-Group
Individuals meet criteria for moods and behaviors that have an impact on the time it takes to assist with personal care needs. There are four sub-groups within B; B-Low, B-Med, B-Med-High, and B-High.

A-Group
Individuals meet criteria for unmet need for personal care. That need is not significantly impacted by cognitive impairment, behaviors or clinically complex conditions. There are three sub-groups within A; A-Low, A-Med, and A-High.

Registered Nurse Delegators
Registered Nurse Delegators are paid in 15 minute units based on a standard hourly rate. The hourly rate is determined by legislative appropriation and is published on the fee schedule referenced above.
Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

B. SKILLS ACQUISITION TRAINING

Skills acquisition training service providers:

1. Individual providers of personal care employed by the CDE
   The CDE is reimbursed an hourly rate which covers the individual provider service hours and employer functions, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the state legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies
   Home care agencies are reimbursed an hourly rate that consists of home care worker compensation, benefits, and taxes, as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. State–certified supported living agencies who are recruited and at the local level by Area Agencies on Aging, and Department field offices. Agencies are paid an hourly rate that must be within the range published by the Department where applicable and shall not be higher than, 1) the prevailing charges in the locality for comparable services under comparable circumstances; or 2) the rates charged by the contractor for comparable services funded under other sources.

4. Home Health Agencies
   Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

   Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Each year the State updates those per-visit rates using the state's annually published vendor rate adjustment factor.

   The Medicaid agency pays the lesser of the usual and customary charge or a fee based on a Medicaid agency fee schedule for these services.

   Rates for Home Health Agencies paid to provide skill acquisition services will be the same as those paid under attachment 4.19 B page 19 of the Plan. Except as otherwise noted in the Plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of Home Health.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

All rates, including current and prior rates, are published and maintained on the agency's website. Payment rates for 1915(k) services will be updated whenever the fee schedule is updated on the corresponding State Plan page under the Home Health benefit.

The State will reimburse up to $550.00 per fiscal year in costs for Skills Acquisition training alone or in combination with Assistive Technology.

C. BACK-UP SYSTEMS

Backup System service providers include:

1. Individual providers of personal care employed by the CDE. The CDE is reimbursed an hourly rate for individual provider services and employer functions, which include hiring and qualification verification, payroll activities, call center support, employee visit verification system, and other legally required employer functions. The hourly rate is determined by a rate setting board and is subject to approval by the State legislature. The rate for personal care services provided by individual providers through the CDE consists of wages, industrial insurance, vacation pay, mileage reimbursement, comprehensive medical, training, seniority pay, training-based differentials, and a retirement plan.

2. State-licensed home-care agencies are paid an hourly rate that consists of home care worker compensation, benefits, and taxes as defined in state parity law, and an additional amount for employer functions performed by the agency.

3. Personal Emergency Response vendors are paid a one- time rate for initial equipment and set up and are then paid a monthly service charge. Rates must be within the ranges published by the Department where applicable and shall not be higher than, 1) the prevailing charges in the locality for comparable services under comparable circumstances; or 2) the rates charged by the contractor for comparable services funded under other sources.

D. VOLUNTARY TRAINING ON HOW TO SELECT MANAGE AND DISMISS ATTENDANTS (Caregiver Management)

Peer Support Specialist and Community Choice Guides are reimbursed on an hourly rate The Department pays a rate negotiated with the providers. Payment cannot exceed, 1) the prevailing charges for comparable services in the locality under comparable circumstances; or 2) the rates charged by the contractor for comparable services funded by other sources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

XXI. First Choice State Plan Option (cont)

5. ASSISTIVE TECHNOLOGY

Assistive technology vendors are Qualified providers are paid for assistive technology (AT) equipment, and repairs of equipment purchased through this service and provided to eligible clients. The Department pays a rate negotiated with the vendors. Payment cannot exceed 1) the prevailing charges in the locality for comparable equipment under comparable circumstances, or 2) the rates charged by the contractor for comparable equipment funded by other sources.

The Department does not pay AT providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

The Department's reimbursement for covered AT includes any adjustments or modifications to the equipment that are required within three months of the date of delivery (not to include adjustments related to a change in the client's medical condition), fitting and set-up, and instruction to the client or client's caregiver in the appropriate use of the equipment and/or supplies.

6. COMMUNITY TRANSITION SERVICES

Community transition services may include the costs for goods or services. The Department pays a rate negotiated with the vendors. Payment cannot exceed 1) the prevailing charges in the locality for comparable goods or services under comparable circumstances, or 2) the rates charged by the contractor for comparable goods or services funded by other sources. The Department will reimburse up to $2,500.00 per transition when a participant moves from a qualified setting to an eligible community-based setting.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN.

XXII. TRIBAL OUTPATIENT SERVICES

A. TRIBAL CLINIC

Outpatient clinic services provided by or through facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act (also known as Tribal 638 facilities), are paid at the applicable all-inclusive rate published in the Federal Register or Federal Register Notices by IHS.

The applicable published outpatient per visit rate (also known as the outpatient all-inclusive rate) is paid for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services. An outpatient visit is "A face-to-face or telemedicine contact between any health care professional authorized to provide services under the State Plan and a Medicaid beneficiary for the provision of Title XIX defined services, as documented in the patient's record."

Included in the outpatient per visit rate are laboratory and x-ray services provided on-site and medical supplies incidental to the services provided to the patient. Pharmaceuticals/drugs are outside the all-inclusive rate and are reimbursed under the fee-for-service system at the applicable fee-for-service rate.

B. TRIBAL FQHC - ALTERNATIVE PAYMENT METHODOLOGY

Tribal facilities operating in accordance with section 1905(l)(2)(B) of the Social Security Act and the Indian Self-Determination and Education Assistance Act (Public Law 93-638) and that enroll in Washington Medicaid as a Tribal Federally Qualified Health Center (Tribal FQHC) have agreed through tribal consultation to be paid using an alternative payment methodology (APM) that is the published outpatient all-inclusive rate. The agency allows reimbursement for the same outpatient services and the same number of encounters per day that Tribal 638 facilities provide under this State Plan.

The agency establishes a Prospective Payment System (PPS) methodology for the Tribal FQHCs so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate is established by reference to the PPS rate that is currently paid to non-tribal FQHCs. Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES.**

XXIII. Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

Unbundled prescribed drugs for dispensed or administered for MAT are reimbursed using the same methodology as described in Attachment 4.19-B(IV) for pharmacy services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN.

XXIV. Payment for items and services furnished in connection with client participation in qualifying clinical trials

A. Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). In this methodology, under WAC 182-531-1850, the agency uses CMS-established relative value units (RVU) multiplied by both the Geographic Practice Cost Indices (GPCI) for Washington State (supplied by the Federal Register) and the conversion factors specific to Washington. The agency's conversion factor that is annually adjusted based on utilization and budget neutrality from year-to-year. For the current conversion factor, and further description, see Supplement 3 to Attachment 4.19-B.

B. When no MFSDB RVU exists, some of the codes are reimbursed using flat fee (based upon market value, other state's fees, budget impacts, etc.), acquisition cost (the cost of the actual item being billed), Medicare Laboratory Fee Schedule, ASP (106% of ASP), and/or Point of Sale (POS) actual acquisition cost (AAC).

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of items and services furnished in connection with participation in a qualified clinical trial. See 4.19-B I, General, #G for the agency's website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE**

**Payment of Medicare Part A and Part B Deductible/Coinsurance**

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State Plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP”.

   For Specific Medicare services that are not otherwise covered by this State Plan, the department uses Medicare payment rates unless a special rate or method is described on Page 3 in item 1 of this supplement.

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below and designated with the letters “MR”.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 item 1 of this supplement, for those groups and payments listed below and designated with the letters “NR”.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item __ of this supplement.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE (cont.)

**Payment of Medicare Part A and Part B Deductible/Coinsurance**

| | | | | | |
|---|---|---|---|---|---|
| QMBs: | Part A | N/R | Deductibles | N/R | Coinsurance |
| | Part B | N/R | Deductibles | N/R | Coinsurance |
| Other: Medicaid Recipients: | Part A | S/P | Deductibles | S/P | Coinsurance |
| | Part B | S/P | Deductibles | S/P | Coinsurance |
| Dual Eligible (QMB Plus): | Part A | N/R | Deductibles | N/R | Coinsurance |
| | Part B | N/R | Deductibles | N/R | Coinsurance |

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE (cont.)

**Payment of Medicare Part A and Part B Deductible/Coinsurance**

1. QMB/QMB Plus:

   State Plan covered services—maximum payment for Medicare deductible and coinsurance is:

   a. The Medicare payment rate; or

   b. In situations where the rate payable under the State Plan exceeds the amount Medicare pays, but is less than the full Medicare-approved amount, payment is the difference between the amount Medicare pays and the rate Medicaid pays under the State Plan for a Medicaid Client not entitled to Medicare.

   Services not covered by the Medicaid State Plan, but covered by Medicare— maximum payment is the Medicare deductible and coinsurance.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE (cont.)

**Payment of Medicare Part C Deductible/Coinsurance**

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State Plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP”.

   For Specific Medicare services that are not otherwise covered by this State Plan, the department uses Medicare payment rates unless a special rate or method is described on Page 6 in item 1 of this supplement.

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below and designated with the letters “MR”.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 6 in item 1 of this supplement, for those groups and payments listed below and designated with the letters “NR”.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 6 in item __ of this supplement.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE (cont.)

**Payment of Medicare Part C Deductible/Coinsurance**

| | | | | | |
|---|---|---|---|---|---|
| QMBs: | Part A | ___ | Deductibles | ___ | Coinsurance |
| | Part B | ___ | Deductibles | ___ | Coinsurance |
| | Part C | N/R | Deductibles | N/R | Coinsurance |
| Other: Medicaid Recipients: | Part A | ___ | Deductibles | ___ | Coinsurance |
| | Part B | ___ | Deductibles | ___ | Coinsurance |
| | Part C | S/P | Deductibles | S/P | Coinsurance |
| Dual Eligible (QMB Plus): | Part A | ___ | Deductibles | ___ | Coinsurance |
| | Part B | ___ | Deductibles | ___ | Coinsurance |
| | Part C | N/R | Deductibles | N/R | Coinsurance |

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE (cont.)

**Payment of Medicare Part C Deductible/Coinsurance**

1. For Qualified Medicare Beneficiaries (QMBs/QMB Plus) enrolled in Medicare Part C (Medicare Advantage) managed health care plans the department will pay the provider the lesser of:

   a. The provider's billed charge for the deductible, coinsurance, and/or copays;

   b. The difference between the Medicare plan's payment to the provider (for a service or services identified) and the maximum allowable payment rate under the Medicaid State Plan (for the same identified service or services); or

   c. The Medicaid liability if the service had been rendered under Medicare Part A or Part B.

   Notes:

   Medicare Part C claims for services covered by Medicaid that have been denied as "not medically necessary" or "experimental/investigational" by the Medicare HMO or the Medicare carrier are not eligible for Medicare Part C payment by Medicaid.
   For Medicare providers under a capitation payment arrangement with the Medicare Part C Plan, the provider may submit the claim to the department based on the pre-determined cost sharing amounts (e.g., copayment amounts) set forth in the provider's agreement with the Medicare Part C Plan. This exception is only applicable for services that the Medicare Part C Plan includes in the capitation payment rate.

   Providers submitting Medicare Part C crossover claims denoting compensation through a capitation arrangement with the Medicare Part C Plan must provide documentation of the capitation payment arrangement they have with the Medicare Part C Plan. This documentation must include specific details about the cost sharing amounts the provider is allowed to collect from Medicare beneficiaries enrolled in the plan.

   The department may upon its own discretion opt to pay Medicare part C premiums for Medicaid clients.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

Conversion Factors

Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB). The MFSDB relative value units (RVU) are established by CMS, and have three components: work, practice expense, and malpractice. These RVUs are geographically adjusted (multiplied) each year by the statewide average geographic practice cost indices (GPCI) for Washington State, as published annually in the Federal Register. The adjusted RVUs are then multiplied by a service-specific conversion factor to derive a fee for each procedure.

Washington calculates the conversion factor through modeling. Modeling is the process of projecting fees into the coming year by using the previous full fiscal year's utilization data. The agency establishes budget neutrality each year when determining its conversion factors. If there is a mandate by the legislature, the conversion factor will then increase or decrease based on that mandate.

The agency has unique conversion factors for: adult primary health care, including E&M office visits; anesthesia services; children's primary health care services, including office visits and EPSDT screens; laboratory services; maternity services, including antepartum care, deliveries, and postpartum care; and all other services (e.g., radiological services, surgical services, consultations, etc.).

The programs listed in Attachment 4.19-B may fall into one or more categories of the conversion factors listed below, depending on the covered codes for that particular program. Each conversion factor category follows the corresponding sections of the CPT and HCPCS code books.

Conversion factors as of July 1, 2022:

Adult primary health: 15.32
Anesthesia services: 21.20
Children's primary health: 23.93
Laboratory services: 0.91
Maternity services: 28.72
All other services: 19.42

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

**REIMBURSEMENT FOR PHARMACY SERVICES**

I. General Information

A. Prescription drug reimbursement through Point-of-Sale (POS) is based on:
1. The standard 11-digit National Drug Code (NDC) (5-4-2 format); and
2. The quantity filled.

B. Total reimbursement for a prescription drug does not exceed the lowest of:
1. Estimated acquisition cost (EAC) plus a dispensing fee;
2. Maximum allowable cost (MAC) plus a dispensing fee;
3. Federal Upper Limit (FUL) plus a dispensing fee;
4. Automated Maximum Allowable Cost (AMAC) plus a dispensing fee;
5. Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340B of the Public Health Services (PHS) Act and dispensed to medical assistance clients; or
6. The provider's usual and customary (U&C) charge to the non-Medicaid population.

C. Drugs administered in the provider's office and billed using the drug-specific HCPCS code and the product-specific NDC are paid at rates showing on Medicare's ASP drug pricing files; claims submitted without the NDC are denied. Exceptions to this methodology:
1. Drugs without published ASP rates which are paid at a fee equal to the POS rate at the beginning of the most recent calendar quarter. The POS rate is calculated as a discount off the Average Wholesale Price (AWP) as published by national drug file carriers or by a methodology listed under B above (EAC, MAC, AMAC, FUL U&C).
2. Drugs without assigned HCPCS and billed under codes set aside for drugs not otherwise classified, which are paid at the POS rate or based on submitted invoice cost; whichever is less. Anti-hemophilia drugs are paid at Medicare's ASP (without clotting factor furnishing fee) or based on submitted invoice cost.

II. Payment

Providers must bill only after providing a service to an eligible client. Delivery of a service or product does not guarantee payment. For example, no payment is made when:

- The request for payment is not presented within the 365 day billing limit;
- The service or product is not medically necessary or is not covered;
- The client has third party coverage and the third party pays as much as or more than, the state allows for the service or product; or
- The service or product is covered in the managed care capitation rate

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

REIMBURSEMENT FOR PHARMACY SERVICES (Cont.)

III. Estimated Acquisition Cost (EAC)

A. The agency uses the Average Wholesale Price (AWP) of each product as posted by the drug file carrier, Medispan.
B. The agency sets EAC by applying a discount off the AWP or at a rate established by a survey of product acquisition and invoice costs.
1. For single source drugs with fewer than five manufacturers/labelers, the automated discount from AWP is 16% or for selected single source drugs. The EAC may be set at a rate established by a survey of product acquisition and invoice costs.
2. For multiple source drugs with fewer than five manufacturers/labelers, the automated discount from AWP is 16%.
3. For multiple source drugs with five or more manufacturers/labelers, the automated discount from AWP is 50%.

Back to TOC

REIMBURSEMENT FOR PHARMACY SERVICES (Cont.)

IV. Dispensing Fees

A. A three-tier dispensing fee structure is used, with an adjusted fee allowed for pharmacies that participate in the Modified Unit Dose and/or True Unit Dose programs.

B. Listed below are the dispensing fee allowances for each drug ingredient in compounded and non-compounded prescriptions for pharmacies, effective for dates of service on and after 4/7/09:

| | |
|---|---|
| High-volume pharmacies (over 35,000 Rxs/yr) | $4.24/Rx |
| Mid-volume pharmacies (15,001-35,000 Rxs/yr) | $4.56/Rx |
| Low volume pharmacies (15,000 Rxs/yr and under) | $5.25/Rx |
| Unit Dose Systems | $5.25/Rx |

C. A provider's dispensing fee is determined by the volume of prescriptions the pharmacy fills for medical assistance clients and the general public, as indicated on the annual prescription count survey distributed to pharmacies.

Back to TOC

**STATE OF WASHINGTON**
**SUPPLEMENTAL REBATE**
**AGREEMENT**

This Supplemental Rebate Agreement ("Agreement") is dated as of this ____day of _____, 200__, by and between the State of Washington Health Care Authority ("State") and (name of manufacturer).

## RECITALS

**WHEREAS**, the State has the authority to enter into agreements with pharmaceutical manufacturers to collect supplemental rebates in addition to the rebates received under the CMS Rebate Agreement, pursuant to section 1927 of the Social Security Act (42 U.S.C. section l396(r)(8) for the benefit of Washington's Medicaid recipients, providing such agreements arc approved by the Centers for Medicare and Medicaid Services (CMS); and

**WHEREAS**, (name of manufacturer) is willing to provide supplemental rebates to the State based on the actual dispensing of (name of manufacturer) Covered Products under the State's Medicaid program.

**NOW THEREFORE**, in consideration of the foregoing and of the representations, warranties and covenants set fo1th below, the parties, intending to be legally bound, agree as follows:

- **Definitions**. As used herein, the following terms shall have the meanings set forth below:

1.1 **"Agreement"** means the entire Supplemental Rebate Agreement, between DSHS and the Contractor, including any Exhibits, documents, and materials incorporated by reference.

1.2 **"Average Wholesale Price ("AWP")"** shall mean the published price of the Covered Product by National Drug Code ("NDC") as supplied by the State's drug pricing file contractor on the last day of the calendar quarter that corresponds to the calendar quarter for which the State utilization data for the Covered Product is reported to (name of manufacturer).

1.3 **"Basic Rebate"** shall mean, with respect to the Covered Product, the quarterly payment by (name of manufacturer) pursuant to (name of manufacturer's) Medicaid Drug Rebate Agreement made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act (42 U.S.C, 1396r-8(c)(l) and 42 U.S.C. 1396r-8(3)).

1.4 **"CMS"** shall mean the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) of the U.S. Depat1ment of Health and Human services, or any successor or renamed agency carrying out the functions and duties heretofore carried out by such office.

1.5 **"Competitive Product"** shall mean any (specific drug class) that competes with Covered Product. (e.g., any Proton Pump Inhibitor)

1.6 **"Covered Product"** shall mean (specific product(s) strength(s) dosage form) (e.g., "Prevacid l5mg and 30mg capsules.")

1.7 **"CPI Rebate"** means, with respect to the Covered Product, the quarterly payment by (name of manufacturer) pursuant to (name of manufacturer's) Medicaid Drug Rebate Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act (42 U.S.C. l396r- 8(c)(l) and 42 U.S.C. 1396r-8(3)).

1.8 **"Ingredient Reimbursement Basis"** shall mean the formula used by State to reimburse Pharmacy providers for branded pharmaceuticals.

1.9 **"Maximum Allowable Cost (MAC)"** shall mean the lowest reimbursement rate established by the State for generic (drug class).

1.l0 **"Medicaid Drug Rebate Agreement"** shall mean the agreement in place between (name of manufacturer) and the Secretary of Health and Human Services, pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508). CMS is the agency within HHS having the delegated authority to operate the Medicaid program.

1.11 **"Medicaid Recipient"** shall mean any person enrolled in the State Medicaid Program and eligible to receive prescription drug benefits under a fee for service arrangement.

1.12 **"Net Cost"** shall mean the prescription drug ingredient reimbursement calculated as (AWP -_%) minus the sum of all rebates paid by (name of manufacturer) to the State for the Covered Product for the calendar quarter. In the event of any change to the calculation used by the State to determine drug ingredient reimbursement paid by the State to Pharmacy providers, the applicable terms of this Agreement shall be amended to reflect such change.

1.13 **"Pharmacy"** shall mean a facility licensed to dispense legend drugs, and enrolled as a State Medicaid provider.

1.14 **"Preferred Drug List"** shall mean a document listing various pharmaceutical products covered by the State Medicaid Program for the purpose of guiding the prescribing, dispensing and acquisition of pharmaceutical products. The Preferred Drug List shall not prevent beneficiaries from obtaining access to medically necessary drugs of manufacturers that participate in the OBRA 90 Medicaid Dug Rebate Program.

1.15 **"State Medicaid Program"** shall mean the joint federal and state medical assistance program as established and defined pursuant to Title 42 U.S.C. 1396, et seq., that provides reimbursement for or coverage of prescription drug products to Medicaid Recipients.

1.16· **"State Supplemental Rebate"** shall mean an amount paid on a calendar quarter basis by (name of manufacturer) _to State for utilization under State's fee for service Medicaid program pursuant to this Agreement which renders at the option of the State, either (a) a Net Cost of Covered Products that is less than or equal to the cost of the competitive product for each quarter covered by the terms of this contract; or (b) a Net Cost that is comparatively low or that is the lowest Net Cost to an equivalent therapeutic dose of Covered Product to become a preferred drug in the drug class.

1.17 **"Unit"** means a single CMS unit of Covered Product.

1.18 **"USC"** means the United States Code. All references to this agreement to USC chapters or sections shall include any successor, amended, or replacement statute.

**"WAC"** means the Washington Administrative Code. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation.

- **State Obligations**

2.1 **Preferred Drug List.** To be eligible for the Supplemental Rebates specified in Attachment B:

State shall place and maintain Covered Product on the Preferred Drug List, it being agreed that utilization shall be eligible for the State Supplemental Rebate only in calendar quarters in which Covered Product is listed on the Preferred Drug List; and

State shall place Covered Products in an advantaged position relative to non- preferred Competitive Products regarding Preferred Drug List status, unless otherwise mutually agreed upon in writing by the State and (name of manufacturer); and

Neither State nor State's fiscal agent will in any way disadvantage Covered Product through usages or restrictions not equally applied to other (drug class) on the Preferred Drug List, unless otherwise mutually agreed upon in writing by the State and (name of manufacturer); and

State shall have on file the folly executed CMS Approval Letter, attached hereto as Exhibit C and incorporated by reference.

2.2 **Preferred Dug List Documentation and Publication**. State shall communicate the inclusion of Covered Product on the Preferred Drug List to State Medicaid Program providers through the standard notification process.

a. **Invoicing.** State shall invoice (name of manufacturer) for State Supplemental Rebates separately from OBRA 90 Rebates using the format set forth by CMS (State Invoice/Utilization (Form CMS-R- 144)). State shall submit the State Supplemental Rebate invoice to (name of manufacturer) within sixty (60) days after the end of each calendar quarter in which the Covered Product subject to such State Supplemental Rebate was paid for by State. Any amended invoice shall be submitted by State within fifteen (15) months after the end of the calendar quarter in which Covered Product was paid for by State.

b. **Patient Information.** State, its agents, employees and contractors shall not provide to (name of manufacturer) any patient identifiable information or protected health information ("PHI") or any other information prohibited or regulated by laws or regulations governing confidentiality of medical or other information.

c. **Approval of Generic.** Ifduring the duration of this Agreement a generic equivalent of any Competitive Product should become available, at the State's discretion, the State will allow Covered Product to remain on the Preferred Drug List so long as the Net Cost to the State, as defined in Attachment B, is not more than the lowest reimbursement cost as established

by WAC 388-530-7000 for a generic equivalent. Nothing in this agreement or its attachments shall preclude the State from adding generic equivalents of any competitive product to the Preferred Drug List as a preferred drug.

2.6 **Competitive Product net cost.** At the option of the State, the Net Cost of (name of manufacturer's) Covered Products to Washington will be either (a) a Net Cost that is less than or equal to the cost of the competitive product for each quarter covered by the terms of this contract; or (b) a Net Cost that is comparatively low or that is the lowest Net Cost for an equivalent therapeutic dose of Covered Product to become a preferred drug in the drug class.

- **(Name of Manufacturer) Obligations**

3.I **State Supplemental Rebate Payment**. (Name of manufacturer) agrees to provide a State Supplemental Rebate for each of its Covered Products that is paid by the State and dispensed to Medicaid Recipients by Pharmacies for each calendar quarter that Covered Products are included in the Preferred Drug List. (Name of manufacturer) shall pay to State the State Supplemental Rebate amount in accordance with the formula set forth in Attachment B and the provisions of this agreement. **Within 38 days** of receipt of the states' invoice for **current quarter** utilization, labelers are required to remit rebate payments, along with the Reconciliation of State Invoice (form CMS-304), better known as the ROSI. The Medicaid drug rebate PQAS **(FORM CMS-304a)** is mandated for use by labelers to uniformly explain prior quarter actions/payments/credits to states. This form may accompany the ROSI or may be submitted separately. In either case, the PQAS must accompany rebate payments or payment adjustments for a prior quarter. Nothing in this Agreement shall be construed to relieve (name of manufacturer) from its obligation to pay OBRA 90 Medicaid Drug Rebates for utilization by State Medicaid Recipients. State shall remit the appropriate share of the State Supplemental Rebate payments made under the Agreement to CMS as required under its approved state plan.

**Payment Timeframe.** (Name of manufacturer) shall pay to State the State Supplemental Rebate amount to which State is entitled in accordance with the formula set forth in Attachment B and the provisions of this agreement, within thirty-eight (38) days after receipt of State's invoice.

3.2(a) INTEREST: Interest will begin accruing on disputed or unpaid amounts 38 calendar days from the date the State mails the State utilization data, as evidenced by the postmark by the United States Postal Service or other common mail carrier on the envelope (not a postage meter stamp). For documentation purposes, States must maintain a record of the date of mailing and manufacturers must maintain the envelope bearing the postmark from the State.

Interest accrues on the disputed portion of the rebate amount or on the total amount of the late rebate payment for all quarters and only stops accruing on the date the check is disbursed.

The interest calculation is based on a 365-day year with simple interest applied to the average of the yield of the weekly 90-day Treasury bill auction rates during the period for which interest will be charged.

**Incomplete Submission.** (Name of manufacturer) shall have no obligation to pay State Supplemental Rebate amounts for claims that are not submitted as part of an invoice in accordance with Section 2.3 of this Agreement. (Name of manufacturer) shall notify State or its designee of any incomplete submission within thirty-eight (38) days of (name of manufacturer's) receipt of such submission pursuant to Section 2.3.

**Over/Underpayment.** If either party discovers an en-or in the payment of State Supplemental Rebates, it shall notify the other of such error. The parties shall attempt to reconcile all differences through discussion and negotiation; if that attempfails, the patties will resolve their dispute in accordance with generally accepted applicable procedures followed by State or CMS in disputes concerning Medicaid Drug Rebates. Any overpayment shall be deducted from subsequent State Supplemental Rebates payable under this Agreement. In the event that no subsequent State Supplemental Rebates are payable, State will refund any such overpayment to (name of manufacturer) within thirty (30) days of the parties' acknowledgement of the overpayment. (Name of manufacturer) will remit any underpayment to State within thirty (30) days of the parties' acknowledgement of such underpayment.

**CMS Rebate Changes**. In the event of a change in the CMS rebate, the (name of manufacturer) shall recalculate their supplemental rebate obligation and pay additional obligations within 60 days.

**Discretion to Market.** Nothing in this Agreement shall be construed to prohibit (name of manufacturer) from discontinuing production, marketing or distribution of any Covered Product or from transferring or licensing any Covered Product to a third party. It is understood that (name of manufacturer) is liable for the payment of State Supplemental Rebates only for Covered Products (as identified by the 11-digit NDC code) distributed to Medicaid Recipients. If (name of manufacturer) elects to discontinue production, marketing or distribution of any Covered Product or to transfer or license any Covered Product to a third party, (name of manufacturer) shall make every reasonable effort to notify State prior to such actions.

## Term and Termination

**Effective Date.** Agreement shall be effective as of (Month. day, year) and shall continue in force through (Month. day, year), unless it is terminated sooner pursuant to the following:

**Breach**. Ifeither party commits a material breach of this Agreement, the non-breaching party shall deliver written notice mailed by certified mail, return receipt requested, of the alleged breach to the breaching party, with an opportunity for the breaching party to cure the breach during the thirty (30) day period following delivery. Failure to cure shall give the non-breaching patty the right to cancel this Agreement at the end of the thirty (30) day period. The non-breaching party shall give the breaching party final written notice of the cancellation of this Agreement.

b) **Without Cause**. Either party may terminate this Agreement without cause as of the end of any calendar quarter by giving the other party ninety (90) days prior written notice.

c) **New Agreements**. Upon signatures of and execution of a more current Supplemental Agreement (SRA) between the two parties to this Agreement, this SRA shall automatically terminate and be replaced by the new Agreement upon its effective date.

4.2 **Accrued Obligations/Remedies.** The expiration or termination of this Agreement shall not affect any rights or obligations of the parties that have accrued prior to the effective date of such termination. The fact that either party exercises any right of termination it may have under this Agreement shall not prevent such party from pursuing any other remedy it may be entitled to in law or equity. Any remedy provided herein shall not be deemed an exclusive remedy unless expressly provided for as such.

4.3 **Execution, Amendment, and Waiver**. This Agreement shall be binding only upon signature by both parties. This Agreement, or any provision, may be altered, amended, or waived by a written amendment executed by both pa1iies. Any alterations or amendments to the Agreement must be authorized by CMS.

5 **Miscellaneous**

5.1 **Record Keeping and Audit.** During the term of this Agreement and for a period of three (3) years thereafter, both parties to the Agreement shall use reasonable efforts at all times to ensure that they maintain accurate books, files and records relevant to this Agreement. At either party's written request, State shall make such information · available for inspection by the representatives or designated auditors during regular business hours. Upon written request, each party shall otherwise have the right to inspect, up to once each year, all such relevant books and records of the other party to verify compliance with the terms of this Agreement.

**Indemnification.** (Name of manufacturer) shall be responsible for and shall indemnify and hold State harmless from all claims resulting from the acts or omissions of (name of manufacturer) and any Subcontractor. State shall be responsible and shall indemnify and hold (name of manufacturer) harmless from all claims resulting from the acts or omissions of State.

**Confidentiality**. Except as otherwise may be required to be disclosed by law and in accordance with the Rebate Agreement between the Secretary of Health and Human Services and the drug manufacturers, information disclosed by (name of manufacturer) in connection with this Agreement will not be disclosed by the State. Each party shall maintain the confidentiality of all the terms and conditions of this Agreement throughout the term hereof and for a period of three (3) years thereafter.

5.4 **Notices.** Any notice required or permitted to be given by either party to the other shall be given in person or sent by first class mail or express delivery, addressed to the other party at the address set forth below.

**(Name of Manufacturer):**
Mailing Address

**State:**
_____
_____
_____
**Attn:** _____

**Force Majeure**. Noncompliance with any obligations hereunder due to force majeure, such as acts of God, laws or regulations of any government, war, civil commotion, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common carriers, and any other causes beyond the reasonable control of the parties, shall not constitute breach of contract.

**Assignment**. Neither party shall have the right to assign this Agreement to a third party without the prior written consent of the other party, which consent shall not be unreasonably withheld. Any permitted assignee shall assume all obligations of its assignor under this Agreement. No assignment shall relieve any party of responsibility for the performance of any obligations that have accrued prior to such assignment.

**No Waiver of Rights.** The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy in the future. Every right and remedy given by this Agreement to the parties may be exercised from time to time as often as appropriate.

**Entire Agreement.** This Agreement contains the entire agreement and understanding of the parties as authorized by CMS. This Agreement (including Attachments) may not be amended or' modified except upon the written agreement of both parties.

**Governing Law.** This Agreement shall be governed by the laws of the State of Washington. In the event of a lawsuit involving this Agreement, venue shall be proper only in Thurston County, Washington.

**Effect of Future Laws.** In the event of the enactment, promulgation, rescission, modification or interpretation of any law or regulation after the date hereof which would (a) materially adversely affect the manner in which either party is obligated to perform under this Agreement, (b) adversely affect for either party the net prices or State Supplemental Rebates or other terms applicable under this Agreement, or (c) have the effect of requiring the net prices or State Supplemental Rebates or other terms applicable under this Agreement to be extended or offered to any third party, each party shall have the right to enter into good faith negotiation with the other in order to seek to agree on reasonable terms for maintaining the intent of the Agreement affected by such enactment, promulgation, etc. Agreement on any such terms shall be in the sole discretion of each party. If the parties do not agree within sixty (60) days of a party's written

request for negotiations, either party may terminate this Agreement with respect to the affected Covered Products upon expiration of the sixty (60) day period, with immediate effect.

**Compliance with Law.** In connection with its respective obligations under this Agreement, each party shall comply with all applicable federal, state and local laws and regulations, including without limitation any disclosure or consent requirements.

**Authority.** State and (name of manufacturer) each represent and warrant to the other that the person signing below has all requisite legal power and authority to execute this Agreement on behalf of each party and each party shall thereby be bound.

5.13 **Best Price Contingency**. The effectiveness of this Agreement shall be contingent on (name of manufacturer's) Best Price and AMP not being affected by State Supplemental Rebates.

**CMS Approval Contingency.** The effectiveness of this Agreement shall be contingent on receipt of CMS approval by State, as evidenced by the CMS Approval Letter, attached hereto as Exhibit C and incorporated by reference.

IN WITNESS WHEREOF, this Agreement has been executed by the parties set forth below:

| **(Name of Manufacturer)** | **State of Washington**<br>**Health Care Authority** |
|---|---|
| _____ | _____ |
| Name | Name |
| Title: _____ | Title: |
| Date: _____ | Date: |

## ATTACHMENT A

### Covered Products

The products to which this Supplemental Rebate Agreement shall apply are the following:

| 11 Digit NDC | Brand | Strength | Package Description | CMS Unit Type |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

These products are effective under this Supplemental Rebate Agreement upon the date below following the appropriate signatures. A new Attachment A shall be signed by both parties upon a new NDC for the product in this Agreement being marketed by the Manufacturer. All NDCs covered under this agreement will be listed above and will replace the previous Attachment A.

**(Name of Manufacturer)**

_____
Name

Title: _____

Date: _____

**State of Washington**
**Health Care Authority**

_____
Name

Title: _____

Date: _____

## ATTACHMENT B

**New offer is for Net Cost for exclusive preferred drug _____**

**New offer is for Net Cost for one of two preferred drugs _____**

**New offer is for Net cost for one of many preferred drugs _____**

### Rebate Formula

Supplemental Rebate shall be calculated on a calendar qua1ter basis according to the following formula.

Supplemental Rebate= ([i] Ingredient Reimbursement) - ([ii] CMS Rebate) - (Net Cost)

(_____Quarter Year) Net Cost for (name of product):

Net Cost for (name/dosage of product) = (price)

Net Cost for (name/dosage of product) = (price)

---

[i] Ingredient Reimbursement based on the Average Wholesale Price (AWP) as supplied by the State's drug pricing file contractor on the last day of a calendar quarter for the quarter in which the rebate applies;

[ii] CMS Rebate as calculated and provided to State by CMS on a calendar quarter for the quarter in which the rebate applies.

# ATTACHMENT C

## CMS Approval Letter



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid and State Operations**

August 27, 2008

Robin Arnold-Williams
Secretary
Department of Social and Health Services
P.O. Box 45010
Olympia, WA 98504-5010

Dear Ms. Arnold-Williams:

We have reviewed Washington's State Plan Amendment (SPA) 08-001 received in the Regional Office on July 15, 2008. This Amendment would allow Washington to modify their currently authorized Supplemental Rebate Agreement (SRA) in order to collect supplemental rebates for Washington's Medicaid beneficiaries. We believe that this Amendment is consistent with the objectives of the Medicaid program and is designed to increase the efficiency and economy of the Medicaid program and benefit Medicaid beneficiaries.

Based upon the information provided, we are pleased to inform you that Washington SPA 08-001 is approved and effective August 27, 2008. Approval of Washington SPA 08-001 extends only to Washington's SRA with its Attachments as submitted to the Centers for Medicare & Medicaid Services (CMS) on July 15, 2008. If changes are subsequently made to the SRA or to the Attachments submitted to CMS on July 15, 2008, a new SPA and any required documents should be submitted to CMS for review and authorization.

Per our request, and with your authorization, we have incorporated the pen-and-ink changes on the CMS-179, including the revised SPA sections and page numbers.

A copy of the CMS-179 form, as well as the pages approved for incorporation into the Washington State plan, will be forwarded by the Seattle Regional Office. If you have any questions regarding this Amendment, please contact Gail Sexton at (410) 786-4583.

Sincerely,

Deirdre Duzor
Director, Division of Pharmacy

cc: Barbara Richards, ARA, Seattle Regional Office
Maria Garza, Seattle Regional Office

**ATTACHMENT A-WA**

**TOP$sm MEDICAID PROGRAM PARTICIPATION AGREEMENT**
**FOR**
**WASHINGTON STATE HEALTH CARE AUTHORITY**

The State of Washington acting by and through the Washington State Health Care Authority, 626 8th Ave. SE, Olympia, WA 98501, hereinafter collectively referred to as "**Participating Medicaid Program**", hereby enters into this TOP$sm Medicaid Program Participation Agreement ("**Agreement**") effective this 1st day of October, 2017, with Provider Synergies, L.L.C. ("**Administrator**").

**WHEREAS,** the Participating Medicaid Program administers Washington State Medicaid pursuant to the Social Security Act (42 U.S.C. 1396 *et seq*.); and

**WHEREAS**, Administrator has negotiated and entered into agreements with prescription drug manufacturers ("**Manufacturers**") to provide discounts and rebates ("**State Supplemental Drug Rebate(s)**") on certain of such Manufacturers' drug products that are covered by the Participating Medicaid Program; and

**WHEREAS,** the Participating Medicaid Program is authorized to enter into State Supplemental Drug Rebate agreements pursuant to Washington Administrative Code (WAC) 182-530-7500 and Revised Code of Washington (RCW) 41.05.021 and 41.05.160 and Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, WSR 07-20-049, and WAC 388-530-7500; and

**WHEREAS,** the Participating Medicaid Program represents and warrants that it is the intent and expectation of such Participating Medicaid Programs that Supplemental Rebates invoiced hereunder shall be excluded from Manufacturer's calculation of Best Price or AMP.

**WHEREAS,** the Participating Medicaid Program desires to access State Supplemental Drug Rebates; and

**WHEREAS**, the Participating Medicaid Program has contracted with Administrator for the provision of State Supplemental Drug Rebate contracting and preferred drug list ("**PDL**") administration services; and

**NOW THEREFORE**, in consideration of the mutual promises and covenants contained herein, Participating Medicaid Program and Administrator agree as follows:

**Definitions**

**WHEREAS**, "**Controlling Agreement**" shall mean the contract between Administrator, as either a prime contractor or a subcontractor, and a Participating State pursuant to which Administrator is obligated to provide one or more of the following services to the Participating State: State Supplemental Rebate negotiation, contracting services, PDL design and maintenance, and pharmacy and therapeutics committee administration services.

**A-1. Obligations of Parties:** Participating Medicaid Program hereby agrees to participate in the multi-state State Supplemental Drug Rebate pooling program known as the The Optimal PDL $olution or TOP$sm. Administrator agrees to negotiate and enter into State Supplemental Drug Rebate agreements

on behalf of Participating Medicaid Program and other state Medicaid agencies who agree to participate in TOP$sm .

**A-2.** **Notices:** All written notices, requests and communications, unless specifically required to be given by a specific method, may be: (i) delivered in person, obtaining a signature indicating successful delivery; (ii) sent by a recognized overnight delivery service, obtaining a signature indicating successful delivery; (iii) sent by certified mail, obtaining a signature indicating successful delivery; or (iv) transmitted by telefacsimile, producing a document indicating the date and time of successful transmission, to the address or telefacsimile number set forth below. A party may at any time give notice in writing to the other parties of a change of name, address, telephone, or telefacsimile number.

**To Participating Medicaid Program**:

Washington State Health Care Authority
Prescription Drug Program
626 8th Ave SE
PO Box 45502
Olympia, WA 98504-5502
Telephone 360-725-1564
Telefacsimile 360-586-9551

**To Administrator:**

Provider Synergies, L.L.C.
Attention: Chief Financial Officer
With a copy to: Legal Department
11013 W. Broad St.
Suite 500
Glen Allen, Virginia 23060-5937

**A-3** **Term.** This Agreement shall be effective as to Participating Medicaid Program as of the date herein stated above in this Agreement subject to CMS authorization and shall continue in effect until September 30, 2018. Thereafter, this Agreement shall automatically renew for successive one (1)-year terms, unless this Agreement is otherwise terminated as provided for in this Agreement or until such time as the Controlling Agreement between the Participating Medicaid Program and Administrator is terminated. Notwithstanding the forgoing, no rebates shall accrue hereunder with respect to any drug product until the latter of the date: (i) such drug product is effective upon public dissemination of Participating Medicaid Program's Preferred Drug List via website for providers and prescribers, (ii) the applicable Manufacturer Participation Agreement is fully executed and returned to the Manufacturer, or (iii) the effective date of CMS approval of the Participating Medicaid Program's applicable state plan amendment.

**A-4.** **Termination without Cause by Participating Medicaid Program**. Notwithstanding any contrary provision in this Agreement, this Agreement may be terminated by Participating Medicaid Program as to the entirety of Participating Medicaid Program's participation herein, or as to any Manufacturer Supplemental Covered Product(s) or as to any NDC(s) at the option of Participating Medicaid Program without cause as of the end of the calendar quarter upon thirty (30) days written notice to

Administrator. Administrator will thereupon be obligated to notify Manufacturer of such termination in writing. In the event that Administrator is no longer contracted to provide or administer Preferred Drug List and State Supplemental Rebate services, the Participating Medicaid Program may not disseminate information regarding the State Supplemental Drug Rebates to any nonparties to this Agreement, except as may be required by law or necessary for the reconciliation of State Supplemental Drug Rebate invoices.

**A-5.** **Addition of Participating Medicaid Programs.** Any Medicaid program which has the necessary state and CMS authorizations to operate a PDL and State Supplemental Drug Rebate program and which is contracted to utilize Administrator to administer its PDL and State Supplemental Drug Rebate program is eligible to join TOP$sm as a Participating Medicaid Program subject to CMS authorization. Upon the expansion or contraction of TOP$sm, to either include a state Medicaid agency as a Participating Medicaid Program or exclude a Participating Medicaid Program, Administrator shall expressly notify in writing all Participating Medicaid Programs as to the identity of the newly included state Medicaid agency or the identity of newly excluded Participating Medicaid Program along with the effective date for such inclusion or exclusion.

**A-6.** **Addition of Participating Medicaid MCOs**. To the extent permitted by: (i) CMS, (ii) applicable law, and (iii) the Participating State Medicaid Program's Medicaid Plan, any Participating Medicaid Program added hereunder may elect, but shall not be required, to include Medicaid Utilization from Participating Medicaid MCOs in their Supplemental Rebate invoices, provided that the Participating Medicaid Program provide to Administrator an executed and complete copy of Attachment A-2 indicating such election, as well as a copy of the applicable Participating Medicaid Program's Medicaid Plan (and/or amendment thereto) permitting such election. Supplemental Rebates shall begin to accrue to any new Participating Medicaid MCO pursuant to this Agreement for a Supplemental Covered Product upon the later of: (i) Administrator receiving the applicable State's complete and executed Attachment A-2 electing to include Participating Medicaid MCO utilization hereunder, or (ii) effective date for such Participating Medicaid MCO utilization, as set forth on Attachment A-2. The Participating Medicaid Program shall be solely responsible for ensuring that all Participating Medicaid MCOs for which utilization is invoiced for Supplemental Rebates comply with all applicable terms and conditions of this Agreement and applicable law, the State Medicaid Plan, and the Medicaid Program's contracts with its Medicaid MCOs.

**A-7.** **Bankruptcy and Insolvency**. Participating Medicaid Program shall have the right to cancel this TOP$sm Medicaid Program Participation Agreement immediately without prior notice in the event that Manufacturer is adjudicated bankrupt, or makes an assignment for the benefit of creditors without Administrator's and the Participating Medicaid Program's prior written consent, which shall not be unreasonably withheld, or in the event that a receiver is appointed for Manufacturer.

**A-8.** **Transfer of Manufacturer Supplemental Covered Product(s) to TOP$sm.** Participating Medicaid Program and Administrator agree that Participating Medicaid Program will realize optimal savings if the Supplemental Covered Products listed on current State Supplemental Drug Rebate agreement(s) Between Participating Medicaid Program and Manufacturer are transferred to this Agreement within one (1) year.

**IN WITNESS WHEREOF, the Participating Medicaid Program and Administrator have caused this Agreement to be executed on the dates shown below by representatives authorized to bind the respective parties.**

| **Administrator** | **Washington State Health Care Authority** |
|---|---|
| By: _____ | By: _____ |
| Gregory Kaupp | Melanie Anderson |
| Title: SVP, Market General Manager | Title: Contracts Administrator |
| Date: _____ | Date: _____ |

**ATTACHMENT A-1**

***RESERVED***

**ATTACHMENT A-2**
**ATTESTATION OF INCLUSION/EXCLUSION OF MEDICAID MCOS**

The State of Washington acting by and through the Washington State Health Care Authority (hereinafter collectively referred to as **"Participating Medicaid Program**"), hereby represents and warrants the following with respect to Medicaid MCOs **(must check one):**

☐ Effective for utilization dispensed to Participating Medicaid MCO members on or after _____ (date*), the Participating Medicaid Program will include utilization of Participating Medicaid MCO(s) for State Supplemental Drug Rebates under this Agreement for:

☐ all preferred Supplemental Covered Products, OR

☐ limited to the following Supplemental Covered Product(s) or Product Category(ies):

1. _____
2. _____

I certify on behalf of the Participating Medicaid Program listed below that the State Medicaid Plan permits the inclusion of Medicaid MCO utilization in State Supplemental Drug Rebates, and that the State's contracts with Participating MCOs do not prohibit such inclusion. I further certify on behalf of the Participating Medicaid Program listed below that the State has reasonably determined that: (i) the utilization of any Participating Medicaid MCO submitted hereunder is eligible for National Rebates under 42 U.S.C. § 1396r-8 and (ii) each such Participating Medicaid MCO shall align their respective formulary(ies) and/or preferred drug list(s), as applicable, assuring access to preferred Supplemental Covered Product is no more restrictive than the Participating Medicaid Program Medicaid PDL, for any period with respect to which the Participating Medicaid Program will invoice for Supplemental Rebates for utilization under this Agreement. It is the intent and expectation of the Participating Medicaid Programs that Supplemental Rebates hereunder shall be excluded from Manufacturer's calculation of Best Price or AMP. ***If this option is checked, the State must have documented the above determination via applicable regulation, law, contract, or other formal state agency issuance and the State must attach hereto: (1) a copy of such documentation, as well as (2) a copy of the applicable Participating Medicaid Program's Medicaid Plan (and/or amendment thereto) permitting the election of this option.***

☐ The Participating Medicaid Program will exclude utilization from all of its Medicaid MCOs under this Agreement.

☐ The Participating Medicaid Program has no Medicaid MCOs.

MANUFACTURER CONSENT SHALL NOT BE REQUIRED FOR A STATE TO AMEND THIS ATTACHMENT A-2

***So Certified:***

State Participating Medicaid Program: **Washington State Health Care Authority**

By: _____

Melanie Anderson
Title: Contracts Administrator

Date: _____

* *Effective date for including Participating MCO utilization shall not predate the date this Attachment A-2 is executed by the State*

| Washington State Health Care Authority | State of Washington<br>Value-based Supplemental Rebate Agreement | HCA Agreement Number: |
|---|---|---|

**THIS AGREEMENT is made by and between Washington State Health Care Authority, hereinafter referred to as "HCA" or "State," and the party whose name appears below, hereinafter referred to as the "Manufacturer."**

| MANUFACTURER NAME | | MANUFACTURER doing business as (DBA) | | |
|---|---|---|---|---|
| MANUFACTURER ADDRESS | | City | State | Zip Code |
| MANUFACTURER CONTACT | MANUFACTURER TELEPHONE | MANUFACTURER E-MAIL ADDRESS | | |

| HCA PROGRAM | HCA DIVISION/SECTION |
|---|---|
| HCA CONTACT NAME AND TITLE | HCA CONTACT ADDRESS<br>Health Care Authority<br>PO Box ____<br>(Street Address: 626 8th Avenue SE)<br>Olympia, WA 98504-____ |
| HCA CONTACT TELEPHONE<br>(360) 725-_____ | HCA CONTACT E-MAIL ADDRESS<br>_____@hca.wa.gov |

| AGREEMENT START DATE | AGREEMENT END DATE |
|---|---|
| PURPOSE OF AGREEMENT:<br>The purpose of this Agreement is to establish terms for HCA to collect Supplemental Rebates in addition to rebates received under the Federal Drug Rebate Program, pursuant to the Federal Drug Rebate Program for quarterly utilization of the Manufacturer's Covered Product(s) in the Washington Medicaid Program. | |

**The parties signing below warrant that they have read and understand this Agreement, and have authority to execute this Agreement. This Agreement t will be binding on HCA only upon signature by HCA.**

| MANUFACTURER SIGNATURE | PRINTED NAME AND TITLE | DATE SIGNED |
|---|---|---|
| HCA SIGNATURE | PRINTED NAME AND TITLE | DATE SIGNED |

**VALUE-BASED SUPPLEMENTAL REBATE AGREEMENT**

This Value-Based Supplemental Rebate Agreement ("Agreement") by and between the Washington Health Care Authority ("State") and _____ ("Manufacturer") sets forth the terms and conditions of this Agreement.

**RECITALS**

WHEREAS, State and Manufacturer both participate in the Medicaid Drug Rebate Program ("MDRP"), which requires Manufacturer to pay a rebate to State on covered outpatient drugs pursuant to a statutory formula;

WHEREAS, MDRP allows for supplemental rebates and there may be an existing supplemental rebate arrangement between State and Manufacturer;

WHEREAS, State and Manufacturer desire to enter into an outcome-based supplemental rebate arrangement for the payment of rebates in excess of the MDRP statutory rebate and any existing supplemental rebate;

WHEREAS, State and Manufacturer would like the flexibility of including bona fide, itemized services to support the outcome-based arrangement in accordance with Section 1927(k)(1)(B)(i)(II) of the Social Security Act, 42 U.S.C. Section 1396r-8(k)(1)(B)(i)(II), and 42 C.F.R. Section 447.502;

WHEREAS, State and Manufacturer desire that the outcome-based supplemental rebate arrangement include the payment of a base administrative fee by the Manufacturer to the State to cover the administrative costs related to this Agreement; and

WHEREAS, State and Manufacturer would like the outcome-based supplemental rebate arrangement to encompass drugs purchased in a fee-for-service ("FFS") structure, drugs purchased in a managed care organization ("MCO") structure or both

NOW THEREFORE, in consideration of the foregoing and of the representations, warranties and covenants set forth below, the Parties, intending to be legally bound, agree as follows:

**1. Definitions.** As used herein, the following terms shall have the meanings set forth below:

1.1. "Average Manufacturer Price or AMP" shall mean the Average Manufacturer Price as defined in Section 1927(k)(1) of the Social Security Act, 42 U.S.C. Section 1396r-8(k)(1), and final regulations promulgated by the Centers for Medicare and Medicaid Services ("CMS"), as such statute or regulations may be amended from time to time. The AMP shall exclude rebates paid under this Agreement.

1.2. "Base Administrative Fee" shall mean the amount paid by the Manufacturer to the State to cover the administrative costs related to performance of this Agreement. The fee may be in the form of a one-time fee, a per claim fee, a percentage-based fee, or some other arrangement as determined by the Parties and described in Appendix A.

1.3. "Best Price" shall mean the Best Price as defined in Section 1927(c)(1)(C) of the Social Security Act, 42 U.S.C. Section 1396r-8(c)(1)(C), and final regulations promulgated by CMS, as such statute or regulations may be amended from time to time. The Best Price shall exclude rebates paid under this Agreement.

1.4. "Bona Fide Service Fee" shall mean a fee paid by Manufacturer to a third-party purchaser of covered outpatient drugs that represents fair market value for a bona fide, itemized service and that otherwise meets the definition of "bona fide service fee" codified at 42 C.F.R. Section 447.502. Examples include fees associated with administrative service agreements and patient care programs, such as medication compliance and patient education programs.

1.5. "Bona Fide Service Plan" shall mean a plan agreed upon by the Parties for Manufacturer to pay Bona Fide Service Fees to third-party purchasers. The value of the Bona Fide Service Fees paid under the Bona Fide Service Plan is described in Appendix A.

1.6. "Confidential Information" means any nonpublic confidential or proprietary information of a party, including but not limited to trade secrets, rebate pricing data, and terms of Manufacturer agreements.

1.7. "Covered Product" shall mean the pharmaceutical product or products identified in Appendix A and subject to evaluation and a supplemental rebate under this Agreement.

1.8. "Covered Product Status" shall mean the status of Covered Product granted by the State. At a minimum, State will ensure access to Covered Product and will not disadvantage Covered Product to competitive drugs in Product Class.

1.9. "Data Aggregator" shall mean a State entity or contractor (such as a consulting company, research institution, State designee or other organization under contract with the State) that tracks Covered Product's utilization, evaluates its performance and calculates the Outcome-Based Supplemental Rebates owed by Manufacturer, if any. The Data Aggregator is identified or otherwise described in Appendix A.

1.10. "Evaluation Methodology" shall mean the methodology described in Appendix A for evaluating the performance of the Covered Product based on the Outcome-Based Benchmarks agreed upon by the Parties.

1.11. "Intervention Population" shall mean the group of patients whose use of Covered Product during the Utilization Period generates the Utilization Data that is evaluated by the Data Aggregator for purposes of assessing the performance of Covered Product and calculating the Outcome-Based Supplemental Rebates. The Intervention Population is described in Appendix A and may be a subset of the total Medicaid population using Covered Product during the Utilization Period.

1.12. "National Drug Code" or "NDC" shall mean a unique eleven-digit, three-segment number for identifying a pharmaceutical based on the drug's labeler, its product strength and dosage form and its packaging. The Covered Product will be identified at the NDC-9 digit level to ensure that all package sizes are captured under this Agreement, unless the terms of Appendix A specify that the Covered Product will be identified at the NDC-11 digit level.

1.13. “Outcome-Based Benchmarks” shall mean the measurable benchmarks, thresholds and/or outcomes described in Appendix A used to evaluate the Covered Product’s performance for purposes of calculating a supplemental rebate.

1.14. “Outcome-Based Supplemental Rebate” shall mean the amount paid by Manufacturer in excess of the MDRP-mandated rebate and any other state supplemental rebate based on the process described in Section 2 and Appendix A.

1.15. “Outcome-Based Supplemental Unit Rebate Amount” shall mean the amount Manufacturer agrees to pay State under this Agreement at the unit level.

1.16. “Party” or “Parties” small mean State and/or Manufacturer.

1.17. “Performance Data” shall mean the data generated by the Data Aggregator by applying the Outcome-Based Benchmarks and Evaluation Methodology to the Utilization Data.

1.18. “Preferred Status” shall mean advantages the State may grant to Covered Product using a preferred drug list (“PDL”), prior authorization procedures, step-edit therapy or other means as described in Appendix A to manage Product Class. The Covered Product in this Agreement may or may not be part of the PDL and subject to PDL edits.

1.19. “Product Class” shall mean a group of pharmaceutical products that are used to treat the same condition or disease state as Covered Product.

1.20. “Rebate Calculation Methodology” shall mean the methodology for calculating the Outcome-Based Supplemental Rebate described in Appendix A.

1.21. “Settle-Up Period” shall mean the period in which the Parties and Data Aggregator evaluate the Performance Data, calculate the Outcome-Based Supplemental Rebates owed by Manufacturer and, if applicable, determine whether the Bona Fide Service Plan was fulfilled. The length of the Settle-Up Period is specified in Appendix A.

1.22. “Unit” shall mean the drug unit is the lowest identifiable amount on which the Outcome-Based Supplemental Rebate is calculated (e.g., tablet or capsule for solid dosage forms, milliliter for liquid forms, gram for ointments or creams) and shall be the same unit as specified by the Manufacturer as part of its submission of data under the MDRP.

1.23. “Utilization” shall mean the total number of units of the Covered Product reimbursed by State during the Utilization Period and included in the assessment of Covered Product’s performance according to the Evaluation Methodology.

1.24. “Utilization Data” shall mean the data collected by the Data Aggregator necessary to evaluate the Covered Product’s performance and to calculate the Outcome-Based Supplemental Rebates owed by Manufacturer for the applicable Utilization Period.

1.25. “Utilization Period” shall mean the period in which Utilization Data is collected. The length of the Utilization Period is specified in Appendix A.

## 2. Evaluation and Settle-Up Process

2.1. Utilization. Utilization Data will be collected during the Utilization Period by the State and forwarded to the Data Aggregator.

2.2. Evaluation. The Data Aggregator shall generate Performance Data by using the Outcome-Based Benchmarks and Evaluation Methodology to evaluate the Utilization Data. The Performance Data will be compiled and summarized prior to the beginning of the Settle-Up Period.

2.3. Data-Sharing. State and Data Aggregator will share with Manufacturer periodic reports during the Utilization Period. Any patient health information ("PHI") contained in the reports provided to Manufacturer shall be de-identified in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Parties may use a unique alpha-numeric code as a case identifier to track the care rendered to any individual patient during the Utilization Period. The alpha-numeric code shall not be derived from "Individually Identifiable Health Information," as specified and defined in HIPAA. The reports provided to Manufacturer shall provide data on:

2.3.1. Application of the Outcome-Based Benchmarks and Evaluation Methodology to the Utilization Data;

2.3.2. The quality and integrity of the Performance Data; and

2.3.3. Preliminary calculation of the Outcome-Based Supplemental Rebates owed by Manufacturer, if any, based on application of the Rebate Calculation Methodology to the Performance Data.

2.4. Settle-Up. During the Settle-Up Period, the State and Data Aggregator shall calculate all Outcome-Based Supplemental Rebates owed using the Rebate Calculation Methodology in Appendix B. A report of these calculations and the Outcome-Based Supplemental Rebates shall be shared with the Manufacturer within [specify time period] of the Settle-Up period commencing. In no case may the Outcome-Based Supplemental Rebate amount be a negative amount such that State would be obligated to pay Manufacturer any amount under the Agreement, except with respect to overpayments by Manufacturer described in Section 6.5 below. If the Parties cannot agree on the amount owed or any other aspect of the utilization, evaluation and settle-up procedures described above, they will use the dispute resolution process described in Section 6 to address their disagreement.

2.5. CMS Approval and Best Price Contingency. The effectiveness of this Agreement shall be contingent on receipt of approval by CMS. It shall also be contingent on Manufacturer's Best Price and AMP not being affected by the Medicaid Outcome-Based Supplemental Rebate nor the Bona Fide Service Fees payable under this Agreement.

2.6. Effect of Subsequent Changes to MDRP or State Supplemental Rebates. Any changes to any rebates required under the MDRP or any other state supplemental rebates (other than the Outcome-Based Supplemental Rebate) shall not invalidate or otherwise affect the calculation of Outcome-Based Supplemental Rebate or the Base Administrative Fee unless intended otherwise by the Parties as reflected in writing in Appendix B.

**3. State Obligations**

3.1. Covered Product Status. At a minimum, State shall ensure access to Covered Product and not disadvantage Covered Product to competitive drugs in Product Class.

3.1.1. Details about Covered Product Status in the FFS setting are described in Appendix A.

3.1.2. With respect to covered outpatient drugs reimbursed by MCOs, State will work with MCOs to ensure that Covered Product has Covered Product Status. If relevant, details about Covered Product Status in the MCO setting are described in Appendix A.

3.2. Preferred Status. State may also arrange for Preferred Status for Covered Product.

3.2.1. With respect to covered outpatient drugs reimbursed on an FFS basis, Covered Product may have Preferred Status. If relevant, details about Covered Product's Preferred Status in the FFS setting are described in Appendix A.

3.2.2. With respect to covered outpatient drugs reimbursed by MCOs, State will work with MCOs to ensure that Covered Product has Preferred Status. If relevant, details about Covered Product's Preferred Status in the MCO setting are described in Appendix A.

3.2.3. State may subject Covered Product to prior authorization, step-edit therapy and other management tools that it applies to other drugs within the Product Class.

3.3. Data Aggregator. State shall contract with or otherwise arrange for a Data Aggregator to track Covered Product's utilization, evaluate its performance and calculate the Outcome-Based Supplemental Rebates owed by manufacturer, if any. The contract between State and a third-party Data Aggregator shall comply with the requirements of state and federal anti-kickback laws, including the federal Anti-Kickback Statute at Section 1128B of the Social Security Act, 42 U.S.C. Section 1320a-7b, to the extent those laws are applicable. Nothing in this provision shall prevent the State from serving as the Data Aggregator. Data Aggregator shall perform the following tasks:

3.3.1. Gather and tabulate Utilization Data relating to the use of the Covered Product during the Utilization Period;

3.3.2. Generate Performance Data by applying the Outcome-Based Benchmarks and Evaluation Methodology to the Utilization Data;

3.3.3. Meet with and provide interim reports to the Parties regarding the collection and evaluation of the Utilization Data;

3.3.4. Make any adjustments to the collection of Utilization Data and/or Performance Data requested by the State;

3.3.5. Calculate the Outcome-Based Supplemental Rebates owed by Manufacturer, if any, by applying the Rebate Calculation Methodology to the Performance Data.

3.4. Patient Privacy. If the Data Aggregator is a third-party entity, State shall, in accordance with HIPAA, enter into a Business Associate Agreement ("BAA") with Data Aggregator and abide by all patient privacy requirements under HIPAA.

3.5. Cooperation. State will provide necessary information or otherwise cooperate with Data Aggregator so that Data Aggregator can perform its duties under Section 3.3.

3.6. Implementation of Bona Fide Service Plan. If applicable, State will assist Manufacturer with implementation of Bona Fide Service Plan as described in Appendix A. The Parties shall ensure that the Bona Fide Service Plan complies with state or federal anti-kickback laws, such as those appearing in Section 1128B of the Social Security Act, 42 U.S.C. Section 1320a-7b and any applicable safe harbor, including but not limited to the safe harbor for personal services and management contracts codified at 42 U.S.C. Section 1001.952(d).

3.7. Invoicing. If applicable, State or its designee will invoice Manufacturer for the Outcome-Based Supplemental Rebates within ninety (90) days after the end of the Settle-Up Period. State or its designee shall invoice Manufacturer for Outcome-Based Supplemental Rebates separately from the MDRP statutory rebate or any other state supplemental rebate, using the format set forth by CMS. State or its designee shall submit the Outcome-Based Supplemental Rebates invoice to the Manufacturer invoice contact, as identified by the Manufacturer to CMS.

**4. Manufacturer Obligations**

4.1. Cooperation. Manufacturer will provide necessary information or otherwise cooperate with State and Data Aggregator so they can perform their respective duties described in Section 3.

4.2. Remittance. If applicable, Manufacturer will remit payment of the Outcome-Based Supplemental Rebates within thirty-eight (38) days of postmark on the invoice from State. Interest will accrue until the postmark date of Manufacturer's payment consistent with Manufacturer's rebate agreement with CMS under the MDRP. Nothing in this Agreement shall be construed to relieve Manufacturer from its obligation to pay any other rebates, including any rebates under the MDRP or a separate supplemental rebate agreement.

4.3. Implementation of Bona Fide Service Plan. Manufacturer will pay Bona Fide Service Fees to third-party entities in accordance with the Bona Fide Service Plan. Manufacturer will provide the information needed by State to evaluate the financial value of the Bona Fide Service Fees as described in Appendix A.

**5. Federal Financial Participation.** State will remit the appropriate share of the Outcome-Based Supplemental Rebates received from Manufacturer to CMS as required under its approved State Plan or a federal waiver.

**6. Dispute Resolution**

6.1. In the event that in any quarter a discrepancy in the Utilization Data is questioned by Manufacturer, the Parties, in good faith, shall attempt to reconcile all differences through discussion and negotiation; if that attempt fails, the Parties will resolve their dispute in

accordance with State hearing procedures as followed by the State or CMS in disputes concerning State Medicaid rebates.

6.2. If Manufacturer, in good faith, believes the Utilization Data is erroneous, the Manufacturer shall pay State that portion of the Outcome-Based Supplemental Rebates claimed, that is not in dispute by the required date. The balance in dispute, including applicable interest, if any, will be paid by Manufacturer to State by the due date of the next quarterly payment after resolution of the dispute.

6.3. State and Manufacturer will use their best efforts to resolve the discrepancy within sixty (60) days of receipt of written notification. Should additional information be required to resolve disputes, State will cooperate with Manufacturer in obtaining the additional information.

6.4. In the event that State and the Manufacturer are not able to resolve a discrepancy regarding Utilization Data, Manufacturer may request a reconsideration of State's determination within thirty (30) days after the end of the 60-day period identified in Section 6.3. Manufacturer shall submit with its written request its argument in writing, along with any other materials, supporting its position to State. State shall review the written argument and materials and issue a decision in the matter.

6.5. Any overpayment or underpayment will be refunded to the other party within thirty (30) calendar days of either the Parties' agreement of the over/underpayment amount or the State's decision of Manufacturer's written request for reconsideration.

**7. Discretion to Market.** Nothing in this Agreement shall be construed to prohibit Manufacturer from discontinuing production, marketing or distribution of any Covered Product or from transferring or licensing any Covered Product to a third party. It is understood that Manufacturer is liable for the payment of Outcome-Based Supplemental Rebates only for Covered Products dispensed or administered to Medicaid recipients. If Manufacturer elects to discontinue production, marketing or distribution of any Covered Product or to transfer or license any Covered Product to a third party, Manufacturer shall make every reasonable effort to notify State prior to such actions.

**8. Confidentiality Provisions**

8.1. Confidentiality. Confidential Information will not be disclosed to any third person or entity not a party to this Agreement or used except in order to implement this Agreement or as may be required by law or judicial order. The term "Confidential Information" does not include information that (a) is or becomes generally available to the public other than as a result of a wrongful disclosure by the receiving party or its employees, officers, directors, agents, advisors, volunteers, contractors, or representatives (collectively, "Agents"), (b) was actually known by the receiving party prior to disclosure hereunder as evidenced by the receiving party's tangible records; (c) is developed or discovered by the receiving party independently and solely without the use of any Confidential Information disclosed hereunder; or (d) is required to be disclosed by law or other legal requirement, provided that the disclosing party is given prompt prior written notice of any such proposed disclosure so it has an opportunity to file appropriate legal objections. Each party shall maintain the confidentiality of all the terms and conditions of this Agreement throughout the term hereof and for a period of not less than three (3) years following termination.

8.2. Patient Information. State, its agents, employees and contractors shall not provide to Manufacturer any patient identifiable information or protected health information or any other information prohibited or regulated by laws or regulations governing confidentiality of medical or other information.

8.3. Ongoing Manufacturer Duty. Subject to Section 8.4 hereof, the Manufacturer will hold Utilization Data confidential. If the Manufacturer audits this information or receives further information on such data from State, that information shall also be held confidential. The Manufacturer shall have the right to disclose Utilization Data to auditors who agree to keep such information confidential.

8.4. Third Parties. Pursuant to 42 U.S.C. Section 1396r-8(b)(3)(D), and other applicable state or federal laws, the Parties agree that this Agreement and all information provided pursuant to this Agreement will not be disclosed and that the Parties will not duplicate or use the information, except in connection with this Agreement or as may be required by law or judicial order. The Parties further agree that any information provided by Manufacturer to State or Data Aggregator pursuant to this Agreement and this Agreement itself constitute trade secrets and/or confidential or proprietary commercial and financial information not subject to public disclosure. If the services of a third party are used to administer any portion of this Agreement, Sections 8.1 through 8.5 of this Agreement shall apply to the third party. In the event that either party is required by law to disclose any provision of this Agreement or pricing information to any person, such party shall provide advance written notice to the other party sufficiently in advance of the proposed disclosure to allow the other party to seek a protective order or other relief.

8.5. Survival. Notwithstanding the non-renewal or termination of this Agreement for any reason by any party, these confidentiality provisions will remain in full force and effect as to all Parties.

**9. Term and Termination**

9.1. Term. The term of this Agreement shall begin on the ___ day of _____, 2018 (the "Effective Date") and shall end on December 31, 2018 with options to renew for five(5) additional one-year periods. Renewal shall be at the option of the State. If the State elects not to renew, then the Manufacturer will be notified with a minim um of 30-day notice. The option to renew shall be contingent upon the needs of the OHCA, and is at the sole discretion of the OHCA. Options to renew shall be executed by mutual agreement.

9.2. Breach. If either party commits a material breach of this Agreement, the non-breaching party shall deliver written notice of the alleged breach to the breaching party, with an opportunity for the breaching party to cure the breach during the thirty (30) day period following the delivery. Failure to cure shall give the non-breaching party the right to cancel this Agreement at the end of the thirty (30) day period. The non-breaching party shall give the breaching party final written notice of the cancellation of this Agreement.

9.3 Termination for Convenience. When it is in the best interest of the State, HCA may terminate this Agreement in whole or in part by providing thirty (30) calendar days'

written notice. No penalty will accrue to HCA in the event the termination option in this section is exercised.

9.3. Accrued Obligations/Remedies. The expiration or termination of this Agreement shall not affect any rights or obligations of the parties that have accrued prior to the effective date of such termination. The fact that either party exercises any right of termination it may have under this Agreement shall not prevent such party from pursuing any other remedy it may be entitled to in law or equity. Any remedy provided herein shall not be deemed an exclusive remedy unless expressly provided for as such.

**10. General Provisions**

Record Keeping and Audit. Unless a longer period is required by law, during the term of this Agreement and for a period of ten (10) years thereafter, both parties to the Agreement shall use reasonable efforts at all times to ensure that they maintain accurate books, files and records relevant to this Agreement. At Manufacturer's written request, State or its agent shall make such information relevant to this agreement available for inspection by Manufacturer representatives or its designated auditors during regular business hours. Upon written request, each party shall otherwise have the right to inspect, up to once each year, all such relevant books, and records of the other party to verify compliance with the terms of this Agreement.

Indemnification. Manufacturer shall indemnify, defend and hold harmless State and its officer, employees and agents from any claims, actions, suits, demands, costs, damages or liabilities (including reasonable attorney's fees and court costs) arising out of or connected with (1) any negligent act or omission of Manufacturer or its employees, agents or contractors, (2) any defect in the Manufacturer's Covered Product, or (3) any breach of this Agreement of any violation of any law or regulation by Manufacturer or its employees, agents or contractors.

Notices. All written notices, requests and communications, unless specifically required to be given by a specific method, may be: (i) delivered in person, obtaining a signature indicating successful delivery; (ii) sent by a recognized overnight delivery service, obtaining a signature indicating successful delivery; (iii) sent by certified mail, obtaining a signature indicating successful delivery; or (iv) sent by electronic mail, requesting confirmation of receipt and addressed as follows:

If to Manufacturer:
[NAME]
[ADDRESS]
[EMAIL]

If to State:
Attention: Supplemental Rebate Manager
Washington Medicaid
P.O. Box 45506
Olympia, WA 98504-5506

Force Majeure. Noncompliance with any obligations hereunder due to a force majeure event, including but not limited to acts of God, laws or regulations of any government, war, terrorism, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common carriers, and any other causes beyond the reasonable control of the parties, shall not constitute breach of contract, and a party's performance shall be excused during such force majeure event.

Assignment. Neither party shall have the right to assign this Agreement to a third party without the prior written consent of the other party. Any permitted assignee shall assume all obligations of its assignor under this Agreement. No assignment shall relieve any party of responsibility for the performance of any obligations that have accrued prior to such assignment.

No Waiver of Rights. The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy in the future. Every right and remedy given by this Agreement to the parties may be exercised from time to time as often as appropriate.

Entire Agreement. This Agreement contains the entire agreement and understanding of the parties relating to the subject matter of this Agreement. This Agreement may not be amended except upon the written agreement of both parties.

Governing Law and Venue. This Agreement shall be interpreted under and governed by the laws of the State of Washington, without regard to its conflict of laws principles. In the event of a lawsuit involving this Agreement, venue shall be in the Superior Court of Thurston County in the State of Washington.

Survival. The provisions of this Agreement that by their nature are intended to continue in their effect following expiration or termination of this Agreement shall survive any such expiration or termination, including, but not limited to, Sections 2, 6, 8, 10.1., 10.2, and 10.8.

Effect of Future Laws. In the event of the occurrence of a Future Law, each Party shall have the right to enter into good faith negotiations with the other in order to seek to agree on reasonable terms for maintaining the intent of the Agreement. Agreement on any such terms shall be at the sole discretion of each Party. If the Parties do not agree within sixty (60) days of a Party's written request for negotiations, either Party may terminate this Agreement with respect to the affected Covered Products upon expiration of the sixty (60) day period, with immediate effect. For purposes of this section "Future Laws" means any statutory enactment or rule promulgation, and any final legal or administrative determinations made by a court or tribunal of competent jurisdiction that materially impairs any Party's ability or obligation to carry out its obligations or receive consideration due under this Agreement. "Future laws" shall not invalidate or otherwise affect the calculation of the Outcome-Based Supplemental Rebate or the Base Administrative Fee except in accordance with Section 2.6.

Compliance with Law. In connection with its respective obligations under this Agreement, each Party shall comply with all applicable federal, state and local laws and regulations, including without limitation any disclosure or consent requirements.

Authority. State and Manufacturer each represent and warrant to the other that the person signing below has all requisite legal power and authority to execute this Agreement on behalf of each party and each party shall thereby be bound.

## Appendix A

**Covered Product –** The Covered Product subject to this Agreement is specified below. The Covered Product is identified by its NDC-9 number to ensure that all package sizes are captured under this Agreement, unless otherwise specified in the chart below. In the event the Agreement covers multiple products with different NDCs and/or labeler names, the information pertaining to each product is also specified below:

| MANUFACTURER/LABELER NAME | NDC | Drug Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Utilization Period –** The Utilization Period shall encompass [_____] calendar quarters. It shall commence on [DATE], the first day of the first calendar quarter, and conclude on the last day of the last quarter.

**Outcome-Based Benchmarks –** The Parties agree to the following Outcome-Based Benchmarks for evaluating the Utilization Data:

*[To be filled in or marked as not applicable]*
_____
_____
_____
_____

**Intervention Population** – The Parties agree to define the Intervention Population on which the Outcome-Based Benchmarks shall be measured as follows:

*[To be filled in or marked as not applicable]*
_____
_____
_____
_____

**Evaluation Methodology –** The Parties agree to the following Evaluation Methodology for evaluating the performance of the Covered Product during the Utilization Period:

*[To be filled in or marked as not applicable]*
_____
_____
_____
_____

**Data Aggregator** – The Data Aggregator is authorized by State to track Covered Product's utilization, to evaluate its performance and to calculate the Outcome-Based Supplemental Rebates. The Data Aggregator selected by the State for purposes of this Agreement is identified and described below:

[*To be filled in or marked as not applicable]*
_____
_____
_____

In the event State desires to change or replace the Data Aggregator, it shall give Manufacturer 30 days written notice prior to implementation. Nothing in this Agreement prevents the State from serving as the Data Aggregator and performing the tasks described in Section 3.3.

**Covered Product Status –** The Parties agree that Covered Product will not be disadvantaged to competing products within its Product Class. The Covered Product Status in the FFS and/or MCO setting is described below:

- Covered Product Status in FFS Setting – *[To be filled in or marked as not applicable]*
  _____
  _____

- Covered Product Status in MCO Setting – *[To be filled in or marked as not applicable]*
  _____
  _____

**Preferred Status –** State may arrange for Preferred Status for Covered Product using a PDL, prior authorization procedures, step-edit therapy or other means to manage Product Class. The Preferred Status for Covered Product in the FFS and/or MCO setting is described below, if applicable:

- Preferred Status in FFS Setting – *[To be filled in or marked as not applicable*
  _____
  _____

- Preferred Status in MCO Setting – *[To be filled in or marked as not applicable*
  _____
  _____

**Bona Fide Service Plan** – The Parties agree to the following Bona Fide Service Plan, including the specific services Manufacturer shall provide under the Bona Fide Service Plan, the financial value of those services:

*[To be filled in or marked as not applicable]*
_____
_____
_____

**Appendix B**

**Base Administrative Fee** – The amount paid by the Manufacturer to cover the administrative costs related to this Agreement.

*[To be filled in or marked as not applicable]*
_____
_____
_____
_____

**Payment for Outcome-Based Benchmarks** – The amount paid by the Manufacturer based on the Outcome-Based Benchmarks calculated as per Appendix A:

*[To be filled in or marked as not applicable]*
_____
_____

**Outcome-Based Supplemental Unit Rebate Amount** – For each Unit of the Covered Product identified and evaluated by Data Aggregator for the Intervention Population during Utilization Period in question, Manufacturer agrees to pay an Outcome-Based Supplemental Rebate beyond the rebate owed under the MDRP or any other state supplemental rebate. The Outcome-Based Supplemental Unit Rebate Amount will vary as a result of the Outcome-Based Benchmarks and/or Evaluation Methodology described in Appendix A. The different amounts will be determined as follows:

| **LABEL NAME** | **NDC** | **CALCULATION TYPE** | **DISCOUNT PER UNIT** | **Outcome measure** |
|---|---|---|---|---|
| PRODUCT A | 99999-9999 | {Specify WAC, GNUP, AMP other} | %, $, other | Note 1 below |
| PRODUCT A | 99999-9999 | {Specify WAC, GNUP, AMP other} | %, $, other | Note 2 below |
| PRODUCT A | 99999-9999 | {Specify WAC, GNUP, AMP other} | %, $, other | Note 3 below |

Calculation Type is *[customize one of the options below and/or insert new description]*

- [a percentage discount of WAC, based on the WAC as shown in pricing compendia for the last day of the Utilization Period.]
- [is WAC based GNUP where Supplemental Rebate amount per Unit = [WAC minus Federal RPU minus Discount Per Unit].
- [insert other description as applicable]

**Outcome measure note 1: [above target]**
**Outcome measure note 2: [target]**
**Outcome measure note 3: [below target]**

**Rebate Calculation Methodology** – The Outcome-Based Supplemental Rebates shall be calculated by multiplying the Outcome-Based Supplemental Unit Rebate Amount by the Covered Product's Utilization during the Utilization Period.

**Settle-Up Period** – The Settle-Up Period shall commence after the close of the Utilization Period and shall terminate [SPECIFY NUMBER] days thereafter. The Settle-Up Period can be extended by written agreement of the Parties.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**DISCHARGE OR LEAVE OF A CLIENT FROM A LONG-TERM CARE FACILITY**

1. A certified nursing facility, hospital having a nursing facility contract, ICF-MR or inpatient psychiatric facility for persons under the age of 21 shall send the appropriate department or division immediate written notification of the date of discharge or death of a patient or client.

2. Discharge and readmission is necessary for all long-term care facility residents who are admitted as hospital in-patients.

3. All social/therapeutic absences must be documented in the resident's clinical record.

4. The department will reimburse the nursing facility for absences not to exceed a total of eighteen (18) days per calendar year.

5. An ICF-MR shall notify the Division of Developmental Disabilities (DDD) of social absences exceeding fifty-three (53) hours. Single social absences over seven (7) days require prior written approval by the Director of DDD, or his designee. Social leaves must be consistent with goals and objectives of individual program plans.

6. In a facility certified as an ICF-MR, social leave in excess of seventeen (17) days per calendar year requires prior written approval by the Director of DDD, or his designee.

7. The department shall reimburse an inpatient psychiatric facility for persons under age 21 for social “week-end” absences not to exceed forty-eight (48) hours. In addition, the facility shall be reimbursed for a social leave of absences not to exceed fourteen (14) days per calendar year. Leave of absence in excess of the annual maximum shall require prior written approval by the Mental Health Division. All absences and leaves shall be documented in the client’s clinical record and shall be consistent with the goals and objectives of the individual treatment plan.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

DISCHARGE OR LEAVE OF A CLIENT FROM A LONG-TERM CARE FACILITY (con't)

8. The department shall reimburse an inpatient psychiatric facility for persons under age 21 for run away absences not to exceed a calendar year maximum of seven (7) days. Payment for run away absence in excess of the annual maximum requires prior written approval of the Mental Health Division. Justification for reserving bed space for run away absences shall be documented in the client's social record and be consistent with the goals and objectives of the individual treatment plan.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS

Section I. Introduction:

This State Plan Amendment (SPA) to Attachment 4.19-D, Part I, describes the overall payment methodology for nursing facility services provided to Medicaid recipients: (1) by privately-operated nursing facilities, both non-profit and for-profit; (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs; and (3) by nursing facilities operated by public hospital districts in the state. Both privately operated and veterans' nursing facilities share the same methodology. Facilities operated by public hospital districts share the methodology described below also, except for proportionate share payments described in Section XVII below, which apply only to them.

Excluded here is the payment rate methodology for nursing facilities operated by the State's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC), chapter 74.46, chapter 34.05, and chapter 70.38 of the Revised Code of Washington (RCW), and any other state or federal laws or regulations, codified or uncodified, as they exist as of July 1, 2017, as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW.

The methods and standards employed by the State to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section II. General Provisions:

Medicaid rates for nursing facility care in Washington continue to be facility specific. Prior to rate setting, nursing facilities' costs and other reported data, such as resident days, are examined, to ensure accuracy and to determine costs allowable for rate setting. Washington is a state utilizing industry median cost data, subject to applicable limits, combined with facility-specific and regularly updated resident case mix data, to set the direct care and indirect care component. The capital rate is set using a fair market rental system. The quality enhancement is set using Centers for Medicare and Medicaid Services quality data.

A facility's Medicaid rate is a total of four component rates: 1) direct care (DC), 2) indirect care (IDC) , 3) capital (C), and 4) quality enhancement (QE).

Medicaid rates are subject to a "budget dial", under which the State is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. Under RCW 74.46.421, the statewide average payment rate for any state fiscal year (SFY) weighted by patient days shall not exceed the statewide weighted average nursing facility payment rate identified for that SFY in the biennial appropriations act (budgeted rate). After the State determines all nursing facility payment rates in accordance with chapter 74.46 RCW and chapter 388-96 WAC, it determines whether the weighted average nursing facility payment rate is equal to or likely to exceed the budgeted rate for the applicable SFY. If the weighted average nursing facility payment rate is equal to or likely to exceed the budgeted rate, then the State adjusts all nursing facility payment rates proportional to the amount by which the weighted average rate allocations would exceed the budgeted rate. Adjustments for the current SFY are made prospectively, not retrospectively and applied proportionately to each nursing facility's component rate allocation. The application of RCW 74.46.421 is termed applying the "budget dial". The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

For SFY 2023 (July 1, 2022 through June 30, 2023), the budget dial rate is $319.82.

If any final order or final judgment, including a final order or final judgment resulting from an adjudicative proceeding or judicial review permitted by chapter 34.05 RCW would result in an increase to a nursing facility's payment rate for a prior fiscal year or years, the State shall consider whether the increased rate for that facility would result in the statewide weighted average payment rate for all facilities for such fiscal year or years to be exceeded. If the increased rate would result in the statewide average payment rate for such year or years being exceeded, the State shall increase that nursing facility's payment rate to meet the final order or judgment only to the extent that it does not result in an increase to the statewide average payment rate for all facilities.

For SFT 2020 and SFY 2021, any Medicaid payments provided to nursing facilities in response to the declared state of emergency related to COVID-19 will not be subject to Medicaid methodology found in RCW 74.46 and will not be included in the calculation of the budget dial.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section II. General Provisions (cont):

For the direct care and indirect care components, adjusted cost report data for calendar year 2014 will be used for rate setting for July 1, 2016 through June 30, 2017.

In contrast, the capital component is rebased annually, utilizing each facility's cost report data for the calendar year ending six months prior to the commencement of the July 1 component rates and RSMeans data.

Additionally, the quality enhancement data is evaluated every six months and the component adjusted accordingly every January 1 and July 1.

Beginning July 1, 2016, the direct care and indirect care component rate allocations shall be rebased biennially during every even-numbered year thereafter using adjusted cost report data from two years prior to the rebase period, so adjusted cost report data for calendar year 2014 will be used for July 1, 2016 through June 30, 2018, and so forth.

Beginning May 1, 2020, the calendar year direct and indirect costs shall be adjusted for inflation by a twenty-four month consumer price index, based on the most recently available index for all urban consumers, as published by the bureau of labor statistics. This inflation factor will be updated on July 1, 2020. On July 1, 2021, a facilty specific add-on equal to the inflation factor of that facility in SFY 20 will be included in the daily rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds (cont)

All component rates calculated and assigned to a facility require, directly or indirectly, use of the examined number of resident days at that facility for the applicable report period. Essentially, days are divided into allowable costs for that period, to obtain facility costs expressed as per resident day amounts.

Resident days for all facilities in indirect and capital component rates is subject to a minimum occupancy of each facility's licensed beds, regardless of how many beds are set up or in use. That is, when the resident days are below the minimum occupancy that applies to the rate component and category of provider, the days are increased to an imputed occupancy for rate setting, which has the effect of reducing per resident day costs and component rates based on them.

When occupancy is above the minimum, the facility's actual occupancy is used. The purpose of minimum occupancy is to prevent inflated rates based on inefficient use of facility resources or failure of the facility to maintain a viable census.

Minimum occupancy for rate setting for all facilities will be ninety percent in the indirect care and ninety percent in capital component rates.

There is no minimum occupancy for direct care.

The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility’s indirect component rate allocation under RCW 74.46.521(3), the State shall apply the minimum facility occupancy adjustment before creating the array of facilities’ adjusted general indirect care costs per adjusted resident day.

Effective July 1, 2016, the State shall not include beds banked under chapter 246-310 WAC in effect on July 1, 2016, in licensed beds for the purpose of computing minimum occupancy.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section IV: Allowable Costs (cont.)

Allowable costs for rate setting, audit and settlement are documented costs, not expressly declared unallowable or otherwise limited under chapter 74.46 RCW or 388-96 WAC, that are necessary, ordinary and related to the care of nursing facility residents. To be ordinary nursing facility expenses, costs must be of the nature and magnitude that prudent and cost-conscious management would pay. Effective July 1, 2001, facility costs of televisions in residents' rooms acquired on and after July 1, 2001, will be included in allowable costs.

Costs in excess of limits or in violation of any rate setting or payment principles contained in chapters 74.46 RCW or 388-96 WAC are expressly unallowable. These limits include, but are not limited to, minimum occupancy for rate setting and peer group median costs in affected cost areas and component rates.

The Medicaid payment rate system for the State of Washington does not guarantee that all costs relating to the care of a nursing facility's Medicaid residents and allowable under the payment system rules will be fully covered or reimbursed in any payment period. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with state and federal laws, not to reimburse costs, however defined, of a provider.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (contd)

Section VI. Direct Care Component Rate

This component rate, which averages approximately 70.0% of each participating facility's total Medicaid rate, corresponds to one resident day of care for nursing services, including supplies, therapy, laundry, food, and dietary services.

In applying case mix principles for direct care rate setting, data is taken from facility-completed, mandatory assessments of individual residents, and using a software program that groups residents by care needs, the State determines for each facility both a facility average case mix index (for all the facility's residents) and a Medicaid average case mix index (for Medicaid residents only). A case mix index is a number indicating intensity of need for services by a resident population, or group within a population.

Effective July 1, 2006, the facility average case mix index will be used throughout the applicable cost-rebasing period. Also, when establishing direct care component rates, the State will use an average of facility case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations.

The State may adjust the case mix index for any of the lowest four resource utilization group categories beginning with PA1 through PB22 to any case mix index that aids in achieving the purpose and intent of RCW 74.39A.007 in effect on July 1, 2016, and cost-efficient care. PA1 through PB2 that also have behaviors will not receive an adjustment in case mix index.

In determining case mix weights, the State will assign the lowest case mix weight to the resource utilization group III classification group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group’s total weighted minutes into each group’s total weighted minutes and rounding weight calculations to the third decimal place.

Each facility's allowable direct care cost per resident day is divided by the facility's average case mix index to derive the facility's allowable direct care cost per case mix unit.

Direct care is paid at a fixed rate based on one hundred percent or greater of statewide case mix neutral median costs. Direct care is performance adjusted for acuity using case mix principles. It is then regionally adjusted using county wide wage index information available through the United States Department of Labor’s Bureau of Labor Statistics.

The State shall determine and update semiannually for each nursing facility serving Medicaid residents a facility-specific per-resident day direct care component rate adjustment for acuity to be effective on the first day of each six-month period.

Direct care includes routine therapy which is the average one-on-one care from qualified therapists delivered to a Medicaid resident during one day, and the average therapy consultation from qualified consultants delivered to a resident during one day. Four types of therapy are recognized for rate setting: speech, physical, occupational, and other. Two general service categories are recognized for each: one-on-one therapy and therapy consulting. These do not include rehabilitative therapies.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VI. Direct Care Component Rate (cont)

To determine allowable routine therapy costs, the department takes from cost reports direct one-on-one therapy charges for all residents by payer, including costs of supplies, and total units or modules of therapy care, for all residents from the report period by type of therapy provided. The department also takes from cost reports therapy consulting expenses for all residents by type of therapy.

The department determines the total one-on-one cost for each type of therapy care at each participating nursing facility, and divides by the facility's total units of therapy for each therapy type, to derive the per unit one-on-one cost for each type. A unit or module of therapy care is defined as fifteen minutes of one-on-one therapy.

The department determines total therapy consulting for each type of therapy at each nursing facility, and divides by the facility's resident days to derive per resident day consulting cost for each type of therapy.

Each facility's allowable cost in each of the four therapy types is then multiplied by the units provided by the facility for the applicable year by type. The result is multiplied by the Medicaid percentage of charges for each category, and divided by adjusted Medicaid resident days from the report period, to derive the Medicaid resident day allowable one-on-one cost for each therapy type.

The facility's allowable Medicaid resident day one-on-one cost and its allowable resident day consulting cost are each multiplied by the facility's total adjusted resident days to calculate its total allowable one-on-one therapy expense and total allowable consulting therapy expense. These products are totaled for each type to derive each facility's total allowable cost for each therapy type.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VII. Reserved for future use

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

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Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section VIII. Reserved for future use

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section IX. Indirect Component Rate

This component corresponds to one resident day of indirect care. It includes administrative services, management, housekeeping, utilities, accounting, minor building maintenance, etc.

To set the indirect care component rate, the State takes data from the applicable cost report year allowable indirect care costs and divides by the greater of adjusted resident days from the same cost report, or days imputed at the applicable minimum occupancy from Attachment 4.19-D, Part 1 Section III *Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds*, whichever is greater.

The State arrays allowable operations costs and determines the median cost. The rate is set at ninety percent or greater of the statewide median costs.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section X. Capital Component Rate:

This component uses a fair rental system to set a price per bed associated with the provision of resident care at a participating nursing facility.

The department rebases the capital component rate annually using cost report data from the calendar year ending six months prior to the commencement of each July 1 rate and RSMeans data. For example, the 2015 cost report is used for July 1, 2016, rate setting, and the 2016 cost report is used for July 1, 2017, rate setting, etc.

The fair rental rate allocation for each facility is determined by multiplying the allowable nursing home square footage by the RSMeans rental rate and by the number of licensed beds yielding the gross unadjusted building value. The sum of the unadjusted building value and equipment allowance is then reduced by the average age of the facility as determined using a depreciation rate of one and one-half percent. The depreciated building and equipment plus land is then multiplied by the rental rate at seven and one-half percent to yield an allowable fair rental value for the land, building, and equipment.

Land is valued at ten percent of the gross unadjusted building value before depreciation.

The equipment allowance is ten percent of the unadjusted building value before depreciation.

The fair rental value determined is then divided by the greater of the actual total facility census from the prior full calendar year or imputed census based on number of licensed beds at ninety percent occupancy.

For the rate year beginning July 1, 2016, all facilities will be reimbursed using four hundred square feet per bed. For the rate year beginning July 1, 2017, allowable nursing facility square footage per bed must be determined using the total nursing facility square footage as reported on the Medicaid cost reports submitted to the Department. The maximum allowable square feet per bed may not exceed four hundred fifty.

Each facility is paid at eighty-three percent or greater of the median nursing facility 2015 RSMeans construction index value per square foot for Washington State. The statewide value per square foot must be indexed based on facility zip code by multiplying the statewide value per square foot times the appropriate zip code based index.

For the rate year beginning July 1, 2016 the value per square foot will be set so that the weighted average fair rental value rate is not less than ten dollars and eighty cents ppd.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XI. Capital Component Rate (cont):

The average age of a facility is the actual facility age reduced for significant renovations. Significant renovations are renovations that exceed two thousand dollars per bed in a calendar year as reported on the annual cost report. For the rate beginning July 1, 2016 the Department will use renovation data back to 1994 as submitted on facility cost reports. Beginning July 1, 2016, facility ages are to be reduced in future years if the value of the renovation completed in any year exceeds two thousand dollars times the number of licensed beds. The cost of the renovation is divided by the accumulated depreciation per bed in the year of the renovation to determine the equivalent number of new replacement beds. The new age for the facility is a weighted average with the replacement bed equivalents reflecting an age of zero and the existing licensed beds, minus the new bed equivalents, reflecting their age in the year of the renovation. At no time may the depreciated age be less than zero or greater than forty-four years.

A nursing facility's capital component rate allocation is rebased annually, effective July 1, 2016.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XII. Quality Enhancement

A quality enhancement of one percent of the statewide average daily rate is paid to facilities that meet or exceed the standard established for the quality enhancement. All providers have the opportunity to earn the full quality enhancement payment.

The quality enhancement component is determined by calculating an overall facility quality score composed of four quality measures for fiscal year 2018. The quality enhancement component is based on Minimum Data Set (MDS) quality measures for the percentage of long-stay resdients who self-report moderate to severe pain, the percentage of high-risk long-stay residents with pressure ulcers, the percentage of long-stay residents experiencing one or more falls with major injury, and the percentage of long-stay residents with a urinary tract infection, short-stay newly administered anti-psychotic medications, and turnover or direct care staff.

Quality measures are reviewed on an annual basis by a stakeholder workgroup established by the Department. The Department may risk adjust individual quality measures as it deems appropriate.

The facility quality score is point based using the facility's most recent available three-quarter average Centers for Medicare and Medicaid Services (CMS) data. Point thresholds for each quality measure are established using the corresponding statistical values for the quality measure (QM) point determinants of eighty QM points, sixty QM points, forty QM points, and twenty QM points, as identified in the most recent available five-star quality rating system technical user's guide published by CMS.

Facilities meeting or exceeding the highest performance threshold (top level) for a quality meaure receive twenty-five points. Facilities meeting the second highest performance threshold receive twenty points. Facilities meeting the third level of performance threshold level receive fifteen points. Facillities in the bottom performance threshold level receive no points. Points from all q uality measures must then be summed into a single aggregate quality score for each facility.

Facilities receiving an aggregate quality score of eighty percent of the overall available total score or higher are placed in the highest tier (Tier V). Facilities receiving an aggregate score of between seventy and seventy-nine percent of the overall available total socre are placed in the second highest tier (Tier IV). Facilities receiving an aggregate score of between sixty and sixty-nine percent of the overall available total score are placed in the third highest tier (Tier III). Facilities receiving an aggregate score of between fifty and fifty-nine percent of the overall available total score are placed in the fourth highest tier (Tier II). Facilities receiving less than fifty percent of the overall available total score are placed in the lowest tier (Tier I).

The tier system is used to determine the amount of each facility's per patient day quality enhancement component. The per patient day quality enhancement component for Tier IV is seventy-five percent of the per patient day quality enhancement component for Tier V. The per patient day quality enhancement component for Tier III is fifty percent of the per patient day quality enhancement component for Tier V. The per patient day quality enhancement component for Tier II is twenty-five percent of the per patient day quality enhancement component for Tier V. Facilities in Tier I receive no quality enhancement payment.

Facilities with insufficient three-quarter average CMS quality data must be assigned to the tier corresponding to their five-star quality rating. For example, a facility with a five-star quality rating would be assigned to Tier V while a facility with a one-star quality rating would be assigned to Tier I.

The quality incentive rates are adjusted semiannually on July 1 and January 1 of each year.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIII. Settlement:

In a process called "settlement", the direct care component rate payment is compared to each participating nursing facility's expenditures in the direct care category each report period. The facility must return to the department all unspent rate payments in this category exceeding 1 percent of the average component rate, weighted by Medicaid resident days, for the report period. The purpose of settlement is to provide licensees of Medicaid nursing facilities additional incentive to make expenditures necessary for the care and well being of residents.

This recovery process does not exist for payments in excess of costs, if any, in the indirect care, capital, or quality enhancement component rates.

Normally settlement covers a calendar year corresponding to a calendar year report period, but a settlement will only cover a partial-year report period for facilities changing ownership during the year. The rate a provider is left with after the process of settlement at the lower of cost or rate in the affected cost area is called the "settlement rate" and it represents final compensation for Medicaid nursing care services for the settlement period.

The rule which allows facilities to keep unspent payments in direct care up to 1 percent of the component rate does not apply to facilities that provided substandard quality of care, or which were not in substantial compliance with state and federal care standards, during the settlement period, as these concepts are defined in federal survey regulations. Such facilities must return all unspent direct care rate payments, without exception, they received during the settlement period.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XIV. Adjustments to Prospective Rates other than for Economic Trends and Conditions, Changes in Case Mix, Fluctuation in Licensed Beds or One-Time Specific Authorizations:

The department may grant prospective rate adjustment to fund new requirements imposed by the federal government or by the department, if the department determines a rate increase is necessary in order to implement the new requirement.

Rates may be adjusted prospectively and retrospectively to correct errors or omissions on the part of the department or the facility, or to implement the final result of a provider appeal if needed, or to fund the cost of placing a nursing facility in receivership or to aid the receiver in correcting deficiencies.

Section XV. Rates for Swing Bed Hospitals:

The average rate comprising the swing bed rate for July 1, 2019, is computed by first multiplying each nursing facility's average daily rate of the preceding calendar year (2018) by the facility's approximate number of Medicaid resident days during the preceding year (2018), which yields an approximate total Medicaid payment for each facility for that calendar year.

Total payments to all Medicaid facilities for the preceding calendar year are added which yields the approximate total payment to all facilities for that year, and then the total is divided by statewide Medicaid resident days for the same year to derive a weighted average for all facilities.

The same methodology is followed annually to reset the swing bed rate, effective July 1 of each year. Effective July 1 of each year, the State follows the same methodology to reset the swing bed rate. The swing bed rate is subject to the operation of RCW 74.46.421.

The swing bed rate for SFY 2023 (July 1, 2022, through June 30, 2023) is $254.61.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XVI.

-- Public Process for Changes to Nursing Facility Medicaid Payment Rates:

For all material changes to the methodology for determining nursing facility Medicaid payment rates occurring on or after October 1, 1997, requiring a state plan amendment, the state follows the following public process:

(1) The proposed estimated payment rates, the proposed new methodologies for determining payment rates, and the underlying justifications are published. Publication i: (a) in the Washington State Register; (b) in the newspapers in each city with a population over 50,000; or (c) on a CMS- approved website.

(2) The state maintains and updates as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility. Medicaid payment rate methodology, and all materials submitted for publication are sent postage prepaid by regular mail to such individuals and organization.

(3) Nursing facility providers, their associations, nursing facility Medicaid beneficiaries, representatives, and other concerned members of the public are given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment will not be less than fourteen (14) calendar days after the date of the Washington State Register containing the published material, or the date the published material has appeared in the appropriate newspapers, or the date the material appears on the website.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

NURSING FACILITIES AND SWING BED HOSPITALS (cont.)

Section XVI. 1997 Balanced Budget Act. Section 4711 -- Public Process for Changes to Nursing Facility Medicaid Payment Rates (cont.)

(4) After receiving and considering all comments, if the department decides to move ahead with a change or changes to its nursing facility payment rate methodologies, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated rates, final rate determination methodologies and justifications. Publication shall be: (a) in the Washington State Register; or (b) in The Seattle Times and The Spokesman Review newspapers. Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication in the Register has occurred or publication in both designated newspapers has occurred. The department shall not be authorized to delay implementation of changes, or to alter, ignore or violate requirements of state or federal laws in response to public process comments.

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Section XVII. Proportionate Share Payments for Nursing Facilities Operated by Public Hospital Districts:

An aggregate Upper Payment Limit is calculated each state fiscal year for supplemental payments to eligible providers of Medicaid nursing facility services. Eligible providers are public hospital districts that operate nursing facilities.

The public hospital districts are responsible for certifying costs eligible for the supplemental payments, which shall not exceed the maximum allowable under federal rules. The state will ensure that the public hospital districts certify these expenditures in accordance with 42 CFR 433.51.

The payments to public hospital districts shall be supplemental to, and shall not in any way offset or reduce, the normal Medicaid nursing facility payments calculated and provided in accordance with part E of Ch. 74.46 RCW. Costs to improve access to health care at nursing facilities operated by public hospital districts that are otherwise allowable for rate-setting and for settlement against payments made under Ch. 74.46 RCW shall not be disallowed solely because such costs have been paid by revenues retained by the nursing facility from these supplemental payments.

The supplemental payments are limited to the difference between Medicaid routine costs incurred by the public hospital district-operated nursing facilities and the total Medicaid routine payments received by the facility during the rate year in which the supplemental payments will be claimed. The process for identifying such eligible incurred Medicaid cost is defined in Supplement A to Attachment 4.19-D, Part 1. The Medicare upper payment limit analysis shall be performed prior to making the supplemental payments.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section XVIII. Supplemental Exceptional Care Payments

Effective July 1, 2001, the department makes available exceptional care payments to augment normally generated payment rates for Medicaid residents.

The payments take the form of increases in the direct care rate allocation for residents with unmet exceptional care needs, as determined by the department criteria. Direct care payment increases made for these residents shall be offset against a facility's allowable direct care and therapy care costs for purposes of normal rate setting and settlement. The cost per patient day for caring for these clients in a nursing home setting may be equal to or less than the cost of caring for these clients in a hospital setting.

A nursing facility (NF) may receive an increase in its direct care component rate allocation for providing exceptional care to a Medicaid resident who:

- Receives specialized services to meet chronic complex medical conditions and neurodevelopment needs of medically fragile children, and resides in an NF where all residents are under age twenty-one with at least fifty percent of the residents entering the facility before the age of fourteen;
- Receives Expanded Community Services (ECS);
- Is admitted to the NF as an Extraordinary Medical Placement (EMP) and the Department of Corrections (DOC) has approved the exceptional direct care and/or therapy payment;
- Is ventilator or tracheotomy (VT)-dependent and resides in an NF that the department has designated as an active ventilator-weaning center;
- Has a traumatic brain injury (TBI) established by a Comprehensive Assessment Reporting Evaluation (CARE) assessment administered by department staff and resides in an NF that the department has designated as capable of caring for TBI patients;
- Has a TBI and currently resides in an NF specializing in the care of TBI residents where more than fifty percent of residents are classified with TBIs based upon the federal minimum data set assessment (MDS 2 or its successor); or
- Is admitted to an NF from a hospital with an exceptional care need that the department staff has determined the NF has the ability to provide the care needed, and the Health and Recovery Services Administration (HRSA) or a successor administration that assumes HRSA's responsibilities has approved the exceptional direct care and/or therapy payment.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Section XIX. Specialized Add-on Services Payments

Payments to providers for medically necessary services must be pre-authorized by the Department. There are two fee schedules for these services, as follows:

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of specialized add-on services provided in the nursing facility. The Medicaid agency's rates were set as of July 1, 2016, and are effective for dates of services provided on and after that date. See 4.19-B I, #G for the agency's websited where the fee schedules are published.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of habilitative services (i.e., those specialized add-on services not covered under the fee schedule described in section 1 above), provided to individuals with intellectual disabilities residing in a nursing facility. The rates for these habilitative services were established using existing home and community based services (HCBS) waiver fee schedules or, where those fee schedules do not include the particular specialized add-on service being authorized, by using other existing fee schedules or benchmarks, such as the Bureau of Labor Statistics Occupational Employment Statistics. The rates were set as of July 1, 2016, and are effective for dates of services provided on and after that date. The fee schedule can be found on the Department's website at
https://www.dshs.wa.gov/sites/default/files/ALTSA/msd/documents/All_HCS_Rates.xls

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**NURSING FACILITIES AND SWING BED HOSPITALS**

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.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) 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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**NURSING FACILITIES AND SWING BED HOSPITALS**

Tribal Nursing Facilities

Payment for nursing homes will be on a per patient, per day rate. The rate negotiated with tribes for calendar year 2019 is $639.57. This 2019 rate will be adjusted annually based on the percentage increase or decrease of the inpatient hospital per diem rate published each year in the Federal Register by the U.S. Department of Health and Human Services' Indian Health Service, under the authority of Sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. §§ 248 and 249(b)), Public Law 83-568 (42 U.S.C. § 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.). On and after July 1, 2019, the rate will be reduced by the portion of the rate related to building a new facility (which is $73.27 for calendar year 2019), as adjusted from 2020 through 2029 in accordance with this paragraph

The rate applies to nursing homes of the Indian Health Service (IHS) which includes, at the option of the tribe, nursing homes operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act (also known as Tribal nursing homes).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE**

Summary of Medicare 2552-10 Cost Report and Step-Down Process for Hospital-Based Nursing Facilities

*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.

Hospital-Based Nursing Facility Costs for Upper Payment Limit Payments Based on Certified Public Expenditures

*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.

*Nursing Facility Costs*
The NF costs are taken from Worksheet B, Part I, lines 44 and/or 45, column 26. These are the NF costs after the step-down allocation of overhead to all cost centers.

*Nursing Facility Patient Days*
The NF days are found on Worksheet S-3 Part I, column 8, lines 19 and/or 20.

*Nursing Costs Per Patient Day*
The cost per patient day is calculated by dividing the total NF costs by the total NF patient days described above. This amount is based on worksheet D-1, Part III, line 71, column 5 for the NF/SNF.

*Upper Payment Limit Amount*
The supplemental payments are subject to the federal Medicare upper payment limit for nursing facility payments. The Medicare upper payment analysis shall be performed prior to making the supplemental payments. The aggregate Upper Payment Limit is the maximum amount that can be paid out to the nursing facilities.

The cost per patient day less the Medicaid payment rate per patient day is the maximum UPL payment per Medicaid day that the nursing facility may receive. For example, if the UPL limit aggregate is $54 per Medicaid day, but the maximum payment gap between the routine costs

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE (CONT)

incurred by the NF and Medicaid payment received by the NF is $18 per day, the nursing facility will receive $18 per day. The aggregate amount is redistributed evenly to the facilities up to their specific cost limits.

The payments for each state fiscal year will be based on the as filed Medicare 2552-10 cost report from two years prior. For example, the payments for state fiscal year 2013 will be based on the cost information from the 2011 as filed Medicare 2552-10 cost report. The NF routine cost per patient day amount from worksheet D-1 will be multiplied by the 2011 Medicaid days from the State's MMIS payment system to compute Medicaid costs. The 2011 Medicaid base NF routine payments will be subtracted from the computed Medicaid costs to determine the NF's maximum supplemental payment amount. An interim reconciliation will be performed with the 2013 as filed 2552-10 cost report and a final reconciliation will be performed with the 2013 Intermediary audited 2552-10 cost report.

With both the interim and final reconciliations, there may be a recoupment if an NF's Medicaid costs are less than what it was paid. If a hospital's Medicaid costs are higher than what it was paid, then it could receive more money as long as the aggregate UPL is not exceeded. The Medicaid costs will be determined by multiplying the per diem costs by the Medicaid days. The Medicaid days will be reconciled to Washington State DSHS payment records for the cost reporting period.

Medicare 2540-10 Cost Report for Skilled Nursing Facilities Operated by Public Hospital Districts in Washington State

The process is essentially the same as for the Medicare 2552-10 cost report, although the line number references on the cost report schedules are not the same.

The schedule references where the nursing home costs and total days are found on the 2540-10 cost reports are as follows:

Skilled Nursing Facility costs are found on Worksheet B Part I, line 30, column 18.

Skilled Nursing total days are found on Worksheet S-3 Part I, line 1, column 7.

Routine cost per patient day is found on Worksheet D-1 Part I, line 16.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PROPORTIONATE SHARE PAYMENTS FOR NURSING FACILITIES OPERATED BY PUBLIC HOSPITAL DISTRICTS IN WASHINGTON STATE (CONT)

The NH UPL for each state fiscal year will be based on the as filed Medicare 2540-10 cost report from two years prior. For example, the 2013 NH UPL payment is based on the 2011 cost information from the 2540-10 as filed. There will be an interim reconciliation with the 2013 as filed cost report 2540-10 and a final reconciliation with the Intermediary audited 2013 cost report 2540-10. The UPL payment will be adjusted using the same method as used with the 2552-10 cost report.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## PART 2 – INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES

Reimbursement for services provided by Intermediate Care Facilities for the mentally retarded (ICFs/MR) for Medicaid recipients is made by rates determined per the following principles, methods, and standards which comply with federal statutory and regulatory requirements.

### I. REIMBURSEMENT PRINCIPLES

A. Medicaid rates are established pursuant to Revised Code of Washington (RCW), Washington Administrative Code (WAC), and Division Policy Directives.

B. Payment rates for non state owned intermediate care facilities for the mentally retarded, hereafter called ICF/MRs, are comprised of three cost center prospective rate components which are: Resident Care and Habilitation (RCH); Administration, Operations and Property (AO and P); and Return on Equity (ROE). Payment rates for state owned facilities, hereafter called Resident Habilitation Centers (RHCs), are their allowable costs.

C. Data used for establishing ICF/IMR prospective rates is from providers' most recent cost reports and cost center cost rates. Data used for setting RHC interim rates is based on the RHCs' most recent cost reports.

D. Cost report data is desk-reviewed to determine that it is correct, complete and reported in conformity with generally accepted accounting principles, and WAC provisions.

E. Allowable costs are documented costs which are ordinary, necessary, and related to care of Title XIX program residents, and which must be incurred by efficiently and economically operated service providers in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

**II. ICF/MR RATES**

A. Prospective Rates

1. The prospective rate for each provider is computed on a resident day basis. The rate is the total of three cost center rates: Resident Care and Habilitation (RCH); Administration, Operations and Property (AO and P); and Return on Equity (ROE).

2. Rates are prospective, subject to settlement in the Resident Care and Habilitation component at the lower of cost or rate, and are individually computed for each non-state owned ICF/MR facility. Rates are settled on a calendar year basis by comparison of the Residential Care and Habilitation rate component to the corresponding costs it was intended to address. Each provider is issued a preliminary settlement for each calendar year and, if an audit is done, a final settlement. A final settlement, if one is issued, incorporates the audit results and supersedes the preliminary settlement. The total rate after the settlement process (called the "settlement rate") represents the final reimbursement rate of the provider for the calendar settlement year in question.

3. Prospective rates are based upon reported costs of a provider for the most recent calendar year. Prospective rates are reset each July 1st utilizing reported costs from the preceding calendar year, after they have been desk reviewed and adjusted. These rates remain in effect until June 30th of the following year except that they are subject to revisions or adjustment for specific circumstances as described below.

B. Inflation Adjustments

1. New rates reflect inflationary cost increases between the most recent and next prior calendar years because rates are based essentially on the most recent calendar year reported costs. In addition, the department is authorized to increase new rates by an add-on inflation factor subject to the Administration and Operations cost center lid as described in subparagraph II.E.2.b. The Property component of the Administration, Operations and Property cost center and the Return of Equity cost center are not subject to inflation adjustments.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

II. ICF/MR RATES (cont.)

2. The adjusted and allowable costs in the Resident Care and habilitation cost center (except for costs relating to resident care and training (RCT) and recreation personnel) and the Administration and Operations components of the Administration, Operations, and Property cost center are adjusted for inflation based on the Implicit Price Deflator For Personal Consumption published by the U.S. Department of Commerce, Bureau of Economic Analysis.

C. Allowable Costs

Allowable costs are documented costs not expressly declared unallowable which are necessary, ordinary and related to the care of Title XIX program recipients. The Washington system does not guarantee that all allowable costs in any particular period will by fully reimbursed.

D. Resident Care and Habilitation Cost Area Rate

The resident care and habilitation cost center rate reimburses for resident living services, habilitation and training services, recreational services and nursing services in accordance with applicable state and federal regulations. A provider's July 1, rate is the sum of the following:

1. The provider's most recent desk-reviewed costs per resident day (except those costs for resident care and training (RCT) and recreation staff and purchased services) from the most recent calendar year cost report, adjusted for inflation as described in section II.B., divided by the provider's total adjusted number of resident days.

2. The provider's total RCT and recreation staff and purchased service cost per hour, adjusted for inflation as described in section II.B., times the adjusted number of paid hours worked during the rate period, divided by the provider's total adjusted number of resident days.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

II. ICF/MR RATES (cont.)

E. Administration, Operations and Property Area Rate

The administration, operations and property cost center rate are comprised of three components: food component rate; administration and operations component rate; and property component rate.

1. The food component rate reimburses for costs of bulk and raw food, dietary supplements and beverages. The rate is a flat rate for all providers based upon the July 1, 1983 IMR food cost center rate of $3.12 per resident day for all providers increased by the inflation factors granted in each rate period since that time.

2. The administration and operations component rate reimburses for costs of overall administration and management of the facility, operation and maintenance of the physical plant, resident transportation, dietary service (other than the cost of food and beverages), laundry service, medical and habilitative supplies, taxes and insurance. A provider's rate is the lessor of:

a. The provider's desk-reviewed administration and operations costs per total resident day, adjusted for inflation and for the period April 1, 1992 through June 30, 1992, a prospective rate adjustment for tax costs levied on total revenue received for ICF/MR services; or,

b. The eighty-fifth percentile ranking of ICF/MR and RHC providers' desk-reviewed administration and operations costs per total resident day, adjusted for inflation plus the amount of the prospective rate adjustment for tax costs as described in subparagraph II.E.2.a. The ranking is based on the most recent ICF/MR and RHC cost reports submitted on or before the effective date of the rate period (July 1) for facilities having an occupancy level of at least eighty-five percent for the cost report period.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

II. ICF/MR RATES (cont.)

E. Administration, Operations and Property Area Rate (cont.)

c. For establishing a provider's desk-reviewed administration and operations costs, certain administrative personnel, management agreements, and central office services are subject to maximum compensation limits prescribed in Washington Administrative Code (WAC) provisions and Division Policy.

3. The property component rate reimburses for costs of depreciation, interest, and leases of buildings, equipment, and vehicles required in the provision of IMR services. For establishing a provider's desk-reviewed property component costs, depreciation for building, land improvements, and fixed equipment is limited to the straight-line depreciation method. A provider's property component rate is the provider's desk-reviewed property cost from their most recent cost report divided by their total adjusted number of resident days.

Effective October 1, 1984, the depreciation base for assets acquired in a change of ownership entered into on or after July 18, 1984 shall not exceed the lower of the purchase price to the new owner or the allowable acquisition cost base to the first owner of record of the assets on or after July 18, 1984. Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of the assets acquired in the change of ownership, where any payment has previously been made by Title XIX, shall not be allowed.

Effective October 1, 1984, allowable debt and interest related to assets acquired in a change of ownership entered into on or after July 18, 1984 shall be the actual debt and interest, except that the rate of interest is limited to the lower of the actual rate of interest or the rate of return on equity related to the acquired assets times the ratio obtained by dividing the allowable acquisition cost base to the new owner (equal to the allowable depreciation base as previously noted) by the purchase price of the assets to the new owner. Debt and interest related to costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to negotiation or settlement of the sale or purchase of the acquired assets in the change of ownership, where any payment has previously been made by Title XIX, shall not be allowed.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

II. ICF/MR RATES (cont.)

E. Administration, Operations and Property Area Rate (cont.)

Effective October 1, 1984, assets acquired in a change of ownership entered into on or after July 18, 1984, are subject to the following depreciation recapture provisions:

a. A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for the loss of, the asset. If the retired asset is replaced, the gain or loss shall be spread over the actual life. of the asset up to the date of retirement, provided the provider has made a reasonable effort to recover at least the outstanding book value of the asset.

b. If a contractor terminates participation in the program, the department shall recover excess reimbursed depreciation for an asset. Excess reimbursed depreciation is the difference between reimbursement actually paid for depreciation of the asset minus the basis for depreciation of the asset, not to exceed the reimbursement actually paid for depreciation. The basis for depreciation is the difference between the historical cost of the asset minus the sale price of the asset. The basis for depreciation will be adjusted for the period under the program.

F. Return on Equity Component Rate

Proprietary providers are eligible for return on equity. Equity is based upon Medicate rules and regulations (42 CFR 413.157), except that goodwill is not included in determining net equity. Net equity is comprised of a provider's working capital plus equity in assets as of the last day of the most recent calendar year, computed as follows:

1. Working capital is calculated as current assets less current liabilities.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

II. INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

F. Return on Equity Component Rate (cont.)

2. Equity in fixed and other assets is determined by subtracting related debts from the net book value of assets (net book value is the historical cost of an asset less accumulated depreciation or amortization). Effective October 1, 1984, the asset value of an acquired asset from a change of ownership entered into on or after July 18, 1984, shall not exceed the lower of the purchase price to the new owner or the allowable acquisition cost base of the asset to the first owner of record on or after July 18, 1984. The debt value related to the acquired assets shall be the actual debt related to the acquired assets times the ratio obtained by dividing the allowable acquisition cost base of the new owner by the purchase price of the assets to the new owner.

3. Net equity is multiplied by the prior calendar years December 31 Medicare rate of return and divided by the providers total annualized resident days for the reporting period. A providers return on equity rate is the lesser of this amount or two dollars per resident day.

G. New Providers

A new provider's rate is based upon the new provider's projected costs, costs and payment rates of the previous provider, and/or rates of other providers in comparable circumstances, taking into account applicable lids or maximums. This data will be used to establish rates until a cost report is submitted which covers at least six months of operation.

H. Rate Adjustment

A provider may request, and the department may grant, a rate adjustment under the following circumstances: changes in staffing or consultant services in order to be in compliance with applicable state and federal laws or regulation; capital additions, improvements or replacements made as a condition of licensure or certification; department changes in program standards or services; or administrative review disposition.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

II. INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED SERVICES (cont.)

I. Final Payment Rates

1. A provider's final payment rate for the resident care and habilitation cost center is established retrospectively and is based on the lower of their prospective rate or their allowable costs. A provider's final payment rate for the administration, operations and property cost center, and return on equity payment is their prospective rate.

2. For the final determination of allowable costs where an ownership change was entered into on or after July 18, 1984, any depreciation which was claimed by a provider will be adjusted so that the owner's historic cost shall take into account actual salvage value (i.e., sales price). Where the depreciation claimed exceeds the actual depreciation based on the adjusted historic cost, the provider shall repay the excess.

**III. RHC PAYMENT RATES**

A. Interim Rates

1. The payment rate for each RHC is computed on a per resident day basis. The rate is a single cost center rate.

2. An RHC's interim rate is based on their most recent desk-reviewed costs per total resident days. These costs are adjusted as follows:

a. Staff costs are adjusted to incorporate legislatively mandated increases in employee related costs.

b. Legislative appropriations for changes necessary to be in compliance with applicable state and federal laws or regulations, as a condition of certification, or for changes in program standards or services.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

III. RHC PAYMENT RATES (cont.)

3. RHC's interim rate will be adjusted for federal, state or department changes in programs services or costs.

B. Final Payment Rates

A RHC's final payment rate is established retrospectively and is their allowable costs.

**IV. PROVIDER APPEALS**

A. A provider may at any time request a revision of their rate. The department will inform the provider of the disposition of the request within sixty days.

B. Within 30 days after notification of a rate action or disposition, a provider may request an administrative review conference for the purpose of presenting additional evidence or argument. The conference must be scheduled within ninety days after the request in received from the provider, unless a later date is mutually agreed upon in writing.

C. Within twenty-eight days after notification of an administrative review conference adverse decision, a provider may request a fair hearing.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**REQUIREMENTS FOR THIRD PARTY LIABILITY - IDENTIFYING LIABLE RESOURCES**

1. The following are the Data matches conducted by Medicaid:

a. SOURCE
Employment Security Wage Records File
IV-D Eligibility File
IV-A Eligibility File
PURPOSE
To match all Medicaid eligibles to a responsible absent parent (IV-D) and then match against the employment security wage file by Social Security number to see if the responsible party is employed. A form is produced which is mailed to the employer to determine if there is health insurance available through the employer to cover the Medicaid eligible.
FREQUENCY
Quarterly

b. SOURCE
Washington State Department of Personnel
IV-D Eligibility File
IV-A Eligibility File
PURPOSE
To match all Medicaid eligibles with responsible absent parent (IV-D) or parent (IV-A) by Social Security number to determine if they are employed by the State of Washington, A report is produced by covering insurance company and is then mailed to the employer to verify coverage dates.
FREQUENCY
Quarterly

c. SOURCE
Department of Labor and Industries
PURPOSE
To match names and Social Security numbers of Medicaid recipients with records of those with employment related injuries or illnesses.
FREQUENCY
Quarterly

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR THIRD PARTY LIABILITY - IDENTIFYING LIABLE RESOURCES (cont.)

d. SOURCE
State Department of Transportation
PURPOSE
To match names and dates of birth of Medicaid clients with the Washington State Patrol motor vehicle accident records. A report is produced and staff validate whether third party liability is available.
FREQUENCY
Weekly

e. SOURCE
Department of Defense
PURPOSE
To match all Medicaid eligible clients to active duty and reserve armed forces members and dependents found in the Defense Eligibility Enrollment Reporting System (DEERS).
FREQUENCY
Annually

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR THIRD PARTY LIABILITY - IDENTIFYING LIABLE RESOURCES (cont.)

2. Within 30 days of receipt of information from above referenced Data Matches, and within 60 days of receipt of health insurance information, a file is set up in the third party data base to affect claims processing.

   When complete information is received on a data match form or health insurance form, the information is immediately entered into the third party data base.

   When incomplete information is received, state and private health insurance eligibility systems (as they become available) are contacted via telephone, mail, electronic correspondence, and online to obtain complete information to enter into the data base within the time frames described above.

   Contact includes the:

   a. Recipient, absent parent, parent
   b. Employer
   c. Insurance company
   d. Providers
   e. Other governmental agencies

3. As a resource for agency staff, Treatment Questionnaires (TQs) are automatically generated in the MMIS system, based on paid claims that contain diagnosis codes indicative of trauma, accident, injury or other consequences of external causes centered on established cost-effective guidelines. The TQs are sent to clients for clarification of the incident that led to the claim. If the client does not respond, one additional TQ letter is generated after the 30 day 'aging date.' The MMIS system tracks the TQ aging date based on a system update made by agency staff, documenting whether or not a response is received.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**Requirement for Third Party Liability – Payment of Claims**

1. The method to determine compliance with requirements of Section 433.139(b)(3)(ii)(c) is as follows: The State Plan as referenced herein requires providers to bill third parties. In a case where medical support is being enforced by the state Title IV-D Agency, the provider will be required to submit written documentation that he has billed the third party and has not received payment from the third party. It must be at least 100 days from the date of service before the state will pay.

   The Medicaid agency pays for medical services and seeks reimbursement from a liable third party when the claim is for preventive pediatric services as covered under the early and periodic screening, diagnosis and treatment (EPSDT) program contained in Section 433.139(b)(3)(i). If the preventive pediatric service is identified in the MMIS as cost-avoidance based on cost-effectiveness or access to care, section 53102(a)(1) of the Bipartisan Budget Act of 2018 warrants cost-avoidance for 90 days.

   State laws are in effect that require third parties to comply with the provisions of 1902(a)(25)(I) of the Social Security Act, including those which require third parties to provide the state with coverage, eligibility, and claims data.

2. Claims for medical services, unless identified under existing state regulations regarding recovery of Agency-paid claims from clients' primary insurance carriers, are cost-avoided when a third party liability (TPL) policy exists within the MMIS (the state's Medicaid payment system known as ProviderOne) that matches the benefit coverage-type and service date. Claims paid by the Agency prior to the TPL policy being entered into the MMIS are pursued for recovery through an invoice submitted to the primary insurance carrier. The cost-effectiveness threshold to pursue recovery on a health insurance claim is monitored by the MMIS and invoices claims to the primary carrier if the total claim paid amount is $15.00 or more.

   Generally, casualty insurance claims are pursued for recovery. Paid claims related to an accident/Injury on a Medicaid client are manually reviewed. The cumulative paid amount on the claim(s) must exceed $50.00 to open a casualty case file on the injured client. An ambulance claim with a paid amount equal to or greater than $220.00 qualifies to open a casualty case file. Additionally, MMIS automatically reviews the paid amount on an accident- or injury-related claim and initiates a Treatment Questionnaire (TQ) letter to the client if the total claim payment is $110.00 or more.

3. The agency will seek recovery from the third party within 60 days after the end of the month in which payment was made. This does not apply to exceptions for Good Cause or Confidential Services cases. Good Cause and Confidential Services cases include Title IV-D domestic violence cases and certain clients with STD/HIV, pregnancy, or abortion-related services/diagnosis. The agency will also seek recovery within 60 days of the date the agency learns of the existence of a third party or when benefits become available. Claims identified under 4.22-B page 1 (1.) should follow the specified 90 to 100 day waiting period before initiating recovery.

4. When the Agency has determined a sum certain receivable amount has been validated and the third party fails to make payment, after 90 days the Agency refers the case to the Department of Social and Health Services' Office of Financial Recovery for formal collection activities. These

REQUIREMENT FOR THIRD PARTY LIABILITY - PAYMENT OF CLAIMS (cont.)

include skip tracing, payment demands, negotiating debts and repayment agreements, and enforcement action, including legal action. “Sum certain receivable” is when a liable third party (regardless of the third-party resource type) and predetermined settlement or recovery has been validated through either court settlement or explanation of benefits (EOBs) and remittance advices (RAs).

4. For Casualty recoveries, the Agency complies with 42 U.S.C.§1396a (a) (25) (B) and uses the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the Agency’s proportionate share of attorney's fee and cost, from a liable party.

A. Ascertain the amount of Medicaid lien and the amount of the gross settlement.

B. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds.

C. If the answer to 2 is Yes; and if the Agency:

a. Is informed the client will not pursue the claim; or

b. Cannot handle the case, once it is tendered to the Agency by the client or the client's attorney to pursue on behalf of the client; or

c. Made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response;

then the Agency follows the procedures stated in 4.

D. The Agency considers the cost effectiveness principle in determining what is the estimated net recovery amount of be pursued, based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors are considered:

a. Settlement as may be affected by insurance coverage or other factors relating to the liable party;

b. Factual and legal issues of liability as may exist between the client and liable party;

c. Problems of proof faced in obtaining the award or settlement; and

d. The estimated attorney's fee and costs required for the Agency to pursue the claim.

5. After considering the above factors, the Agency may pursue a lesser recovery amount to the extent that the Agency determines it to be cost-effective to do so.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR THIRD PARTY LIABILITY DELEGATION OF THIRD PARTY RESPONSIBILITIES TO MANAGED CARE ORGANIZATIONS

The Agency does not exempt clients from enrollment in managed care based solely on the presence of third party liability (TPL). The Agency assigns TPL responsibility to managed care organizations by contract.

In order to preserve TPL recoveries in the managed care setting, the state:

1) Takes reasonable and prudent steps to spell out TPL responsibilities in managed care contracts and subcontracts.

2) Monitors those contracts to assure compliance with TPL responsibilities by managed care plans and their subcontractors.

3) Takes appropriate corrective action where there are contract deficiencies and requires reporting by plans on their actual TPL recoveries in order to gauge the accuracy of capitation rate reductions to account for TPL..

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

| Citation | Condition or Requirement |
|---|---|
| 1906 of the Act | State Method on cost effectiveness of Employer-Based Group Health Plans and non-1906A qualified clients with health plans.<br><br>1. Review of policy to determine if coverage is comprehensive.<br><br>2. Determine cost of policy on a monthly basis.<br><br>3. Review Expenditure and Utilization Analysis Report that shows cost per user and cost per eligible for those covered on Medicaid. This report is broken down by age and sex.<br><br>4. If policy costs are less than the average cost per user for the age and sex and the coverage under the policy is comprehensive, it is determined to be cost-effective and the State pays the premium payments.<br><br>5. If policy cost is over the average cost per user, the client's medical condition is reviewed to determine if he/she has required or will be requiring extensive medical care. If it is determined there will be extensive medical care required and the plan is comprehensive in its coverage, the State will cover the cost of insurance premiums. |
| 1906A of the Act | The State offers a premiums assistance subsidy for qualified employer-sponsored coverage to all individuals under age 19 (and the parent of such an individual) who are entitled to medical assistance.<br><br>1. Review of policy to determine if coverage is comprehensive as a group health plan or health insurance coverage through an employer as qualified in section 2701(c)(1) of the Public Health Service Act. The policy must not include benefits provided under a health flexible spending arrangement as defined in section 160(c)(2) or be a high deductible health plan as defined in section 223(c)(2) of the IRS Code of 1986, without regard to whether the plan is purchased in conjunction with a health savings account.<br><br>2. Validate that the employer contributes at least 40% toward the premium and that the plan is offered to all individuals in a manner considered to be nondiscriminatory eligibility classification per paragraph 93 (a)(ii) of section 105(h) of the IRS Code of 1986.<br><br>3. The Agency will provide a premium assistance subsidy equal to the amount of the employee contribution for enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State Plan. |

Back to TOC

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Washington

| Citation | | Sanctions for Psychiatric Hospitals |
|---|---|---|
| 1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)) | (a) | The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(A) of the Act | (b) | The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(B) of the Act | (c) | When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:<br>1. terminate the hospital's participation under the State plan; or<br>2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or<br>3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding. |
| 1902(y)(2)(A) of the Act | (d) | When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after to date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period. |

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Washington

| Citation | Sanctions for Psychiatric Hospitals | |
|---|---|---|
| 1932(e)<br>42 CFR 428.726 | (a) | The State will monitor for vilations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in a manner specified below: |
| | (b) | The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed fviolations of section 1903(m) and thus subject to imposition of empormary management:<br><br>DSHS would impose temporary management only when the MCO has committed repeated acts that pose a thereat to client safety. All other incidients of repeated violations would be handled through termination of the contract for services rather than temporary management. |
| | (c) | The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, papyment for those enrollees is denied by CMS under 42 CFR 438.730(e). |
| | __ | Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs. |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS**

Issuance of Medicaid eligibility cards to homeless individuals is arranged with the client by reviewing the following options in the order presented below. The first option to be appropriate is used.

1. Cards mailed to a protective payee, if one has already been designated.

2. Cards mailed to a mutually agreeable friend or relative.

3. Cards mailed to a social agency that has regular contact with the client. The social agency designated must agree with the plan.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE**

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

**1. Introduction**

a. The Patient Self-Determination Act, as part of OBRA 1990, requires that each state develop a written description of the law of the state concerning advance directives. The following is a summary of Washington law.

b. Applicable law in this area is primarily statutory. Washington recognizes two types of advance directives: (1) A Directive to Physicians (or "Living Will") and (2) A Durable Power of Attorney for Health Care. The related subjects of informed consent and anatomical gifts will also be summarized.

**2. Health Care Directives**

a. Washington Natural Death Act ("Act") provides for the use of directives to physicians. The pertinent parts are codified at RCW 70.122.010 - 100. Under the Act, a patient may direct that his/her life not be artificially prolonged if he/she is suffering from an incurable injury, disease or illness that has been certified to be terminal, when such measures would only prolong the moment of death.

b. Two physicians must diagnose and certify in writing that the patient is afflicted with a terminal condition. One of the two physicians must be the attending physician and both must personally examine the patient.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE (cont.)

c. The client has a right to create an Advance Directive for psychiatric care which complies with RCW 71.32 and the requirements of 42 CFR §422.128, Subpart I of part 489 and 42 CFR §438.6 as they pertain to psychiatric care. The Advance Directive must be a written document in which the principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both.

d. Before a directive is effectuated, the written certification of the diagnosis shall be attached to the directive and made a permanent part of the patient's medical records. The directives must be in writing, and signed and witnessed by two persons who are not related to the signer by blood or marriage, and who, at the time of signing are not entitled to any portion of the signer's estate by will, codicil or operation of law, or have a claim against the estate. The witness may also not be treating physicians, the physicians' employees, or employees of the health care facility where the signer is a patient.

e. A directive may be revoked by destroying it with the intent of revoking it. A revocation is effective without regard to competency. A living will may also be revoked verbally or in writing, but the cancellation does not take effect until it is made known to the attending physician. If the person is comatose or is incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until the patient is able to communicate with the attending physician.

f. There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation, unless that person has actual or constructive notice of the revocation.

g. No physician, health facility, or licensed health personnel (acting under the direction of a physician), acting in good faith and within the requirements of the Act shall be held civilly, criminally or professionally liable for withholding or withdrawing life-sustaining procedures.

h. No physician and no licensed health personnel acting in good faith under the direction of a physician may be held civilly or criminally liable for failing to effectuate a directive. However, if the physician refuses to effectuate the directive, the physician must make a good faith effort to transfer the patient to a physician who will effectuate the directive.

i. The Act does not authorize mercy killings or other affirmative acts or omissions to end life, other than to permit the natural process of dying. The Act also provides criminal penalties for violation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE (cont.)

**3. Durable Power of Attorney for Health Care**

a. Washington law authorizes a durable power of attorney for health care pursuant to RCW 11.94.010 - 060. The durable power of attorney for health care may specify when and under what circumstances the power of attorney becomes effective.

b. A durable power of attorney for health care must be in writing and when effective, an "attorney-in-fact" to be responsible for the principal's health care decisions. Unless the attorney-in-fact is a spouse, adult child, or brother or sister, the attorney-in-fact may not be the principal's physician or physician's employee, or the owners, administrators or employees of the health care facility where the principal resides or receives care. A durable power of attorney for health care may be specific or broad in scope with regard to the type of health care decisions to be made. The durable power of attorney for health care does not require witnesses but must be in writing and signed by the principal. The document may be revoked by the principal, a court appointed guardian or by court order.

**4. Informed Consent**

a. RCW 7.70.060 - 065 contains Washington law regarding informed consent. Before medical treatment can occur, a physician must obtain informed consent. Information regarding the proposed treatment must be given in a language understandable to the patient. The information must include the nature of the proposed treatment, anticipated results of the treatment, recognized possible alternative forms of treatment and recognized serious possible risks, complications and anticipated benefits involved in the treatment and the recognized possible alternative forms of treatment including non-treatment. Except in certain circumstances (see below), the proposed treatment cannot be given without informed consent.

b. A patient may also elect not to be informed of the possible risks, benefits and alternatives to the treatment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE (cont.)

**4. Informed Consent (cont.)**

c. In some compelling circumstances, involuntary treatment may be administered. In these instances, health professionals or a judge may determine whether treatment is warranted.

d. If a patient is incapacitated, informed consent may be obtained from a person authorized by law to make treatment decisions. Such a person or "surrogate" may be, in descending order of priority: (1) an appointed guardian; (2) an individual to whom the patient has given a durable power of attorney for health care; (3) the patient's spouse; (4) children of the patient who are 18 or over; (5) parents of the patient; or (6) the patient's brothers or sisters who are over 18.

e. The physician seeking informed consent must make a reasonable effort to get authorization from someone in the first or second group. If such a person is not available, authorization may be given by someone in the next group in the order of descending priority. However, no person may provide consent if a person in a higher priority group has refused to give authorization or if there are two or more individuals in the same group and the decision is not unanimous among all available members of that group.

f. Before giving informed consent, a surrogate decision-maker must make a good faith effort to determine that the patient, if competent, would consent to the proposed treatment. If that is not possible, the surrogate decision-maker may give informed consent to treatment if it is determined that such treatment is in the patient's best interest.

**5. Anatomical Gifts**

a. Washington's Anatomical Gift Act, RCW 68.50.340 - 420 provides that persons over 18 of sound mind may give all or any part of their bodies for medical research or transplant purposes.

b. A spouse, adult child, either parent, an adult brother or sister or guardian (in descending priority, when persons in prior classes are not available at time of death) may also decide to give all or part of the decedent's body for medical research or transplant purposes. This may occur if there was no known opposition by the decedent, or no known opposition by a person in the same or prior class.

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE (cont.)

**5. Anatomical Gifts (cont.)**

c. An anatomical gift may be made by will or separate document. The document may or may not be delivered to the donee, without affecting the gift's validity. The document must be signed and witnessed by two persons. The document may be amended or revoked orally or in writing, or if made by will, in the same manner as an amendment or revocation of a will under Washington law.

**6. Form**

RCW 70.122.030(12) provides in part: ...The directive shall be essentially in the following form, but in addition may include other specific directions.

**HEALTH CARE DIRECTIVE**

Directive made this _____ day of _____ (month, year).

I, _____having the capacity to make health care decisions, willfully, and voluntarily make known that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

a. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE (cont.)

**7. Forms** (cont.)

b. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences from such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

c. If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.

I DO NOT want to have artificially provided nutrition and hydration.

d. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

e. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

f. I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

g. It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed _____

City, County, and State of Residence

The declarer has been personally known to me and I believe him/her to be of sound mind.

Witness _____

Witness _____

B. To comply with chapter 71.32 RCW, the Mental Health Advance Directive must be in essentially the form described in Supplement A to Attachment 3.34-A; any other form must meet the requirements in chapter 71.32 RCW.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**Example of Mental Health Advance Directive Form**

## NOTICE TO PERSONS
## CREATING A MENTAL HEALTH ADVANCE DIRECTIVE

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document you should know these important facts:

(1) This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

**YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM.**
**IF YOU DO NOT SIGN THIS FORM, IT WILL NOT TAKE EFFECT.**

If you choose to complete and sign this document, you may still decide to leave some items blank.

(2) You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.

(3) The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.

(4) You have the right to revoke this document in writing at any time you have capacity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**YOU MAY NOT REVOKE THIS DIRECTIVE WHEN YOU HAVE BEEN FOUND TO BE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU WANT IT TO BE REVOCABLE WHEN YOU ARE INCAPACITATED.**

(5) This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.

(6) You cannot use your advance directive to cons. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.

(7) If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

(8) You should be aware that there are some circumstances where your provider may not have to follow your directive.

(9) You should discuss any treatment decisions in your directive with your provider.

(10) You may ask the court to rule on the validity of your directive.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## PART I.

## STATEMENT OF INTENT TO CREATE A MENTAL HEALTH ADVANCE DIRECTIVE

I, _____being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that he or she determines is in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I understand that there are some circumstances where my provider may not have to follow my directive.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____WASHINGTON_____

## PART II.

## WHEN THIS DIRECTIVE IS EFFECTIVE

*YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.*

I intend that this directive become effective *(YOU MUST CHOOSE ONLY ONE)*:

_____Immediately upon my signing of this directive.

_____If I become incapacitated.

_____When the following circumstances, symptoms, or behaviors occur:

_____

_____

_____

_____

_____

## PART III.

## DURATION OF THIS DIRECTIVE

*YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.*

I want this directive to *(YOU MUST CHOOSE ONLY ONE)*:

_____Remain valid and in effect for an indefinite period of time.

_____Automatically expire _____ years from the date it was created.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## PART IV.

## WHEN I MAY REVOKE THIS DIRECTIVE

*YOU MUST COMPLETE THIS PART FOR THIS DIRECTIVE TO BE VALID.*

I intend that I be able to revoke this directive *(YOU MUST CHOOSE ONLY ONE):*

_____Only when I have capacity.

I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.

_____Even if I am incapacitated.

I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

## PART V.

## PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS

### A. Preferences and Instructions About Physician(s) to be Involved in My Treatment

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____

Contact information:_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Dr. _____

Contact information:_____

I do not wish to be treated by

Dr._____

**B. Preferences and Instructions About Other Providers**

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name _____

Profession _____

Contact information _____

Name _____

Profession _____

Contact information _____

**C. Preferences and Instructions About Medications for Psychiatric Treatment**
*(initial and complete all that apply)*

_____I consent, and authorize my agent (if appointed) to consent, to the following

medications: _____

_____

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

_____I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

_____

_____

_____I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include

_____

_____

and these side effects can be eliminated by dosage adjustment or other means.

_____I am willing to try any other medication the hospital doctor recommends.

_____I am willing to try any other medications my outpatient doctor recommends.

_____I do not want to try any other medications.

**Medication Allergies**

I have allergies to, or severe side effects from, the following:

_____

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## Other Medication Preferences or Instructions

I have the following other preferences or instructions about medications

_____

_____

## Preferences and Instructions About Hospitalization and Alternatives

*(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)*

_____In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

_____I would also like the interventions below to be tried before hospitalization is considered:

_____Calling someone or having someone call me when needed.

Name:_____ Telephone:_____

_____Staying overnight with someone.

Name:_____ Telephone:_____

_____Having a mental health service provider come to see me.

_____Going to a crisis triage center or emergency room.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

_____Staying overnight at a crisis respite (temporary) bed.

_____Seeing a service provider for help with psychiatric medications

_____Other, specify:_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____WASHINGTON_____

## Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days *(not to exceed 14 days)*
*(Sign one)*:

_____If deemed appropriate by my agent (if appointed) and treating physician.

_____
*(Signature)*

or

_____Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

_____

_____

_____
*(Signature)*

or

_____I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment.

_____
*(Signature)*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:

_____

_____

I do not consent to be admitted to the following hospitals:

_____

_____

## E. Preferences and Instructions About Pre-emergency

I would like the interventions below to be tried before use of seclusion or restraint is considered *(initial all that apply)*:

_____"Talk me down" one-on-one

_____ More medication

_____ Time out/privacy

_____ Show of authority/force

_____ Shift my attention to something else

_____ Set firm limits on my behavior

_____ Help me to discuss/vent feelings

_____ Decrease stimulation

_____ Offer to have neutral person settle dispute

_____ Other, specify _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____WASHINGTON_____

**F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications**

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen *(choose "1" for first choice, "2" for second choice, and so on)*:

_____Seclusion

_____Seclusion and physical restraint (combined)

_____Medication by injection

_____Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

**G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)**

My wishes regarding electroconvulsive therapy are *(sign one)*:

_____I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

_____
*(Signature)*

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

_____
*(Signature)*

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions: ____
_____
_____
_____
*(Signature*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**H. Preferences and Instructions About Who is Permitted to Visit**

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: _____

Name: _____

Name: _____

I understand that persons not listed above may be permitted to visit me.

**I. Additional Instructions About My Mental Health Care**

Other instructions about my mental health care:

_____

In case of emergency, please contact:

Name:_____Address:_____ Work telephone:_____ Home telephone:_____

Physician: _____ Address:_____

Telephone: _____

The following may help me to avoid a hospitalization:

_____

I generally react to being hospitalized as follows:

_____

Staff of the hospital or crisis unit can help me by doing the following:

_____

**J. Refusal of Treatment**

I do not consent to any mental health treatment.

_____
*(Signature)*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## PART VI.

## DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

*(Fill out this part only if you wish to appoint an agent or nominate a guardian.)*

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

### A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name:_____Address:_____Work telephone:_____ Home telephone:_____

Relationship: _____

### B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name:_____Address:_____Work telephone:_____ Home telephone: _____

Relationship: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____WASHINGTON_____

**C. When My Spouse is My Agent *(initial if desired)*:**

_____If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

**D. Limitations on My Agent's Authority**

I do not grant my agent the authority to consent on my behalf to the following:

_____

_____

**E. Limitations on My Ability to Revoke this Durable Power of Attorney**

I choose to limit my ability to revoke this durable power of attorney as follows:

_____

_____

**F. Preference as to Court-Appointed Guardian**

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name:_____Address:_____Work

telephone:_____ Home telephone: _____

Relationship: _____

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

_____
*(Signature required if nomination is made)*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____WASHINGTON_____

## PART VII.

## OTHER DOCUMENTS

*(Initial all that apply)*
I have executed the following documents that include the power to make decisions regarding health care services for myself:

_____ Health care power of attorney (chapter 11.94 RCW)

_____ "Living will" (Health care directive; chapter 70.122 RCW)

_____ I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

## PART VIII.

## NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

*(Fill out this part only if you wish to provide nontreatment instructions.)*

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

### A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name:_____ Address:_____ Day telephone:_____ Evening telephone: _____

Name:_____Address:_____Day telephone:_____ Evening telephone: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**B. Preferences or Instructions About Personal Affairs**

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

_____

_____

_____

C. Additional Preferences and Instructions:

_____

_____

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## PART IX.

## SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature: _____ Date: _____

Printed Name:_____

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

1. A person designated to make medical decisions on the principal's behalf;
2. A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
3. An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;
4. A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
5. An incapacitated person;
6. A person who would benefit financially if the principal undergoes mental health treatment; or
7. A minor.

Witness 1: Signature: _____Date: _____

Printed Name:_____

Telephone _____ Address_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____WASHINGTON_____

_____

Witness 2: Signature: _____Date: _____

Printed Name:_____

Telephone _____ Address_____

**PART X.**

**RECORD OF DIRECTIVE**

I have given a copy of this directive to the following persons:

_____

_____.

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

DO NOT FILL OUT PART XI UNLESS YOU INTEND TO REVOKE
THIS DIRECTIVE IN PART OR IN WHOLE

## PART XI.

## REVOCATION OF THIS DIRECTIVE

*(Initial any that apply)*:

_____I am revoking the following part(s) of this directive (specify):

_____

_____

_____

_____

_____I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

Signature: _____Date: _____

Printed Name:_____

**DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE**

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Nursing Facilities

**Termination of Provider Agreement**: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Chapter 18.51 RCW

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Nursing Facilities

**Temporary Management:** Describe the criteria (as required at §1919 (h) (2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Chapter 18.51 RCW

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Nursing Facilities

**Denial of Payment for New Admissions**: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Chapter 18.51 RCW

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Nursing Facilities

**Civil Money Penalty:** Describe the criteria (as required at §1919 (h) (2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Chapter 18.51 RCW

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Nursing Facilities

**State Monitoring:** Describe the criteria (as required at §1919 (h) (2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Chapter 18.51 RCW

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Nursing Facilities

**Transfer of residents; Transfer of residents with closure of facility**: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Chapter 18.51 RCW

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Enforcement of Compliance for Intermediate Care Facilities for Individuals with Intellectual Disabilities ICF/IID

**Additional Remedies:** Describe the criteria (as required at §1902(i)(1)(B)) for applying the additional remedy.

I. Termination of agreement when the immediate jeopardy is not abated/removed

If there is immediate jeopardy to resident health or safety, the state terminates the ICF/IID's provider agreement within 23 calendar days from the date of notice to the facility.

II. Termination of agreement or non-renewal when there is no immediate jeopardy or the immediate jeopardy is abated/removed

A. If, prior to the termination date, the facility removes the serious and immediate threat, but a Condition of Participation (CoP) is still not met, the state may extend the compliance deadline for up to 90 days.

B. When immediate jeopardy does not exist, the state terminates an ICF/IID's provider agreement no later than 90 calendar days from the finding of noncompliance, if the facility does not meet the CoPs.

III. In lieu of termination of agreement

In lieu of termination of agreement, the state may consider imposing one or more of the following sanctions if deficiencies do not immediately jeopardize the health and safety of individuals. The application of the alternative sanctions are in accordance with current state laws.

With the exception of denial of payment for new admissions, the timing and notice of the alternative sanctions begin on the date the facility receives the written notice and Statement of Deficiencies, as documented by the Certified Mail Return Receipt. The facility has 45 days (state licensed ICFs) or 60 days (Residential Habilitation Centers) from the date the facility receives formal verbal notice of the state's findings (known as the "exit date") for the correction to be accomplished.

A. A Directed Plan of Correction (DPOC)

1. The state may impose a DPOC when the Conditions of Participation (CoPs) are out of compliance. The state chooses a DPOC when it determines the facility needs to make specific systemic changes in order to gain compliance and it has (or will be) unable to do so.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Enforcement of compliance for ICF/IIDS (contd)

2. A DPOC is a plan of correction that contains all the elements of a traditional Plan of Correction (POC). It differs from a traditional POC in that the state develops the DPOC, not the facility. The facility must take action or accomplish the DPOC within specified time frames.

3. If the facility fails to achieve substantial compliance after complying with the DPOC, the state may impose another alternative sanction or sanctions until the facility achieves substantial compliance or it is terminated from the Medicaid program. The state measures substantial compliance when it determines the facility has complied with the DPOC and meets the requirements of the CoPs and standard level deficiencies.

B. Directed In-Service Training

1. The state may impose directed in-service training when CoPs or repeat citations of standard level regulations are out of compliance. The state chooses directed in-service training when it determines the facility needs the acquisition of specific knowledge in order to make specific systemic changes in order to gain compliance and it has (or will be) unable to do so.

2. The state may choose directed in-service training when it concludes that education is likely to correct the deficiencies. This remedy requires the staff of the ICF/IID to attend in-service training program(s). The purpose is to provide knowledge required to achieve compliance and remain in compliance with the CoPs.

3. The state measures substantial compliance when facility staff successfully complete the directed in-service-training and the facility meets the requirements of the CoPs and standard level deficiencies.

C. State Monitoring

1. The state may impose state monitoring when CoPs or repeat citations of standard level regulations are found to be out of compliance. The state chooses state monitoring when it determines the facility needs close monitoring of the implementation of its PoC or the DPOC to ensure the Plan is fully implemented and the systemic changes required are progressing and occur as needed in order to gain compliance, and the facility has (or will be) unable to do so.

2. A state monitor oversees the correction of cited deficiencies in the facility as a safeguard against further noncompliance when a situation with a potential for jeopardizing health and safety has occurred, but has not risen to the level of immediate jeopardy.

3. The state measures substantial compliance when it receives assurance from the state monitor that the facility has completed the PoC or DPOC and meets the requirements of the PoC or DPOC and standard level deficiencies

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Enforcement of compliance for icf/iidS (contd)

D. Deny payment for new admissions

1. When a facility has failed to meet one or more conditions of participation, the state gives the facility 60 days from the survey date to meet the conditions. If the facility does not correct the conditions by the specified date, and if the state chooses to impose a Denial of Payment for new admissions, the state gives the facility notice of intent to impose the remedy.

2. The state may impose a Denial of Payment for up to 11 months. If the state finds serious violations during this 11-month period, it may terminate the facility while the Denial of Payment is in effect.

3. The state may lift the Denial of Payment earlier if a facility is in compliance or is making a good faith effort to comply. (42 CFR 442.118)

4. The state must terminate the agreement if the facility is not in substantial compliance at the end of the 11 months. The state measures substantial compliance through a follow-up survey process related to compliance with cited CoPs and cited Standard level regulations. The facility is entitled to an Evidentiary Hearing. (42 CFR 442.119)

E. Temporary management and receivership

1. Temporary management permits the state to impose temporary management for a facility when the state determines the facility's continued substantial non-compliance with federal regulations is due to the inability of the facility's management staff to ensure compliance with the regulations.

2. Temporary management is for a specified period of time set at the time of enforcement. The state will determine compliance through a survey re-visit when the facility/temporary manager sends the state a letter alleging compliance has been achieved. When the state determines that the facility has achieved compliance, temporary management will be stopped.

3. The state considers receivership to correct problems associated with either the disregard of clients' safety, health, or welfare, or with the possible closure of the ICF/IID for any reason.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION**

State's description of information to be disclosed from the registry in addition to the information required by 42 CFR 483.156(c)(i)(iii) and (iv):

Method by which individual became state certified--(deeming, competency evaluation or interstate endorsement).

State licensing information--whether individual holds other credentials in Washington besides nurse aide.

Name and address of employer

Names of individuals who voluntarily meet state certification requirements and choose to be on registry.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**COLLECTION OF ADDITIONAL REGISTRY INFORMATION**

State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c):

Method by which individual became state certified--(deeming, competency evaluation or interstate endorsement).

State licensing information--whether individual holds other credentials in Washington besides nurse aide.

Name and address of employer

Names of individuals who voluntarily meet state certification requirements and choose to be on registry.

Additional comments

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**DEFINITION OF SPECIALIZED SERVICES**

“Specialized Services" for a person with mental retardation or related conditions means a continuous program for each person which includes:

- Aggressive, consistent implementation of a program of specialized and generic training;
- Treatment, health services, and related services directed toward the acquisition of the behaviors necessary for the person to function with as much self-determination and independence as possible; and
- The prevention or deceleration of regression or loss of current optimal functional status.

Specialized services does not include services to maintain a generally independent person able to function with little supervision or in the absence of a treatment program;

**Note:** Residents requiring specialized services for a developmental disability may be provided these services in a nursing facility. Components of a specialized services plan may already be among the services that nursing facilities are required to arrange or provide. Two examples are in-house activity programs and social services. Other components of a specialized services plan may be services that the department must arrange. Examples include vocational services, educational services and some aspects of community integration.

"Specialized services" for a person with serious mental illness means the implementation of an individualized plan of care, developed under and supervised by a physician and other qualified mental health professionals, prescribing specific therapies and activities for the treatment of a person experiencing an acute episode of severe mental illness necessitating twenty-four hour supervision by trained mental health personnel. Specialized services are generally considered psychiatric inpatient care, emergency respite care or stabilization and crisis services that are directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

**Note:** Residents requiring specialized services for a serious mental illness are referred to appropriate in-patient psychiatric facilities for care during their acute episode. If a resident has been treated and his/her mental illness symptoms are no longer acute; and has been determined to require the services provided by a nursing facility, the person may be re-admitted to the first available bed in a nursing facility.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## CATEGORICAL DETERMINATIONS

I. The State may make an advanced group determination that nursing facility (NF) services are needed under the following categories:

A. CONVALESCENT CARE:

The applicant is admitted directly to a NF from a hospital for convalescent care for an acute physical illness under the following circumstances:

1. The individual's attending physician has certified before admission to the facility that the individual is likely to require less than 45 days of nursing facility services.

2. Convalescent care is required to treat a condition other than the one that resulted in the hospital admission.

B. TERMINAL ILLNESS:

The applicant's attending physician has certified prior to NF placement, an explicit terminal prognosis with a life expectancy of less than 6 months.

C. SEVERE PHYSICAL ILLNESS:

The applicant’s level of impairment is so severe that the individual is determined to reed NF services. An individualized assessment for specialized services must be performed.

D. RESPITE CARE:

The applicant is admitted to a NP for a period not to exceed 30 days a year in order to provide respite to in-home caregivers. The applicant is expected to return home after this period.

E. EMERGENCY SITUATIONS:

Provisional admission pending further assessment in emergency situations requiring protective services, with placement in a NF not to exceed 7 days.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

CATEGORICAL DETERMINATIONS (con't)

F. Provisional admission pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears. The applicant must have a primary diagnosis of delirium as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III-R).

II. The State may make an advanced group determination that specialized services are not needed under the following categories:

A. INDIVIDUALS WITH DEMENTIA WHICH EXIST IN COMBINATION WITH MENTAL RETARDATION:

Individuals with dementia, which exist in combination with mental retardation or a related condition, do not need specialized services. The applicant has a primary diagnosis of dementia as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III-R).

B. DELIRIUM:

Provisional admission pending further assessment in cases of delirium where an accurate evaluation cannot be made until the delirium clears. The applicant must have a primary diagnosis of delirium as defined in the DSM-III-R.

C. EMERGENCY SITUATIONS

Provisional determination pending further assessment in emergency situations requiring protective services, with placement in the NF not to exceed 7 days.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

CATEGORICAL DETERMINATIONS (con't)

D. RESPITE CARE:

An individualized assessment regarding the reed for specialized services is required only when there is reason to believe the individual may suffer a developmental or physical decline if these services are not provided during the respite stay. The individual's respite care schedule should remain as close to the home environment's schedule as possible.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

**Survey and Certification Education Program**

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The state has regular meetings and forums with providers, consumers and staff in an effort to provide current information regarding procedural, regulatory and policy issues. Residents and other interested persons are offered meeting opportunities, trainings and printed publications concerning regulations and policies:

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Process for the investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The state provides a toll-free hotline to receive complaints of abuse, neglect or misappropriation of resident property. The complaint system processes such complaints in a timely manner by assignment to survey and certification staff for investigation and by referral to the appropriate professional licensing board for investigation and action.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State EWASHIINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken alt reasonable steps to avoid giving notice.

1. Survey schedules are decentralized and are directed by a local district manager. This results in the fewest possible persons being aware of when surveys are scheduled.

2. The State Fire Marshall, who is responsible for the Life Safety Code survey, is not notified in advance of which facilities are scheduled for surveys. The State Fire Marshall is advised of the need for a Life Safety Code survey **only after** the health survey has begun. Therefore, the Life Safety Code survey cannot provide advance notice of an upcoming health survey.

3. All new surveyors are given an orientation to the survey program. This orientation includes information on the prohibition of providing an advance notice of a survey. This prohibition is based not only on federal requirements, but also on state law. (Revised Code of Washington 18.51.210(2) provides "Any public employee giving such advance notice in violation of this section shall be suspended from all duties without pay for a period of not less than five nor more than fifteen days.)

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The State's plan to reduce inconsistency in the application of survey results is managed by two Quality Assurance Chiefs for 10 survey Districts and includes:

1. A 100 percent supervisory review by the District Manager of all written deficiencies, using the March 1992 HCFA document "Principles of Documentation for the Statement of Deficiencies," before the full health survey, statement of deficiencies (HCFA 2567), is given to the nursing home provider. Each surveyor has received documentation training and has been instructed to use the March document as a guide when writing citations.

2. A quarterly review and report of 10 percent of all full surveys conducted (HCFA 2567), by the training unit. The review evaluates the written citations for accuracy and consistency in each District, using the HCFA March 1992 document "Principles of Documentation for the Statement of Deficiencies. A report is completed highlighting any problems and suggesting plans if needed for training. Each District manager follows up by reviewing the report with the surveyors and implementing any training plans.

3. Annually the trainers (2) observe one full health survey in each of the 10 districts. The provide a report with recommendations for areas that need correction. The District Manager implements recommendations as needed. The District Manager annually observes a full survey conducted by the surveyors within their respective units, and, if needed, implements changes.

4. A desk audit is conducted of all Federal look-behind surveys to compare state versus federal deficiencies. A report is prepared, including when necessary, a corrective plan which may include need for further training. This is sent to Olympia for review by the Quality Assurance Chief for the District. If necessary, a statewide strategy for correction may be implemented.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

The state monitors onsite, as needed, compliance with the requirements of subsection (v), (c) and (d) as follows:

(i) A facility not in compliance and in the process of correcting is monitored weekly, or, as needed, through an onsite visit by the Quality Assurance Nurse (QAN) assigned to the facility. The QAN reviews the full health survey which found the facility out of compliance, monitors key areas not in compliance for degree of correction occurring and provides the District Manager with a monitoring report.

(ii) and (iii) A quality assurance monitoring visit is conducted by the QAN at least quarterly and more frequently for all T. 18/19 facilities. A report is developed at the end of the visit. It is given to the facility and technical assistance provided. If problems are found, an out of sequence survey could result.

The complaint intake and investigation process ensures timely assignment and investigation of allegations of abuse, neglect and misappropriation of resident properties. Complaint investigations may result in sanctions, civil fines or full survey investigations.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

**Employee Education Regarding False Claims Recovery**
**Methodology of Compliance Oversight**

**Compliance, oversight, and enforcement**

An entity that receives or makes annual medical assistance payments under the State Plan of at least $5,000,000, must comply with the requirements of section 1902 of the Social Security Act in order to receive payments.

The State has implemented various monitoring processes for entities that receive Medicaid funds on or after September 1, 2007. During the normal cycle of monitoring payments of medical assistance under the State Plan, the State determines if an entity is required to comply with section 1902(a)(68) of the Act. If the entity is required to comply, the State will provide notice that the entity is subject to the requirements under section 1902(a)(68). The entity is responsible for submitting an attestation under penalty of perjury to the State to verify the entity has compliant written policies, and that they have been disseminated as required. The State may also obtain copies of an entity's written policies and proof of dissemination for review to verify the entity has complied with the requirements.

For those entities the State determines are not in compliance with section 1902(a)(68), the State may provide a warning for a reasonable period of time for the entity to become compliant, or the State may suspend or forfeit medical assistance payments until such time as an entity establishes with the State that it has become compliant .

Back to TOC