

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



Center for Medicaid and State Operations

Robin Arnold-Williams, Secretary
Department of Social and Health Services
PO Box 45010
Olympia, Washington 98504-5010

APR 25 2007

RE: State Plan Amendment 05-006

Dear Secretary Arnold-Williams:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 05-006. This amendment delineates the specific elements of a cost-based reimbursement methodology for hospitals participating in the State's CPE program, establishes a base community psychiatric payment rate and updates the DSH and UPL programs. It is approved effective July 1, 2005.

Under regulations at 42 CFR 430.12(c)(i), States are required to amend State plans whenever necessary to implement changes in Federal law, regulations, policy interpretations, or court decisions. On January 18, 2007, CMS published a notice of proposed rule making that would modify Medicaid reimbursement and State financing of their Medicaid programs. Should this proposed rule be adopted in final regulations, some or all of the payments under this plan amendment may no longer be allowable expenditures for federal Medicaid matching funds. States will be expected to review their payment methodologies and, if necessary, submit conforming amendments to reflect the new regulations. Approval of the subject State plan amendment does not relieve the State of its responsibility to comply with changes in federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

To carry out Federal oversight responsibilities, please be advised that the Seattle regional office will conduct a financial management review of the payments authorized under Attachment 4.19-A, Part I of the State Medicaid plan and funded through certified public expenditures. The purpose of this review will be to ensure that claimed expenditures are accurate and that claims for Federal funding are matched by adequate non-Federal funding. If you have any questions, please call Joe Fico of the National Institutional Reimbursement Team at (206) 615-2380.

Sincerely,

A handwritten signature in cursive script that reads "Bill Farnsworth".

Dennis G. Smith
Director

cc: Doug Porter, Assistant Secretary, DSHS, HRSA

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

1. TRANSMITTAL NUMBER:
05-006

2. STATE
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2005

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

- a. FFY 2005 \$775,000
b. FFY 2006 \$3,168,750

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

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

Attachment 4.19-A Part I
Supplement ~~1~~ to Attachment 4.19-A, Part I
(P+I) 3 (P+I)

Attachment 4.19-A Part I

10. SUBJECT OF AMENDMENT:

Inpatient Hospital Payment Methodology

11. GOVERNOR'S REVIEW (Check One):

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Robin Arnold-Williams

13. TYPED NAME:
ROBIN ARNOLD-WILLIAMS

14. TITLE:
Secretary

15. DATE SUBMITTED:

Sept. 28, 2005

16. RETURN TO:

Ann Myers
Department of Social and Health Services
Medical Assistance Administration
925 Plum St SE MS: 45533
Olympia, WA 98504-5533

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

SEP 28 2005

18. DATE APPROVED:

APR 25 2007

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL 1 2005

PLAN APPROVED - ONE COPY ATTACHED

20. SIGNATURE OF REGIONAL OFFICIAL:

Karen's O'Connor

21. TYPED NAME:

KAREN'S O'CONNOR

22. TITLE: Associate Regional Administrator

Division of Medicaid &
Children's Health

23. REMARKS:

P+I changes authorized by the state on 3/13/07.
P+I changes authorized by the state on 4/20/07.

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4-25-07

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL - 1 2005

20. SIGNATURE OF REGIONAL OFFICIAL:

Bull Brown R D.S.

21. TYPED NAME:

William Lasowski

22. TITLE:

Deputy Director, CMSO

23. REMARKS:

P & I changed authorized by the state on 4/20/07

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 State of Washington's Department of Social and Health Services (DSHS) implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's. This system, as revised through this amendment, is used to reimburse for admissions on or after January 1, 2001. Revisions to this system are made as necessary through amendments to the State plan.

This plan incorporates revisions that eliminate all disproportionate share and pro-share programs involving intergovernmental transfers. These changes will be effective on July 1, 2005. This plan also incorporates a new payment methodology to be effective July 1, 2005 for public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. The new payment methodology is a full cost payment method paying only federal Medicaid share of funding for medically necessary patient care.

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 rates: DRG cost-based rates; DRG contract rates; full cost rates (beginning on July 1, 2005); and rates based on hospitals' ratio of costs- to-charges (RCC).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

A. INTRODUCTION (cont.)

Other payment methods used include per member per month (PMPM) graduate medical education (GME) payments, fixed per diem, cost settlement, 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. Newborn screening tests approved through legislative direction are covered services reimbursed by the department and payment adjustments are made when necessary. The DRG, "full cost," 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. Monthly PMPM GME payments are provided by HRSA directly to the University of Washington Medical Center and the Harborview Medical Center for GME related to Healthy Options care.

Contract hospitals participating in the federally waived Medicaid Hospital Selective Contracting Program are reimbursed for services paid by the DRG payment method based on their negotiated DRG contract rate.

Hospitals not located in contract areas and hospitals located in a contract area that are exempt from selective contracting, are reimbursed for services paid under the DRG payment method using a cost-based DRG rate.

Non-contract hospitals in selective contracting program areas will be paid by MHRSA for inpatient services only when those services are determined by HRSA to be emergency services.

Beginning on July 1, 2005, public hospitals located in the State of Washington, that are not department 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 HRSA's Medicaid RCC rate to determine cost.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

A. INTRODUCTION (cont.)

Each public hospital district for its respective non-CAH public hospital district hospital(s), the Harborview Medical Center, and the University of Washington Medical Center, provide certified public expenditures which represent its costs of the patients' medically necessary care.

Hospitals and services exempt from the DRG payment methods are reimbursed under the RCC, "full cost", cost settlement, or fixed per diem payment method. Under the DRG, RCC and "full cost" methods a base community psychiatric hospitalization payment rate is also used to determine the allowable for certain psychiatric claims.

The following plan specifies the methods and standards used to set these payment rates, including: definitions; general reimbursement policies; methods for establishing; cost-based DRG rates; "full cost" reimbursement; RCC payment rates; CAH rates; fixed per diem reimbursement; Disproportionate Share Hospital (DSH) reimbursement; upper payment limits (UPL); UPL reimbursement; and administrative policies on provider appeal procedures, uniform cost reporting requirements, audit requirements, and public notification requirements.

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 charges, where mentioned in this attachment to the state plan, refers to the DSHS covered charges on a claim that are used to determine any kind of reimbursement for medically necessary care.

1. *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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

2. *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.

3. *Critical Access Hospital (CAH) Program*

Critical Access Hospital (CAH) program means a Title XIX inpatient and outpatient hospital reimbursement program where in-state hospitals, that are department approved and DOH Medicare-certified as a CAH, are reimbursed through a cost settlement method.

4. *DSHS or Department*

DSHS or department means the Department of Social and Health Services. DSHS is the State of Washington's state Medicaid agency.

5. *Diagnosis Related Groups (DRGs)*

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program currently uses The All Patient Grouper 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 are exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

6. *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.

7. *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.

8. *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.

9. *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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

10. *Long Term Acute Care*

Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have exceeded high-cost outlier status. At the point at which that determination is made, the mode of care and reimbursement may switch to LTAC under a fixed per diem rate if authorized by DSHS. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

11. *PII/GAU*

PII/GAU, as used in Paragraph G.2 and G.3 below, means the DSHS Limited Casualty Program Psychiatric Indigent Inpatient (PII) or General Assistance Unemployable (GAU) services.

12. *RCC*

RCC means a hospital ratio of costs-to-charges (RCC) calculated using annual CMS 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. A reduced RCC is used to calculate MIDSH and GAUDSH payments on RCC paid claims.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

13. *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; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

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.

14. *Uninsured Indigent Patient*

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system.

Charity care and bad debt, as defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and chapter 70.170 RCW "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

Services covered by an insurance policy are not considered an uninsured covered service.

15. *Cost Limit For DSH Payments*

For the purpose of defining cost under the DSH program a ratio of costs-to-charges (RCC) is calculated prospectively using annual CMS 2552 Medicare Cost data. The RCC is applied through a prospective payment method to historical total hospital billed charges to arrive at the hospitals total cost.

16. *DSH One Percent Medicaid Utilization Rate*

All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the DSHS disproportionate share programs.

17. *DSH Limit*

The DSH limit in Section B.15 is applicable for public hospitals. In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

18. *Trauma Centers*

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

B. DEFINITIONS (cont.)

19. *"Full Cost" Payment Program*

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

20. *Peer Groups*

Peer groups mean MAA designated peer groups. MAA's peer grouping has six classifications: Peer group A, which are rural hospitals paid under an RCC methodology; peer group B, which are urban hospitals without medical education programs and which are not in peer group E; peer group C, which are urban hospitals with medical education programs and which are not in peer group E; peer group D, which are specialty hospitals and which are not in peer group E; and peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are certified CAH.

21. *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.

22. *Base Community Psychiatric Hospitalization Payment Rate*

The base community psychiatric hospitalization payment rate is a minimum per diem allowable calculated for claims for psychiatric serviced provided to covered patients, to pay hospitals that accept commitments under the state's involuntary treatment act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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. Under the DRG, RCC and "full cost" methods a base community psychiatric hospital payment rate is also used to determine the allowable for certain psychiatric claims.

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.

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

2. DRG Relative Weights

The reimbursement system uses Washington State, Medicaid-specific DRG relative weights. To the extent possible, the weights are based on Medical Assistance (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 Medical Assistance 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. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

3. DRG High-Cost Outlier Payments

High-cost 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. To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment and \$33,000.

Reimbursement for outlier cases other than cases in children's hospitals (Children's Hospital and Medical Center, Mary Bridge Children's Hospital), and psychiatric DRGs, is the applicable DRG payment amount plus 75 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

Reimbursement for DRG psychiatric (DRGs 424-432) outliers is at the DRG rate plus 100 percent of the hospital RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for outlier cases at the state's two children's hospitals is the applicable DRG payment amount plus 85 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

4. DRG Low Cost Outlier Payments

Low cost outliers are cases 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 ratio.

5. DRG Long-Stay Day Outlier Payments

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.15 Day Outlier payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

6. Non DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the 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 ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. Recipient responsibility (spend-down) and third-party liability, as identified on the billing invoice or otherwise by DSHS, 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.

7. DRG Exempt Hospitals

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

a. Peer Group A Hospitals

As defined in Section D.2.

b. 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, Puget Sound Behavioral Health, the psychiatric unit at Children's Hospital & Medical Center, and all other Medicare-certified and State-approved distinct part psychiatric units doing business with the State of Washington.

c. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

In addition, services for clients in the HRSA Physical Medicine and Rehabilitation program (PM&R), and who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for PM&R services and placement into the rehabilitation unit.

d. Critical Access Hospital (CAHs)

Department-approved and Medicare designated CAHs receive Medicaid prospective payment based on Departmental Weighted Cost-to-Charge (DWCC). Post-period cost settlement is then performed.

e. 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 contract or non-contract hospitals described in Section D, Section E and/or Section F.

f. 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 medically necessary treatment of emergencies that occur while a client is out-of-state, these hospitals are exempt from DRG payment methods, and are paid an RCC ratio based on the weighted average of RCC ratios for in-state hospitals. For DSHS referrals to out-of-state providers after HRSA's Medical Director or designee approved an Exception to Rule for the care:

- (1) In absence of a contract, DSHS pays the rate mentioned above.
- (2) When DSHS is successful negotiating a contract, out-of-state hospitals are paid using a negotiated contract rate. DSHS 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals (cont.)

g. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed charges.

h. Public Hospitals Located In The State of Washington

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

8. DRG Exempt Services

a. Neonatal Services

DRGs 620 and 629 (normal newborns) are reimbursed by DRG payment under the DRG payment method, but not under "full cost", or cost settlement. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 neonatal services are exempt from the DRG payment methods, and are reimbursed under the RCC, "full cost", or cost settlement payment method.

b. AIDS-Related Services

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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

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

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.

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 rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through a vendor rate adjustment (VRA). Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

g. Services Provided in DRGs that do not have a Health and Recovery Services Administration (HRSA) relative weight assigned.

Services provided in DRGs that do not have a Health and Recovery Services Administration (HRSA) 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt 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 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 services will be reimbursed 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. The payment is made through lump-sum supplemental payments made quarterly.

The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

h. Inpatient Pain Center Services

Services in HRSA-authorized inpatient pain centers are paid using a fixed per diem rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

9. Transfer Policy

For a hospital transferring a client to another acute care hospital, 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, the payment 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.

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 the full DRG payment; however, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied.

10. Readmission Policy

Readmissions occurring within 7 days of discharge, to the same hospital that group to the same medical diagnostic category, will 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. All psychiatric inpatient admissions must be prior authorized and are considered distinct admissions, regardless of the number of days occurring between admissions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

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.

For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The administrative rate is adjusted November 1. For DRG exempt cases, administrative days are identified during the length of stay review process.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

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 DSHS's rates or fee schedule as if they were paid solely by Medicaid using the RCC payment method.

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.

14. Fixed Per Diem Rate

A fixed per diem rate is used to reimburse for the LTAC program. A fixed per diem is also used to pay for authorized inpatient pain center services.

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 DRG billed amount minus the TPL payment and other appropriate deductible amounts, or the applicable DRG allowed amount (basic payment) for the case minus the TPL payment and other appropriate deductible amounts. For RCC cases involving TPL, a hospital will be reimbursed the RCC allowed amount (basic payment) minus the TPL payment and other appropriate deductible amounts. For 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

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 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.
- 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.

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 Level I, II, and III trauma center enhanced payment is 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. The payment is made through lump-sum supplemental payments made quarterly.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

17. Trauma Care Enhancement (cont.)

The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) of 13 or greater for adults, 9 or greater for pediatric patients (through age 14 only), and transferred trauma patients regardless of ISS.

Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

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.

19. Base Community Psychiatric Hospitalization Payment Rate

Under the DRG, RCC and "full cost" methods 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

D. DRG COST-BASED RATE METHOD

The DRG cost-based rate is a calculated hospital specific dollar amount that is multiplied by the applicable DRG weight to produce the DRG payment. The rate has three components (operating, capital and direct medical education). The rate is established on the basis of hospital's average cost for treating a Medicaid patient during a base period. This amount is adjusted for the hospital's case mix and updated for inflation.

1. Base Period Cost and Claims Data

The base period cost data for the rates are from hospitals' Medicare cost reports (Form CMS 2552) for their fiscal year (FY) 1998. Cost data that was desk reviewed and/or field audited by the Medicare intermediary before the end of the rebasing process was used in rate setting when available.

Three categories of costs (total costs, capital costs, and direct medical education costs) are extracted from the CMS 2552 for each of the 38 allowed categories of cost/revenue centers used to categorize Medicaid claims.

Nine categories are used to assign hospitals' accommodation costs and days of care, and 29 categories are used to assign ancillary costs and charges. Medicaid paid claims data for each hospital's FY 1998 period are extracted from the state's Medicaid Management Information System (MMIS).

Department of Health Composite Hospital Abstract Reporting System (CHARS) claims representative of services covered and provided by Healthy Options managed care plans are also extracted. Line item charges from claims are assigned to the appropriate 9 accommodation and 29 ancillary cost center categories and used to apportion Medicaid costs. These data are also used to compute hospitals' FY 1998 case-mix index.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

2. Peer Groups & Caps

HRSA's peer grouping has six classifications: Peer group A, which are non-CAH, rural hospitals which are not in peer group E and for Medicaid claims are paid under an RCC methodology; peer group B, which are non-CAH urban hospitals without medical education programs which are not in peer group E; peer group C, which are urban hospitals with medical education programs which are not in peer group E; peer group D, which are specialty hospitals which are not in peer group E; peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are department approved and DOH certified as CAH.

For the DRG payment method, indirect medical education costs are removed from operating and capital costs, and direct medical education costs are added.

Peer group caps for peer groups B and C are established at the 70th percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs. In computing hospitals' rates, hospitals whose costs exceed the 70th percentile of the peer group are reset at the 70th percentile cap. The hospitals in peer group D are exempted from the caps because they are specialty hospitals without a common peer group on which to base comparisons. The hospitals in peer group E are exempted from the peer group caps because they are paid "full cost" of services as determined through the Medicare Cost Report using the Medicaid RCC rates to determine cost. The hospitals in peer group F are also exempted from the peer group caps.

Changes in peer group status as a result of HRSA approval or recommendation are recognized. However, in cases where post-rate calculation corrections or changes in individual hospital's base year cost or peer group assignment result in a change in the peer group cost at the 70th percentile, and thus have an impact on the peer-group cap, the cap is updated only if it results in a 5.0 percent or greater change in total Medicaid payment levels.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

3. Conversion Factor Adjustments

Indirect medical education costs are added back into costs before application of any inflation adjustment. A 0.008219 percent per day inflation adjustment (3.0 percent divided by 365 days) is used for hospitals that have their fiscal year ending before December 31, 1998. A 9.1086 percent inflation adjustment is used for the period from January 1, 1999 to October 31, 2001.

Annually all cost-based conversion factors are adjusted by a predetermined vendor rate adjustment.

4. Medicaid Cost Proxies

In some instances, hospitals had Medicaid charges (claims) for certain accommodation or ancillary cost centers that are not separately reported on their Medicare cost report. To ensure recognition of Medicaid related costs, proxies are established to estimate these costs. Per diem proxies are developed for accommodation cost centers; RCC proxies for ancillary cost centers.

5. Case-Mix Index

Under DRG payment systems, hospital costs must be case-mix adjusted to arrive at a measure of relative average cost for treating all Medicaid cases. A case-mix index for each hospital is calculated based on the Medicaid cases for each hospital during its FY 1998 cost report period.

6. Indirect Medical Education Costs

An indirect medical education cost is established for operating and capital components in order to remove indirect medical education related costs from the peer group caps.

To establish this factor, a ratio based on the number of interns and residents in approved teaching programs to the number of hospital beds is multiplied by the Medicare's indirect cost factor of 0.579. The resulting ratio is multiplied by a hospital's operating and capital components to arrive at indirect medical education costs for each component.

The indirect medical cost is trended forward using the same inflation factors as apply to the operating and capital components and added on as a separate element of the rate as described in paragraph 7.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

7. Rate Calculation Methodology

Step 1: For each hospital, the base period cost data are used to calculate total costs of the operating, capital, and direct medical education cost components in each of the nine accommodation categories. These costs are divided by total hospital days per category to arrive at a per day accommodation cost.

The accommodation costs per day are multiplied by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

Step 2: The base period cost data are also used to calculate total operating, capital and direct medical education costs in each of the 29 ancillary categories. These costs are divided by total charges per category to arrive at a cost-to-charge ratio per ancillary category.

These ratios are multiplied by MMIS Medicaid charges per category to arrive at total Medicaid ancillary costs per category for the three components.

Step 3: The Medicaid accommodation and ancillary costs are combined to derive the operating, capital and direct medical education's components. These components are then divided by the number of Medicaid cases to arrive at an average cost per admission.

Step 4: The three components' average cost per admission are next adjusted to a common fiscal year end (December 31, 1998) using the appropriate DRI-HCFA Type Hospital Market Basket update and then standardized by dividing the average cost by the hospital's case-mix index.

Step 5: The indirect medical education portion of operating and capital is removed for hospitals with medical education programs. Outlier costs were also removed. For hospitals in Peer Group B and C, the three components aggregate cost is set at the lesser of: hospital specific aggregate cost or the peer group cap aggregate cost.

Step 6: The resulting respective costs with the indirect medical education costs and an outlier factor added back in are next multiplied by the DRI-HCFA Type Hospital Market Basket update for the period January 1, 1999 through October 31, 2001. The outlier set-aside factor is then subtracted to arrive at the hospital's January 1, 2001 cost-based rate. This cost-based rate is multiplied by the applicable DRG weight to determine the DRG payment for each admission.

Those in-state and border city hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

8. Bordering City Hospitals Rate Methodology

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.

These hospitals' cost-based rates are based on their FY 1998 Cost Reports and FY 1998 claims, if available.

Those bordering city hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to January 1, 2001. A change in ownership does not constitute the creation of a new hospital. New hospitals' cost-based rates are based on the peer group average final conversion factor for their hospital peer group, less the outlier set aside factor.

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.

REVISION

ATTACHMENT 4.19-A
Part I, Page 28

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. RCC RATE METHOD

The RCC payment method is used to reimburse Peer Group A hospitals for their costs 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 RCC rates are used to determine "full cost" for those hospitals.

The RCC ratio for out-of-state hospitals is the average of RCC ratios for in-state hospitals. The RCC ratio for in-state and bordering city hospitals, which the State determines have insufficient data or Medicaid claims to accurately calculate an RCC ratio, is also the average of RCC ratios for in-state hospitals. Hospital's RCC ratios 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

F. "FULL COST" PAYMENT METHODOLOGY (effective July 1, 2005)

The public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, will be reimbursed using the "full cost" payment method using their respective Medicaid RCC rate to determine cost for covered medically necessary services. The payment method pays only the federal match portion of the allowable on claims based on federal Medicaid funding for the cost of medically necessary patient care. Recipient responsibility (spend-down) and third-party liability as identified on the billing invoice or by DSHS 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 DSHS claim will be the allowed federal match on the amount of the related certified public expenditures. DSHS will verify that the expenditures certified were actually incurred. For a description of the Certified Public Expenditure protocol see Supplement A to Attachment 4.19-A Part 1.

3

G. BASE COMMUNITY PSYCHIATRIC HOSPITALIZATION PAYMENT RATE

Under the DRG, RCC, and "full cost" methods, 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 is 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DISPROPORTIONATE SHARE 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 program, a hospital must meet the Medicaid one-percent utilization to qualify. A hospital will receive any one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility requirements for that respective DSH payment component.

All the DSH payments will not exceed the State's DSH allotment. To accomplish this goal, it is understood in this State Plan that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

Cost is established through prospective payment methods and is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan, plus the cost of services to indigent and uninsured patients, less any cash payments made by them.

DSHS 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 DSHS DSH programs' payments are prospective payments, and these programs are: LIDSH, PIIDSH, GAUDSH, SRHAPDSH, SRHIAPDSH, NRHIAPDSH, and PHDSH.

DSH programs for which payments are fixed represent 97 percent of DSHS' disproportionate share payments to hospitals. The other two DSH programs, PIIDSH and GAUDSH, are paid on a by-claims basis. To adjust for these unknowns in the PIIDSH and GAUDSH, HRSA uses claims data and estimates what expected expenditures would be paid during the current state fiscal year. This estimate then becomes a part of the hospital's cost limit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

The Health and Recovery Services Administration (HRSA) will monitor payments monthly. Each month, HRSA will receive a PII Summary Report and GAU Summary Report from the Medicaid Management Information System (MMIS) identifying expenditures paid to each hospital under the PIIDSH and GAUDSH programs.

Each month HRSA will also receive the DSHS Allotment/Expenditure Transaction Register identifying the remaining DSH program expenditures. The figures in these reports will be accumulated monthly to determine that hospitals have not exceeded the DSH limit.

If a hospital reaches its DSH limit, payments will be stopped. The Department of Social and Health Services (DSHS) will determine the extent to which and how each DSH program is funded. Any specific guidance that may be provided by the State legislature will be followed by DSHS.

If a hospital exceeds its DSH limit, DSHS will recoup the DSH payments in the following program order: PHDSH, SRHAPDSH, NRHIAPDSH, SRHIAPDSH, GAUDSH, and LIDSH. For example, if a hospital were receiving payments from all DSH programs, the overpayment adjustment would be made in SRHAPDSH to the fullest extent possible before adjusting LIDSH payments. If the DSH state-wide allotment is exceeded, DSHS will similarly make appropriate adjustments in the program order shown above.

Medicaid Management Information System (MMIS) identifying expenditures paid to each hospital under the PIIDSH and GAUDSH programs.

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. DSH PAYMENTS (cont.)

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

Hospitals shall be deemed eligible for a LIDSH payment adjustment if:

- a. 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,
- b. The hospital's low-income utilization rate (as defined in Section 1923 (b) (3)) exceeds 25 percent.
- c. The hospital qualifies under Section 1923 (d) of the Social Security Act; and
- d. The hospital is not in Peer Group E effective July 1, 2005.

Hospitals deemed eligible under the above criteria shall receive disproportionate share payment amounts that in total will equal the funding set by the State's appropriations act 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 base payment is multiplied by the hospital's low income utilization factor standardized to one, by the hospital's most recent Fiscal Year case mix index by the hospital's subsequent year's estimated admissions of Title XIX eligibles. Results for all hospitals are summed and compared to the appropriated amount.

If the sum differs from the appropriated amount, a new base payment figure is selected. The selection of base payment figures continues until the sum of the calculated payment equals the appropriated amount. The appropriation amount may vary from year to year. Each hospital's disproportionate share payment is made periodically.

REVISION

ATTACHMENT 4.19-A
Part I, Page 33

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. DSH PAYMENTS (cont.)

2. Psychiatric Indigent Inpatient Disproportionate Share Hospital Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a PIIDSH payment if:

- a. The hospital is an in-state or border area hospital; and,
- b. The hospital provides 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 has a low-income utilization rate of one percent or more; and,
- d. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for PIIDSH payments will receive a periodic per claim payment. The payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. The equivalency factor ensures that PIIDSH payments will equal the State's estimated PIIDSH appropriation level. The payment is reduced further by multiplying it by 97 percent.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

3. General Assistance Unemployable Disproportionate Share Hospital (GAUDSH)
Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a GAUDSH payment if:

- a. The hospital is an in-state or border area hospital; and,
- b. The hospital provides services to low-income, General Assistance Unemployable (GAU) patients. GAU persons are low-income individuals who are not eligible for any health coverage and who are encountering a medical condition; and,
- c. The hospital has a low-income utilization rate of one percent or more; and,
- d. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for GAUDSH payments will receive a periodic per claim payment. For all hospitals, except public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, the payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. For the excepted hospitals, the payment equals "full cost" using the Medicaid RCC to determine cost for the medically necessary care. The equivalency factor insures that GAUDSH payments will equal the State's estimated GAUDSH appropriation level.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

4. Small Rural Hospital Assistance Program Disproportionate Share Hospital
(SRHAPDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a SRHAPDSH payment if:

- a. The hospital is an in-state (Washington) hospital; and
- b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and
- c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of 15,500 or less for state fiscal year (SFY) 2003 with this population standard to be increased by two percent each subsequent SFY;
- d. The hospital qualifies under Section 1923(d) of the Social Security Act; and
- e. The hospital is not in Peer Group E effective July 1, 2005.

Hospitals qualifying for SRHAPDSH payments started earning payments under this plan July 1, 1994, from a legislatively appropriated pool. The apportionment formula is based on each SRHAPDSH hospital's Medicaid and other low-income reimbursement during the most current state fiscal year less any low-income disproportionate share payments.

To determine each hospital's percentage of Medicaid payments, the sum of individual hospital payments is divided by the total Medicaid payments made to all SRHAPDSH 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.

As of July 1, 2003, 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% of actual payments. HRSA will calculate each hospital's net operating margin based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

4. SHRHAPDSH Payments (cont.)

Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them. Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRHAPDSH pool. The payments are made periodically. SRHAPDSH payments are subject to federal regulation and payment limits.

5. Small Rural Hospital Indigent Assistance Program Disproportionate Share Hospital (SRHIAPDSH) Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a SRHIAPDSH payment if:

- a. The hospital is an in-state (Washington) hospital; and
- b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and
- c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of 15,500 or less for state fiscal year (SFY) 2003 with this population standard increased by two percent each subsequent SFY; and
- d. The hospital qualifies under Section 1923(d) of the Social Security Act; and
- e. Effective July 1, 2005, the hospital provided services to charity patients during the calculation base year; and
- f. The hospital is not in Peer Group E effective July 1, 2005.

Hospitals qualifying for SRHIAPDSH payments started earning payments under this plan July 1, 2003, from a legislatively appropriated pool. Beginning July 1, 2005, the apportionment formula is based on each SRHIAPDSH hospital's calculated costs for qualifying Charity patients during the most currently available state fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

5. SRHIAPDSH Payments (cont.)

To determine each hospital's percentage of SRHIAPDSH payments, the sum of individual hospital calculated charity costs is divided by the total charity calculated costs of all SRHIAPDSH 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.

As of July 1, 2005 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% of calculated charity costs. HRSA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Payments for SRHIAPDSH will be made in conjunction with payments for SRHAPDSH.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

6. Non-Rural Hospital Indigent Assistance Program Disproportionate Share Hospital
(NRHIAPDSH) Payment

Effective July 1, 2003, hospitals shall be deemed eligible for a NRHIAPDSH payment if:

- a. The hospital provides at least one percent of its services to low-income patients in Washington state; and
- b. The hospital does not qualify as a Small Rural Hospital as defined in section G.4.a and G.4.c. of this plan; and
- c. The hospital qualifies under Section 1923(d) of the Social Security Act; and
- d. The hospital is not in Peer Group E effective July 1, 2005.

Hospitals qualifying for NRHIAPDSH payments started earning payments under this plan July 1, 2003, from a legislatively appropriated pool. Beginning July 1, 2005, the apportionment formula is based on each NRHIAPDSH hospital's calculated costs of charity care during the most currently available state fiscal year.

To determine each hospital's percentage of NRHIAPDSH payments, the sum of individual hospital calculated charity costs is divided by the total calculated charity costs of all NRHIAPDSH hospitals. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2005, 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. HRSA will calculate each hospital's net operating margins based on the most recent annual audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed a ceiling of 100 percent of the projected cost of care, except as allowed by federal guidelines. Cost is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provision of the State Plan, plus the cost of services to uninsured patients, less any cash payments made by them.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

6. NRHIAPDSH Payments (cont.)

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

7. Public Hospital Disproportionate Share Hospital (PHDSH) Payment

Effective July 1, 2005, hospitals shall be deemed eligible for a PHDSH payment if:

- a. The hospital provides at least 1 percent of its services to low-income patients;
- b. 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 owned by public hospital districts;
- c. The hospital qualifies under section 1923 (d) of the Social Security Act.
- d. The hospital is not department-approved and DOH certified as CAH under Washington State Law and federal Medicare rules.

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 deemed eligible under the above criteria shall 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 shall 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DSH PAYMENTS (cont.)

7. PHDSH Payments (cont.)

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

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 shall 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 and Managed Care Rates, 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

J. ADMINISTRATIVE POLICIES (cont.)

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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTONMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT
HOSPITAL SERVICES (cont.)

J. ADMINISTRATIVE POLICIES (cont.)

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.

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 will be periodically audited.

In addition, hospital billings and other financial and statistical records will be periodically audited.

4. Rebasing & Recalibration

DSHS 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

- K. UPPER PAYMENT LIMIT PAYMENTS FOR PUBLIC HOSPITALS OWNED BY PUBLIC HOSPITAL DISTRICTS, AND STATE AND COUNTY TEACHING HOSPITALS, THAT ARE LOCATED IN THE STATE OF WASHINGTON
1. An upper payment limit (UPL) pool is created each state fiscal year for supplemental payments to eligible providers of Medicaid patient services. Eligible providers are King County-owned or Washington State-operated teaching hospitals, and public hospitals owned by public hospital districts, located in the State of Washington that are not department approved and DOH certified as CAH, as designated each year by the department.
 2. The supplemental payments made to eligible providers are subject to prior federal approval for obtaining federal matching funds for the supplemental payments. The supplemental funds are subject to the federal Medicare upper payment limit for hospital payments. The Medicare upper limit analysis will be performed prior to making the supplemental payments.
 3. The Medicare Upper Payment Limit (UPL) payment for each payment year is determined as follows:

The cumulative difference between the UPL and Title XIX payments and third party liability payments for all eligible hospitals during the most recent Federal Fiscal year becomes the total UPL payment that will be distributed during the payment year. The source of the charge and payment data is the State's Medicaid Management Information System (MMIS) for the base year. Only charges and payments for inpatient hospital services are included in the computation, and the base year determined amount is not inflated to the payment year.
 4. Payments will be assigned to the eligible hospitals based on eligibility under the UPL, in proportion to the dollars resulting from the difference between Hospital payments under Medicare reimbursement policy and Title XIX payments, including third party, during the most recent state fiscal year. The supplemental payment is distributed at least annually during each federal fiscal year and may be paid to one or more of the hospitals in the pool annually as determined by the department.
 5. Payments must be used by the receiving hospital(s) to improve health care services to low income patients.

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 ProcessWorksheet 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.

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:

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 result from Step 3 from the result of Step 2 to arrive at the Total Adjusted RCC revenue.

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

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**CPE Protocol (cont)**

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 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 SFY2006 (7/1/05-6/30/06). 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 7/1/2005-12/31/2005. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

CPE Protocol (cont)

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 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 State Fiscal Year (SFY) 2006. The SFY2006 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**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 SFY 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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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 reporting period, compute the whole cost reporting period's uncompensated care cost, and then allocate that cost into the State Plan rate year using the number of months as an allocation basis. For example, for a hospital period ending 12/31/2006, the UCC cost and days/charges from that hospital cost reporting period cover half of SFY 2006 and half of SFY 2007. So to fulfill reconciliation requirements, the hospital will need to split the UCC cost from that hospital cost reporting period in half to match the DSH payments for SFY 2006 and 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 cost 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.