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State/Territory Name: Washington

State Plan Amendment (SPA) # WA 22-0004

This file contains the following documents in the order listed:

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

Financial Management Group

May 3, 2022

Dr. Charissa Fotinos, Acting Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) 22-0004

Dear Ms. Fontinos:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 22-0004 effective for services on or after April 1, 2022. The purpose of this SPA is to update references to the 3M APR-DRG software grouper used to group hospital claims for payment.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act. We hereby inform you that Medicaid State plan amendment 22-0004 is approved effective April 1, 2022. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,

Rory Howe

Rory Howe
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0004

2. STATE: WA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
1902(a) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.1-A Part 1 pages 6, 13, 14, 18

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Part 1 pages 6, 13, 14, 18

9. SUBJECT OF AMENDMENT
Update Hospital Grouper Classification Software

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Charissa Fotinos MD, MSc

12. TYPED NAME
Charissa Fotinos, MD, MSc

13. TITLE
Acting Medicaid Director

14. DATE SUBMITTED
March 7, 2022

15. RETURN TO
State Plan Coordinator
POB 42716
Olympia, WA 98504

FOR CMS USE ONLY

16. DATE RECEIVED
March 7, 2022

17. DATE APPROVED
May 3, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

B. DEFINITIONS (cont.)

Diagnosis Related Groups (DRGs)
DRG means the patient classification system which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program uses the All Patient Diagnosis Related Group (AP-DRG) classification software (Grouper) to classify claims into a DRG classification prior to July 1, 2014.

For dates of admission before August 1, 2007, the Agency uses version 14.1 of the AP-DRG Grouper for this purpose, and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470.

The remainder of the 241 DRGs is exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

For dates of admission between August 1, 2007, and June 30, 2014, the Agency uses version 23.0 of the AP-DRG Grouper to classify claims into a DRG classification, and has established relative weights for 423 DRG classifications used in the DRG payment system. Of the remaining DRG classifications, two are used to identify ungroupable claims under DRG 469 and 470. The remainder of the DRG classifications in version 23.0 of the AP-DRG Grouper are either not used by the grouper software, or are used by the Agency to pay claims using a non-DRG payment method.

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

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

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

Emergency Services
Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

2. DRG Relative Weights (cont.)
The relative weights are standardized to an overall case-mix index of 1.0 based on claims used during the recalibration process, but are not standardized to a case-mix index of 1.0 regarding the previous relative weights used.

For dates of admission between August 1, 2007, and June 30, 2014, Washington State Medicaid recalibrated the relative weights using the All Patient DRG (AP-DRG) grouper version 23.0 classification software. The relative weights are cost-based and developed using estimated costs of instate hospitals' Medicaid fee-for-service claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care from SFY 2004 and 2005.

The AP-DRG classification is unstable if the number of claims within the DRG classification is less than the calculated N for the sample size. The AP-DRG classification is also considered low-volume if number of claims within the classification is less than 10 claims in total for the two-year period.

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

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

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

3. High Outlier Payments

High-outliers are cases with extraordinarily high costs when compared to other cases in the same DRG. The reimbursement system includes an outlier payment for these cases.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

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

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

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

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services

a. Unstable, Low Volume, and Specialty Services DRG Classifications

For dates of admission before August 1, 2007, neonatal services, DRGs 620 and 629 (normal newborns) are reimbursed by DRG payment under the DRG payment method, but not under the RCC, "full cost" or cost settlement payment methods. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 are exempt from the DRG payment methods, and are reimbursed under the RCC, "full cost", or cost settlement payment method.

For dates of admission on and after August 1, 2007, the claims that classified to DRG classifications that have unstable DRG relative weights or are considered low volume DRG classifications, are exempt from the DRG payment methods, and are reimbursed under the per diem payment method unless the hospital is participating in the "full cost", or cost settlement payment method.

Specialty services, defined as psychiatric, rehabilitation, detoxification and Chemical Using Pregnant program services, are reimbursed under the per diem payment method unless the hospital is participating in the "full cost", or cost settlement payment method.

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

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

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

b. AIDS-Related Services

For dates of admission before August 1, 2007, AIDS-related inpatient services are exempt from DRG payment methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and other Human Immunodeficiency Virus (HIV) infections.

For dates of admission on and after August 1, 2007, AIDS-related inpatient services are not exempted from the DRG payment method and are paid based on the claim data matched to the criteria for the payment methods described in this attachment.