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State/Territory Name: Washington

State Plan Amendment (SPA) # WA 24-0010

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

March 6, 2024

Sue Birch, Acting Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) 24-0010

Dear Director Birch:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 24-0010 effective for services on or after January 1, 2024. The purpose is to update inpatient hospital uniform cost reporting information.

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 24-0010 is approved effective January 1, 2024. 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: 24 — 0010

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
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATIONS
Section 1902a of the Social Security Act, 42 CFR 447.253

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Part 1 pages 59. 60

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Part 1 pages 59, 60

9. SUBJECT OF AMENDMENT
Uniform Cost Reporting Update

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: Exempt

11. SIGNATURE OF STATE AGENCY OFFICIAL
Susan E. Birch

12. TYPED NAME
Susan E. Birch, MBA, BSN, RN

13. TITLE
Director and Acting Medicaid Director

14. DATE SUBMITTED
2/14/2024

15. RETURN TO
State Plan Coordinator
POB 42716
Olympia, WA 98504-2716

FOR CMS USE ONLY

16. DATE RECEIVED
February 14, 2024

17. DATE APPROVED
March 6, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

J. ADMINISTRATIVE POLICIES (cont.)

1. Provider Appeal Procedure (cont.)

Increases in rates resulting from a rate appeal filed after the 60-day period or exception period will be effective the date the appeal is filed with DSHS. Appeals resulting in rate decreases will be effective on the date specified in the appeal decision notification.

A hospital may request a Dispute Conference to appeal an administrative review decision. The conference will be conducted by the HRSA's Assistant Secretary or designee. The hospital must submit a request for a conference within 30 days of receipt of the administrative review decision. The Dispute Conference decision is the state agency's final decision regarding rate appeals.

2. Uniform Cost Reporting Requirements

Hospitals are required to complete their official annual Medicare cost report (CMS 2552) according to the applicable Medicare statutes, regulations, and instructions and submit a copy of their official annual Medicare cost report (CMS 2552), including Medicaid related data, to the agency. This submittal 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 the agency within one hundred fifty days from the end of the hospital's fiscal year, or if the hospital provider's contract with the agency 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). The extension request must be in writing and be received at least ten calendar days prior to the established due date for receiving the report. The extension request must clearly explain the circumstances leading to the reporting delay. The agency may grant the extension request if it determines the circumstances leading to the reporting delay are valid.

In cases where Medicare has granted a hospital provider a delay in submitting its "as filed" Medicare cost report (CMS 2552) to the Medicare fiscal intermediary, the agency may grant an equivalent reporting delay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

J. ADMINISTRATIVE POLICIES (cont.)

2. Uniform Cost Reporting Requirements (cont.)

This reporting delay may be granted when the hospital provider provides the agency 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 the agency, along with the copy of the written notice from Medicare, at least ten calendar days prior to the established due date for receiving the Medicare cost report (CMS 2552).

If a hospital provider submits 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 the established due date or approved extension date, The agency may withhold all or part of the payments due the hospital until it 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 to establish rates.

3. Financial Audit Requirements

The financial and statistical records of participating providers will be periodically reviewed and audited by the agency as necessary.

4. Rebasing & Recalibration

The Medicaid agency 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.