

## **Table of Contents**

**State/Territory Name: Washington**

**State Plan Amendment (SPA) # WA 24-0010**

This file contains the following documents in the order listed:

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

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



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**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,

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

Rory Howe  
Director

Enclosure

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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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

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

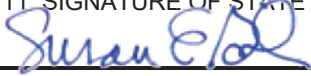
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  
a. FFY \_\_\_\_\_ \$ \_\_\_\_\_  
b. FFY \_\_\_\_\_ \$ \_\_\_\_\_

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

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  


12. TYPED NAME

13. TITLE  
and Acting Medicaid Director

14. DATE SUBMITTED

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

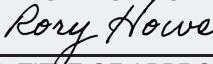
**FOR CMS USE ONLY**

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  


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

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**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

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**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.