Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 14-0016

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

MAY 12 2015

MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 42716
Olympia, Washington 98504-2716

RE: WA State Plan Amendment (SPA) Transmittal Number #14-0016 – Approval

Dear Ms. Lindeblad:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0016. This SPA updates the DRG grouper from All-Patient Diagnosis Related Groups (AP-DRG) to All-Patient Refined Diagnosis Related Groups (APR-DRG) for SFY 2015 (starting July 1, 2014).

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 and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 14-0016 is approved effective as of July 1, 2015. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan page.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-861-9838 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-0016**

2. STATE: **Washington**

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, 2014

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:
Section 1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $286,000
b. FFY 2015 $1,145,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att.4.19-A
~~Att. 4.19-B~~ Part 1 pages 5, 6, 10, 11, 12, 13, 14, 18, 26a, ~~26b(new). 26c (new),~~ 29, 30, 30a, 31, 34, 36, 38, 39a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-A
~~Att. 4.19-B~~ Part 1 pages 5, 6, 10, 11, 12, 13, 14, 18, 26a, 29, 30, 30a, 31, 34, 36, 38, 39a

10. SUBJECT OF AMENDMENT

Inpatient Hospital Rates Rebasing

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
9-30-14

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 12 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

23. REMARKS:

10/01/14: State authorizes P&I change to box 8 and 9.

3/11/15: state authorizes P&I change to box 8

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

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

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

DRG Conversion Factor (DRG rate)
The DRG conversion factor is a calculated amount based on the statewide-standardized average payment per discharge adjusted by the Medicare wage index for each hospital's geographical location and any indirect medical education costs to reflect the hospital's specific costs.

DSH Limit
The total DSH payments to an eligible hospital may not exceed the hospital-specific cost limit for DSH payments, in accordance with federal regulations. The total DSH payments to all eligible hospitals in a given year are limited to the State allotment for that year.

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

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 July 1, 2014, and after, 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.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

B. DEFINITIONS (cont.)

Per Diem Rate
The per diem rate is a calculated amount based on the statewide, standardized, average payment per day adjusted by the Medicare wage index for each hospital's geographical location and any indirect medical education costs to reflect the hospital's specific costs (for more detail see Attachment 4.19-A, Part 1, page 32).

Present on admission (POA) indicator
Present on admission (POA) indicator is a status code the hospital uses on an inpatient hospital claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that develops during an outpatient encounter. (Outpatient encounters include, but are not limited to, emergency department visits, diagnosis testing, observation, and outpatient surgery.)

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

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

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

- Are the events that must be reported to the Washington State Department of Health (DOH) under WAC 246-320-146 in effect as of January 1, 2010;
- Has a negative consequence for the beneficiary;
- Is auditable; and
- Includes the Medicare national coverage determinations.

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.)

Quality Incentive Payment
Effective for dates of admission on or between July 1, 2012 and June 30, 2013, and dates of admission beginning July 1, 2014, an additional one percent increase in inpatient hospital rates will be added to inpatient hospital payments for all qualifying non-critical access hospital providers in accordance with Chapter 74.60 RCW.

RCC
RCC means a hospital ratio of costs-to-charges (RCC) calculated annually using the most recently filed CMS 2552 Medicare Cost Report data provided by the hospital. The RCC is calculated by dividing adjusted operating expense by adjusted patient charges. If a hospital's costs exceed charges, a hospital's RCC is limited to 100 percent.

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

Uninsured Patient
Means an individual who receives hospital services and does not have health insurance or other creditable third party coverage.

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

The following section describes general policies governing the reimbursement system. Payment will only be made to the provider for covered services for that portion of a patient admission during which the client is Medicaid eligible. Unless otherwise specified, the agency uses Medicare cost report data from the Healthcare Cost Report Information System (HCRIS), CMS form 2552-10, or successor federal cost reporting forms or data sources to determine the cost of providing hospital services. The cost report data used for rate setting must include the hospital fiscal year (HFY) data for a complete 12-month period for the hospital. Otherwise, the in-state average RCC is used

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

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

1. DRG Payments
Except where otherwise specified (DRG-exempt hospitals, DRG-exempt services and special agreements), payments to hospitals for inpatient services are made on a DRG payment basis. The basic payment is established by multiplying the assigned DRG's relative weight for that admission by the hospital's rate as determined under the method described in Section D.

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

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

2. DRG Relative Weights
For dates of admission prior to July 1, 2014, the reimbursement system uses Washington State Medicaid-specific DRG relative weights.

For dates of admission before August 1, 2007, to the extent possible, the weights are based on Medicaid claims for hospital fiscal years (HFYs) 1997 and 1998, spanning the period February 1, 1997 through December 31, 1998, and on Version 14.1 of the Health Information Systems (HIS) DRG All Patient Grouper software.

The relative weight calculations are based on Washington Medicaid claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care. Each DRG is statistically tested to assure that there is an adequate sample size to ensure that relative weights meet acceptable reliability and validity standards.

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 on and after July 1, 2014, 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.

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).

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,

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.)

3. High Outlier Payments (cont)

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.

a) 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 0.95 for claims grouping to severity of illness (SOI) 1 and 2 and 0.80 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 on and after July 1, 2014, 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.

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.

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.)

(d) Reduce preventable emergency room (ER) visits. Hospitals will develop and submit a plan to the Agency addressing five sections of possible ER intervention, community partnerships, data reporting, strategic plan for prevention of visits, ER visit follow-up, and participation in continuing education. Each section may be approved or not approved by the Agency. A hospital will be awarded 10 points for all five sections begin approved, five points for four sections, three points for three sections, no points for two sections or less. Psychiatric, rehabilitation, and cancer hospitals are not included in this measurement.

(e) Patient discharges with prescriptions for multiple antipsychotic medications. Documentation must appear in the medical record with appropriate justification for discharging the patient with two or more routine antipsychotic medication prescriptions. A hospital will be awarded 10 points for 31% or greater medical records with appropriate justifications, five points for 21-30%, three points for 11-20%, and no points for 10% or less. Hospitals that do not have behavioral health units are not included in this measurement.

For dates of admission July 1, 2014, and after, a quality incentive payment of "an additional one percent increase in inpatient hospital rates" will be added to inpatient hospital payments for all qualifying non-critical access hospital providers in accordance with Chapter 74.60 RCW.

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

D. DRG COST-BASED RATE METHOD

Rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) data. The cost report data used for rate setting must include the hospital fiscal year (HFY) data for a complete 12-month period for the hospital. Otherwise, the in-state average RCC is used.

For dates of admission on and between August 1, 2007, and June 30, 2014, the claim estimated cost was calculated based on Medicaid paid claims and the hospital's Medicare Cost Report. The information from the hospital's Medicare cost report for fiscal year 2004 was extracted from the Healthcare Cost Report Information System ("HCRIS") for Washington in-state hospitals.

The database included only in-state, non-critical access hospital Medicaid data. Data for critical access, long term acute care, military, bordering city, critical border, and out-of-state hospitals were not included in the claims database for payment system development.

The Agency applies the same DRG payment method that is applied to in-state hospitals to pay bordering city, critical border, and out-of-state hospitals. However, the payment made to bordering city, critical border and out-of-state hospitals may not exceed the payment amount that would have been paid to in-state hospital for a corresponding service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

D. DRG COST-BASED RATE METHOD (cont)

8. Conversion Factor Determination

For dates of admission between August 1, 2007, and June 30, 2014, Washington State Medicaid uses the DRG-based payment method to pay for claims grouped into stable AP-DRG classifications. The DRG-based payment method is based on the DRG conversion factor and relative weights. Services grouped into one of the AP-DRG classifications with relative weights were identified as stable AP-DRGs.

The Agency determined the DRG conversion factors or DRG rates based on the statewide-standardized average cost per discharge. That cost per discharge was adjusted by the Medicare wage index, indirect, and direct medical education costs to reflect the hospital's specific costs.

The hospital's specific conversion factor determination processes are described as follows:

a. Statewide-standardized average operating and capital cost per discharge calculation:

Each hospital's estimated operating and capital costs were calculated based on Medicaid FFS and HO paid claims in the 2005 claims dataset for all in-state hospitals. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs. Adjusted operating and capital costs were divided by each hospital's facility-specific case-mix index to standardize the hospital's estimated costs related to the case-mix index of 1. The statewide-standardized average costs per discharge for operating and capital were calculated by dividing aggregate estimated costs of all hospitals by the total number of discharges associated with the estimated costs.

To remove the wage differences from the hospital estimated operating costs, the labor portion of the operating cost component was divided by the FFY 2004 Medicare wage index. The wage difference is related to the hospital location in different regions of the State

To remove the indirect costs from the hospital estimated operating and capital costs, the adjusted operating and capital costs were divided by the FFY 2004 Medicare indirect medical factors. The indirect costs are costs that relate indirectly to the approved medical education programs for hospitals with teaching programs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

b. Hospital-specific DRG conversion factors or DRG rate calculation:

The hospital-specific DRG conversion factors were based on the statewide-standardized average operating and capital costs per discharge amounts. Operating costs were adjusted for differences in wage index and indirect medical education costs. Capital costs were adjusted for differences in indirect medical education costs.

To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs was multiplied by the FFY 2007 Medicare wage index.

To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs were multiplied by the FFY 2007 Medicare indirect medical factor.

The hospital's specific conversion factors are the total of the operating and capital amounts per discharge plus the facility-specific direct medical education cost per discharge (hospital-specific direct medical education cost per discharge divided by the hospital-specific case-mix index.)

The hospital-specific DRG conversion factor amounts were inflated using the CMS PPS Input Price Index to reflect the inflation between SFY 2005 and 2008.

Effective for dates of admission on or after February 1, 2010, DRG rates for hospitals paid under the prospective payment system (PPS) method were increased by thirteen percent (13.0%) from the rates that were established for dates of admission on and after July 1, 2009. This rate adjustment was in accordance with RCW 74.60.080.

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

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

c. Supplemental payments

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

1. Prospective payment hospitals other than psychiatric or rehabilitation hospitals,
2. Psychiatric hospitals
3. Rehabilitation hospitals, and
4. Border hospitals.

For hospitals designated as prospective payment system (PPS) hospitals, $58,450,000 per state fiscal year. For hospitals designated as freestanding psychiatric specialty hospitals, $1,250,000 per state fiscal year. For hospitals designated as freestanding rehabilitation specialty hospitals, $300,000 per state fiscal year. For hospitals designated as out-of-state border area hospitals, $500,000 per state fiscal year.

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

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

d. Hospital-specific DRG conversion factors for critical border hospitals and bordering city hospitals

The hospital-specific DRG conversion factors for critical border hospitals were calculated using a process similar to the hospital specific conversion factors process for instate hospitals. The conversion factor for bordering city hospitals that are not designated by the Agency as critical border hospitals is the lowest hospital specific conversion factor for a hospital located instate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

Bordering city hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River and Sandpoint.

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to August 1, 2007. A change in ownership does not necessarily constitute the creation of a new hospital. New hospitals' ratio of cost-to-charge rates are based on the instate average rate. For their DRG conversion factor or per diem rate, the statewide average rate is used. For new hospitals that have direct medical education costs and a submitted Medicare cost report with at least twelve months of data, the Agency will identify and include the direct medical education cost to the hospital-specific rate. For a new hospital that has direct medical education cost and Medicare cost report submitted to Medicare with less than twelve months of data, the Agency will not identify and include the direct medical education cost to the hospital-specific rate.

10. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities' rates. The blended rate is weighted by admission for the new entity.

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

Rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) data. The cost report data used for rate setting must include the hospital fiscal year (HFY) data for a complete 12-month period for the hospital. Otherwise, a proxy rate may be used for the hospital.

1. Per diem rate

For dates of admission on and between August 1, 2007, and June 30, 2014, the claim estimated cost was calculated based on Medicaid paid claims and the hospital's Medicare Cost Report. The information from the hospital's Medicare cost report for fiscal year 2004 was extracted from the Healthcare Cost Report Information System ("HCRIS") for Washington in-state hospitals.

The database included only in-state non-critical access hospital Medicaid data. Data for critical access, long term acute care, military, bordering city, critical border, and out-of-state hospitals were not included in the claims database for payment system development.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

1. Per diem rate (cont.)

g. Data resources

(1) State Medicaid Management Information System ("MMIS") fee-for-service (FFS) paid claim data

(2) Inpatient Healthy Options (HO) claims extracted from the Department of Health's Comprehensive Hospital Abstract Reporting System ("CHARS") dataset for SFY 2004 (7/1/2003-6/30/2004) and 2005 (7/1/2004-6/30/2005)

(3) Hospital Medicare Cost Report - CMS 2552 - Hospital fiscal year ending 2004

h. Per Diem Rates Determination for Unstable AP-DRG Classifications

For dates of admission on and between August 1, 2007, and June 30, 2014, Washington State Medicaid uses per diem method to pay for claims grouped into the unstable (or low-volume) AP-DRG classifications. Services identified as unstable AP-DRGs were grouped into one of the following four categories:

- Neonatal claims, based on assignment to MDC 15
- Burn claims based on assignment to MDC 22
- Medical claims based on AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified above
- Surgical claims based on AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified above

The Agency determined the per diem rates for paying unstable AP-DRG classifications based on the statewide-standardized average cost per day. That cost per day was adjusted by Medicare wage index, indirect, and direct medical education costs to reflect the hospital's specific costs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

1. Per diem rate (cont.)

To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs was multiplied by the FFY 2007 Medicare wage.

To adjust for the indirect medical costs, the hospital statewide-standardized average adjusted operating and capital costs were multiplied by the FFY 2007 Medicare indirect medical factors.

The hospital's specific per diem rates are the total of the adjusted operating and capital costs per day plus the facility-specific direct medical education cost per day.

The hospital-specific per diem amounts were inflated using the CMS PPS Input Price Index to reflect the inflation between SFY 2005 and 2008.

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

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

i. Per Diem Rates Determination for Specialty Services

Washington State Medicaid uses per diem rates to pay for claims grouped into specialty services. AP-DRG and APR-DRG classifications identified as specialty services are grouped into:

- Psychiatric Services. Psychiatric claims are claims with a psychiatric diagnosis (i.e., assigned to a psychiatric DRG classification).
- Rehabilitation Services. Rehabilitation claims are claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation DRG classification).
- Detoxification Services. Detoxification claims are claims from freestanding detoxification hospitals, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification DRG classification).
- Chemically Using Pregnant Women (CUP) Program Services. CUP Program services are claims with units of service (days) submitted with revenue code 129 in the claim record.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

1. PER DIEM RATE (cont.)

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

Exceptions to the psychiatric per diem development process, the statewide-standardized average operating and capital amounts were calculated twice:

- The first statewide-standardized average operating and capital amounts were calculated based on data including only hospitals with distinct psychiatric units and hospitals that have 200 or more Washington State Medicaid psychiatric days in SFY 2005. Excluded from the database were freestanding psychiatric hospitals and hospitals with non-distinct psychiatric units with less than 200 Washington State Medicaid psychiatric days.

- The second statewide-standardized average operating and capital amounts were calculated based on data including freestanding psychiatric hospitals, hospitals with distinct psychiatric units, and hospitals that have 200 or more Washington State Medicaid psychiatric days in SFY 2005. Excluded from the database were non-distinct psychiatric unit hospitals with less than 200 Washington State Medicaid psychiatric days.

✓ Hospital-specific per diem rates for specialty services

The hospital-specific per diem rates were based on the statewide-standardized average operating and capital cost per day. The cost per day amounts are adjusted by the wage index, indirect, and direct medical costs to reflect the hospital's specific costs.

To adjust for the wage differences, the labor portion of the statewide-standardized average operating costs is multiplied by the Medicare wage index. This factor may be updated on an annual basis in July of each year, using the most recently available Medicare wage index.

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

The hospital's specific per diem rates were the total of the adjusted operating and capital amounts per day, plus the facility-specific direct medical education cost per day.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

1. PER DIEM RATE (cont)

- ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.
- ✓ Effective for dates of admission on or after July 1, 2014, psychiatric rates were rebased at cost using the same methods as described above, based on cost information for hospital fiscal years ending in 2013. The Agency applied a budget adjuster so that aggregate inpatient payments would remain constant after the rebased costs were determined. The Agency increased funding by psychiatric services by $3,500,000.

- For non-distinct psychiatric unit hospitals with less than 200 psychiatric days:
  - ✓ The hospital's specific per diem rates were defined as the greater of the two statewide-standardized average operating and capital costs adjusted by the wage differences, indirect medical education, and direct medical education calculation. The two statewide-standardized average operating and capital costs determination processes were described in the "Statewide-standardized average operating and capital cost per day calculation" section.
  - ✓ Effective for dates of admission on or after February 1, 2010, the psychiatric per diem rates for prospective payment system hospitals will be increased by thirteen percent.
  - ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.
  - ✓ Effective for dates of admission on or after July 1, 2014, the statewide-standardized average cost was recalculated using the same methods as described above, based on cost information for hospital fiscal years ending in 2013. The Agency applied a budget adjuster so that aggregate inpatient payments would remain constant after the rebased costs were determined.