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State/Territory Name: Washington

State Plan Amendment (SPA) #: 14-0017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104
Centers of Medicaid and CHIP Services

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

MAY 1 1 2015

RE: Washington State Plan Amendment (SPA) Transmittal Number 14-0017

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number WA 14-0017. This SPA amended hospital outpatient payment methods to comply with state and federal rules and the states 2013-2015 operating budget.

This SPA also implemented a change in software in the outpatient prospective payment system from the current Ambulatory Payment Classification (APC) to the Enhanced Ambulatory Patient Groups (EAPG) software.

This SPA is approved with an effective date of July 1, 2014.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact James Moreth at (360) 943-0469 or James.Moreth@cms.hhs.gov.

Sincerely,

[redacted]

Frank A. Schneider
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Ann Myers, SPA Coordinator

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: **14-0017**

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 $0
b. FFY 2015 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-B page 16, 16-1, 16-a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-B page 16, 16-1, 16-a

10. SUBJECT OF AMENDMENT

Outpatient 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: 9/30/14

18. DATE APPROVED: 5/11/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Frank A. Schneider

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

23. REMARKS:

FORM HCFA-179 (07-92)

VIII. Institutional Services

A. Outpatient hospital services

Duplicate payment for services does not occur. Non-Critical Access Hospital (CAH) outpatient hospital services are reimbursed using the Medicaid Agency's Outpatient Prospective Payments System (OPPS). Under OPPS, services are reimbursed using one of the following payment methods:

1. Payment Grouping
   a. Ambulatory Patient Classifications
   b. Enhanced Ambulatory Patient Groups
   c. Supplemental Payments
2. Fee schedule
3. Hospital Outpatient Rate

1. Payment Grouping

a. For dates of service prior to July 1, 2014, the Agency uses the Ambulatory Patient Classifications (APC) to classify OPPS services.

Effective for dates of service on or after July 1, 2013, payments for services reimbursed using the APC method at Prospective Payment System hospitals (as defined in Attachment 4.19-A, Part 1) will decrease by twenty-four and fifty-five hundredths percent (24.55%) from the rates that were established for dates of admission on and after July 7, 2011. This 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.

b. Effective July 1, 2014, the Agency uses the Enhanced Ambulatory Patient Groups (EAPG) to classify OPPS services. Under the EAPG system, the reimbursement of outpatient hospital services will include packaging of like services into groups with similar resource use.

For a significant procedure, the EAPG payment formula is as follows:
EAPG Relative Weight (RW) multiplied by the Hospital-Specific Conversion Factor multiplied by the Pricing Discount (if applicable) multiplied by the Policy Adjustor (if applicable)

To pay outpatient services under EAPG, the Agency:

i. Uses the national standard RWs developed by the 3M Corporation for determining relative resource intensity within the EAPG system. The relative weights effective July 1, 2014, are published at: http://www.hca.wa.gov/medicaid/hospitalpymt/pages/outpatient.aspx
ii. Calculates a conversion factor for each hospital. Each conversion factor is based on a statewide standardized rate. The statewide standardized rate is determined at the time of rebasing as the maximum amount which can be used to ensure that aggregate outpatient reimbursement levels remain consistent. The statewide standardized rate is adjusted by a hospital-specific wage index and medical education component.
iii. Uses the wage index information established and published by the Centers for Medicare and Medicaid Services (CMS) at the time the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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VIII. Institutional Services (cont)

based statistical area (CBSA) where a hospital is located

iv. Calculates the hospital-specific graduate medical education (GME) by dividing the direct GME cost reported on worksheet B, part 1, of the CMS cost report by the adjusted total costs from the CMS cost report. The formula for determining a hospital's specific conversion factor is:

Statewide Standardized Rate x ((0.6 x WageIndex) + 0.4) / (1 – (DMECost/TotalCost))

The statewide standardized conversion factor and all hospital-specific adjustments effective July 1, 2014, are published at http://www.hca.wa.gov/medicaid/hospitalpymt/pages/outpatient.aspx

v. Uses the EAPG software to determine the following discounts:

- Multiple Surgery/Significant Procedure – 50%
- Bilateral Pricing – 150%
- Repeat Ancillary Procedures – 50%
- Terminated Procedures – 50%

vi. Establishes a policy adjustor of 1.35 for services to clients age 17 and under, and establishes a policy adjustor of 1.10 for chemotherapy and combined chemotherapy/pharmacotherapy groups. These policy adjustors are not exclusive.

c. Effective for dates of admission on or after July 1, 2013, supplemental payments will be paid for outpatient Medicaid services not to exceed the upper payment limit as determined by the 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
4. Border hospitals.

For hospitals designated as prospective payment system (PPS) hospitals, $60,000,000 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 outpatient 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.

2. Fee schedule

For covered services not paid using the OPPS or the "hospital outpatient rate," the Agency pays for covered procedures when a technical component has been established in the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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VIII. Institutional Services (cont)

Medicare Fee Schedule Data Base (MFSDB) and procedures specifically identified by the Agency. Fees for these services are set using the Resource Based Relative Value Scale (RBRVS) methodology.

The Agency's Outpatient fee schedule effective July 1, 2014, is published at http://www.hca.wa.gov/medicaid/rbrvs/pages/index.aspx#O

Services paid using the Agency's Outpatient fee schedule prior to July 1, 2014, include, but are not limited to, laboratory/pathology, radiology and nuclear medicine, computerized tomography scans, magnetic resonance imaging, other imaging services, physical therapy, occupational therapy, speech/language therapy, EKG/ECG/EEG, other diagnostics, synagis, sleep studies, and other hospital services as identified and published by the Agency.

Services paid using the Agency's fee schedule for dates of service on or after July 1, 2014, include, but are not limited to, physical therapy, occupational therapy, speech/language therapy, corneal transplants, diabetic education, and other hospital services as identified and published by the Agency.

3. Hospital Outpatient Rate

The "hospital outpatient rate" is a hospital-specific rate having as its base the hospital's inpatient ratio of costs-to-charges (RCC) multiplied by an outpatient adjustment factor that factors annual cost and charge level changes into the rate. The "hospital outpatient rate" is used to reimburse services which cannot be reimbursed using the OPPS or fee schedule method, such as services designated as "inpatient-only" or other services identified and published by the Agency on the Outpatient fee schedule. The outpatient adjustment factor is 0.48 effective July 1, 2014.

Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services.

4. 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 1, the highest level of trauma care, through Level V, the most basic trauma care.

Level of designation is determined by specific 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 receive additional reimbursement from the trauma care fund established by the State of Washington in 1997 to improve the compensation to designated hospitals for care to Medicaid trauma patients.

The Agency's annual supplemental payments to hospitals for trauma services (inpatient and outpatient) total eleven million dollars, including federal match.