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**State/Territory Name: Washington**

**State Plan Amendment (SPA) #: 15-0015**

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

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

**Financial Management Group**

AUG 25 2015

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

**RE: WA State Plan Amendment (SPA) Transmittal Number #15-0015 – 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) 15-0015. This SPA allows government-operated hospitals to opt out of the CPE program using specified criteria.

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 15-0015 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: **15-0015**

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, 2015

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:

7. FEDERAL BUDGET IMPACT:
a. ~~FFY 2016 $0~~ FFY 2015 $0 P&I
b. ~~FFY 2017 $0~~ FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A Part 1 pages 3, 7, 17, 47, 51, 52, 57, 57a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Att. 4.19-A Part 1 pages 3, 7, 17, 47, 51, 52, 57, 57a

10. SUBJECT OF AMENDMENT

Certified Public Expenditure Program Opt-Out

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:
6-17-15

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: 6/17/15

18. DATE APPROVED: AUG 25 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Kristin Fan

22. TITLE:
Deputy Director, FMG

23. REMARKS:

7.22.15: State authorizes P&I change to box 7

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.)**

A. INTRODUCTION (cont.)

Other payment methods used include fixed per diem, cost settlement, per case rate (for Medicaid agency-approved bariatric surgery), disproportionate share hospital (DSH), and proportionate share hospital. All are prospective payment methods except the cost settlement payment method used to reimburse critical access hospitals. The DRG, "full cost," per diem, and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement provides reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly.

A fixed per diem payment method is used in conjunction with the LTAC program. A cost settlement payment method is used to reimburse hospitals participating in the state's Title XIX Critical Access Hospital (CAH) program.

Effective for admissions on and after July 1, 2005, participating public hospitals located in the State of Washington that are not Agency-approved and DOH-certified as CAH, are paid using the "full cost" payment method for inpatient covered services as determined through the Medicare Cost Report, using the Agency's Medicaid RCC to determine cost. Each public hospital district, for its respective non-CAH participating public hospital district hospital(s), the Harborview Medical Center, and the University of Washington Medical Center, provide certified public expenditures which represent the costs of the patients' medically necessary care.

A hospital may opt-out of the inpatient "Full Cost" Payment Program if the hospital meets the criteria for the inpatient rate enhancement under Washington Administrative Code (WAC) 182-550-3830 or is not eligible for public hospital disproportionate share hospital (PHDSH) payments under WAC 182-550-5400. To opt-out, the hospital must submit a written request to opt-out to the agency's Chief Financial Officer by July 1st in order to be effective for January 1st of the following year.

Hospitals and services exempt from the DRG payment methods are reimbursed under the per diem, per case rate, RCC, "full cost", cost settlement, or fixed per diem payment method for dates of admission on or after August 1, 2007, and for dates of admission before August 1, 2007, under, RCC, "full cost" methods, and a base community psychiatric hospitalization payment rate used to determine the allowable for certain psychiatric claims.

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.)

*"Full Cost" Payment Program*
"Full cost" payment program means a hospital payment program for participating public hospitals located in the State of Washington that are operated by public hospital districts and are not Agency-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center. These hospitals are reimbursed based on the full cost of services as determined through the Medicare Cost Report and RCCs(ratio of costs–to-charges). Each of these hospitals' certified public expenditures represent the cost of the patients' medically necessary care. Each hospital's inpatient claims are paid by the "full cost" payment method, using the Medicaid RCCs to determine cost.

*HCFA/CMS*
HCFA means the Department of Health and Human Services' former Health Care Financing Administration (HCFA) renamed the Centers for Medicare and Medicaid Services (CMS) in June 2001. CMS (formerly named HCFA) is the federal agency responsible for administering the Medicaid program.

*Health care-acquired condition (HCAC)*
Means a medical condition for which an individual was diagnosed in a Medicaid inpatient hospital setting that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act with the exception of deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement in pediatric and obstetric patients.

*Hospital*
Hospital means a treatment facility which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

*Inpatient Services*
Inpatient services means all services provided directly or indirectly by the hospital, subsequent to admission and prior to discharge of an inpatient, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, related services provided by the hospital within one calendar day of the client's admission as an inpatient.

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.)

7. DRG Exempt Hospitals (cont.)

*e. Out of State Hospitals (cont.)*

For dates of admission on and after August 1, 2007, for medically necessary treatment of emergencies that occur while a client is out-of-state, these hospitals are exempt from DRG payment method only for those services that are exempt from the DRG payment method on and after that date.

For Agency referrals to out-of-state providers after the Agency's Medical Director or designee approved an Exception to Rule for the care:

(1) In absence of a contract, the Agency pays based on the payment methods mentioned above.

(2) When the Agency is successful negotiating a contract, out-of-state hospitals are paid using a negotiated contract rate. The Agency first negotiates for the rate mentioned above, then for the other state's Medicaid or Medicare rate, and finally for the best rate possible beyond the other tiers.

*f. Military Hospitals*

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed covered charges multiplied by the applicable RCC.

*g. Public Hospitals Located In the State of Washington*

Beginning on July 1, 2005, for participating public hospitals located in the State of Washington that are operated by public hospital districts and are not Agency-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, Medicaid and MCSDSH covered services are paid by the "full cost" public hospital certified public expenditure (CPE) payment method. The new payment methodology incorporates the use of certified public expenditures at each hospital as the basis for receiving federal Medicaid funding.

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State WASHINGTON

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

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

3. RCC PAYMENT METHOD (cont)

a. 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' cost-based rates are based on the in-state average rate.

b. 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 sub-providers receive a blended rate based on the old entities' rates. The blended rate is weighted by admission for the new entity.

F. "FULL COST" PAYMENT METHODOLOGY (effective July 1, 2005)

The participating public hospitals located in the State of Washington that are operated by public hospital districts and are not Agency-approved and DOH-certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, will be reimbursed using the "full cost" payment method using their respective Medicaid RCC to determine costs for covered medically necessary services. The payment method pays only the federal match portion of the allowable costs on fee for service inpatient Medicaid claims. Recipient responsibility (spend-down) and third-party liability as identified on the billing invoice or by the Agency are deducted from the allowed amount (basic payment) to determine the actual payment for that admission. The costs as determined above will be certified as actual expenditures by the hospital and the Agency claim will be the allowed federal match on the amount of the related certified public expenditures. The Agency will verify that the expenditures certified were actually incurred. For a description of the Certified Public Expenditure protocol, see Supplement 3 to Attachment 4.19-A Part 1.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

2. Psychiatric Indigent Inpatient Disproportionate Share Hospital (PIIDSH) Payment

Effective July 1, 2003, hospitals will be considered eligible for a PIIDSH payment if:

a. The hospital is an in-state (Washington) hospital;

b. The hospital provides emergency, voluntary inpatient services to low-income, Psychiatric Indigent Inpatient (PII) patients. PII persons are low-income individuals who are not eligible for any health care coverage and who are encountering a psychiatric condition; and

c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for PIIDSH payments will receive a per claim payment for inpatient claims.

For all hospitals, except hospitals participating in the "full cost" payment program through certified public expenditures, the inpatient payments made are at a rate lower than the Medicaid rate and are based on published, non-Medicaid rates. The hospital claims are processed through the Provider One (MMIS) system where the PII clients are identified based upon their assigned Recipient Aid Category (RAC) code. If a hospital does not qualify for DSH payments, these claims are paid with State funds.

The total of each hospital's claims-based PIIDSH payments will not exceed its hospital-specific DSH cap. The hospital-specific DSH cap 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

For the excepted hospitals, the payment equals "full cost" using the Medicaid RCCs to determine cost for the medically necessary care.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DISPROPORTIONATE SHARE PAYMENTS (cont.)

**3.** Medical Care Services Disproportionate Share Hospital (MCSDSH) Payment

Effective July 1, 1994, hospitals will be considered eligible for a MCSDSH payment if:

a. The hospital is an in-state (Washington) or border area hospital;

b. The hospital provides services to low-income, Medical Care Services (MCS) patients. MCS persons are low-income individuals who are not eligible for Title XIX coverage and who are unemployable for at least 90 days due to a medical, mental health, or substance abuse incapacity; and

c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for MCSDSH payments will receive a per claim payment for inpatient claims. For all hospitals, except hospitals participating in the "full cost" payment program through certified public expenditures, the inpatient payments made are at a rate lower than the Medicaid rate and are based on published, non-Medicaid rates. The hospital claims are processed through the Provider One (MMIS) system where the MCS clients are identified based upon their assigned Recipient Aid Category (RAC) code. If the hospital does not qualify for DSH, these claims are paid with State funds.

The total of each hospital's claims-based MCSDSH payments will not exceed its hospital-specific DSH cap. The hospital-specific DSH cap 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.

For the excepted hospitals, the payment equals "full cost" using the Medicaid RCCs to determine cost for the medically necessary care

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

H. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (cont.)

7. Public Hospital Disproportionate Share Hospital (PHDSH) Payment

Effective July 1, 2005, hospitals will be considered eligible for a PHDSH payment if:

a. The hospital is a public hospital in Washington State (includes the Harborview Medical Center, the University of Washington Medical Center, and public hospitals located in the State of Washington that are operated by public hospital districts);
b. The hospital qualifies under section 1923 (d) of the Social Security Act; and the hospital participates in the "full cost" inpatient payment program through certified public expenditures

Harborview is a county-owned, state-operated hospital. The University of Washington Medical Center is a state-owned and operated hospital. Public hospital districts located in the State of Washington are organized and exist as a result of the Washington State Legislature's authorization of public hospital districts. Those public hospital districts are authorized to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.

Hospitals that apply and are considered eligible under the above criteria will receive a disproportionate share payment for hospital services during the State's fiscal year that, in total, will not exceed 100 percent of cost as defined in Section 1923(g) of the Social Security Act, except as allowed by federal guidelines.

Payments in the program will be based on the amount of uncompensated care incurred by the hospital during the most recently reported fiscal year (usually two years prior) trended forward to the year of payment.

The PHDSH payment will be based on expenditures certified by the hospital in an amount as specified in the preceding paragraph.

The PHDSH payments for the Certified Public Expenditures (CPE) program are cost settled on an interim and final basis per Supplement 3 to Attachment 4.19A Part 1.

8. Children's Health Program Disproportionate Share Hospital (CHPDSH) Payment

Effective July1, 2011, hospitals will be considered eligible for a CHPDSH payment if:

a. The hospital is an in-state (Washington) or border area hospital;
b. The hospital provides services to low-income, Children's Health Program patients who, because of their citizenship status, are not eligible for Medicaid health coverage and who are encountering a medical condition; and
c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

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

H. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (cont.)

8. Children's Health Program Disproportionate Share Hospital (CHPDSH) Payment

For all hospitals, except hospitals participating in the "full cost" payment program through certified public expenditures, the inpatient payments made are at a rate lower than the Medicaid rate and are based on published, non-Medicaid rates. The hospital claims are processed through the Provider One (MMIS) system where the eligible clients are identified based upon their assigned Recipient Aid Category (RAC) code. If the hospital is not eligible for DSH funds, these claims are paid with State Funds.

The total of each hospital's claims based CHPDSH payments will not exceed its hospital specific DSH cap. The hospital-specific DSH cap 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

Hospitals qualifying for CHPDSH payments will receive a per claim payment for inpatient and outpatient claims at the equivalent Medicaid rate.

For the excepted hospitals, the inpatient payment equals "full cost" using the Medicaid RCCs to determine cost for the medically necessary care.