Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 15-0028

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

Division of Medicaid & Children's Health Operations

March 10, 2016

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

RE: Washington State Plan Amendment (SPA) Transmittal Number 15-0028.

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 15-0028. This SPA updated the effective date of the Outpatient fee schedule and reflected the annual change to the hospital conversion factors. This SPA also reinserted reimbursement language that was inadvertently removed in a prior SPA.

This SPA is approved with an effective date of July 16, 2015.

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]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2016.03.17 06:39:02 -07'00'

David Meacham
Associate Regional Administrator

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: **15-0028**

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 16, 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:
1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B pages 16, 16-1, 16-2, 16-3 (new), 16-4 (new), 16-5 (new), 17, 18-1 (new)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Att. 4.19-B pages 16, 16-1, 16-2, 17, 16a (remove), 16b (remove)

10. SUBJECT OF AMENDMENT

Outpatient Prospective Payment System (OPPS) Fee Schedule Effective Date Update

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:
9-29-15

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: 9/29/15

18. DATE APPROVED: 03/10/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/16/15

20. SIGNATURE OF [redacted]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, [redacted].2.840.113556.1.4.8200300.100.1.1=2000041858 cn=David L. Meacham -S
Date: 2016.03.17 06:39:49 -07'00'

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services

A. Outpatient hospital services

Outpatient Prospective Payment System (OPPS)
Duplicate payment for services does not occur. Non-Critical Access Hospital (CAH) outpatient hospital services are reimbursed using the Medicaid agency's Outpatient Prospective Payment 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 are changed when grouper versions are changed. The relative weights effective July 1, 2014, are published on the agency's website. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published .

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. See 4.19-B, I. General

The formula for determining a hospital's specific conversion factor is: Statewide Standardized Rate x ((0.6 x WageIndex) + 0.4) / (1 – (DMECost/TotalCost))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

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-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.
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.

The statewide standardized conversion factor and all hospital-specific adjustments are effective July 16, 2015. See 4.19-B, I, General, #G for the agency's website where the fee schedules are published.

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:
- Prospective Payment hospitals other than psychiatric or rehabilitation hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- 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 (4) to calculate the quarterly amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

Rate enhancement for Sole Community Hospitals

Effective January 1, 2015, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.25 if the hospital meets all of the following criteria. To qualify for the rate enhancement, the hospital must:

- Be certified by CMS as a sole community hospital as of January 1, 2013
- Have a level III adult trauma service designation from the Washington State Department of Health as of January 1, 2014
- Have less than one hundred fifty acute care licensed beds in fiscal year 2011
- Be owned and operated by the state or a political subdivision

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

2. Fee Schedule

For non-CAH hospitals and covered services not paid using the OPPS or the “hospital outpatient rate”, the agency pays the lesser of the usual and customary charge or a fee based on an agency fee schedule for covered procedures.

Services paid using the agency’s fee schedule include, but are not limited to, physical therapy, occupational therapy, speech/language therapy, corneal transplants, and other hospital services as identified and published by the agency.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency’s outpatient fee schedule is effective for services provided on and after July 16, 2015. See 4.19-B, I, General, #G for the agency’s website where the fee schedules are published.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

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) adjusted by an outpatient adjustment factor that factors annual cost and charge level changes into the rate. The “hospital outpatient rate” is used to reimburse under OPPS as explained earlier in this subsection, or for non-CAH hospitals exempt from the agency’s OPPS, for all other covered outpatient services (those not mentioned in the previous paragraphs as covered by fee schedule) on the hospital’s outpatient claim.

Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency’s outpatient fee schedule is effective for services provided on and after July 16, 2015. See 4.19-B, I, General, #G for the agency’s website where the fee schedules are published.

VIII. Institutional Services (cont)

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

The trauma care fund provides additional reimbursement to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly. The supplemental payment each designated trauma hospital receives is proportional to the hospital's percentage share of the value of qualifying trauma care services provided to Medicaid clients by all Level I, II, and III trauma centers for the service year to date. Effective July 1, 2013, the supplemental payments proportion will be calculated using the aggregate trauma care cases provided in both fee for service and managed care. Payments for outpatient Medicaid services are not to exceed the upper payment limit for federal financial participation for fee for service.

A trauma case qualifies for supplemental payment if its Injury Severity Score (ISS) meets or exceeds the specified threshold.

Level IV and V trauma centers receive a trauma care grant from the Department of Health using only state funds.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont.)

B. Ambulatory surgery centers that are hospital-owned facilities.

Ambulatory surgery centers (ASC) that are hospital-owned (hospital-based) will be reimbursed as part of the hospital, using the payment methods used to pay hospital outpatient claims.

C. Inpatient vs. Outpatient Stay Policy

Through October 31, 2004, stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are considered inpatient and are reimbursed under the respective inpatient payment method designated for the hospital and/ or the covered services.

On and after November 1, 2004, a new clinical-based inpatient vs. outpatient stay determination rule is in effect.

An inpatient stay is an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

An outpatient hospital stay consists of outpatient hospital services that are within a hospital's licensure and provided to a client who is designated as an outpatient based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

Back to TOC

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont.)

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below