Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) # WA 24-0034

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

August 13, 2024

Charissa Fotinos, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: TN 24-0034

Dear Director Fotinos:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Washington state plan amendment (SPA) to Attachment 4.19-A WA 24-0034, which was submitted to CMS on July 18, 2024. This plan amendment updates the outdated payment methodology for Diagnosis Related Group (DRG) hospital payments, remove the reference to a specific version of the All Patient Refined Diagnosis Related Group (APR-DRG) classification software, replace references to "chemical" use with "substance" use, and add a definition for medically necessary gender affirming care.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at tom.caughey@cms.hhs.gov.

Sincerely,

Rory Howe

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0034

2. STATE: WA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
1902(a) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Part pages 13, 14, 15, 16, 18 , 19

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Part 1 pages 13 (TN#22-0004), 14 (TN# 22-0004), 15 (TN# 11-20), 16 (TN# 11-22B), 18 (TN# 22-0004) , 19 (TN# 23-0028)

9. SUBJECT OF AMENDMENT
Diagnostic Related Group Hospital Payment Methodology Updates

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Exempt

11. SIGNATURE OF STATE AGENCY OFFICIAL
Charissa Fotinos MD, MSc

12. TYPED NAME
Charissa Fotinos, MD, MSc

13. TITLE
Medicaid and Behavioral Health Medical Director

14. DATE SUBMITTED
July 18, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
July 18, 2024

17. DATE APPROVED
August 13, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

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.

The Agency uses the All Patient Refined Diagnosis-Related Group (APR-DRG) classification software to assign DRGs and Severity of Illness (SOI) indicators.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

C. GENERAL REIMBURSEMENT POLICIES (cont.)

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 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 0.80 for claims grouping to severity of illness (SOI) 1 and 2 and 0.95 for SOI 3 and 4.

4. Reserved

5. Reserved

6. Reserved

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

C. GENERAL REIMBURSEMENT POLICIES (cont.)

6. Non-DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the per diem, per case rate (effective August 1, 2017, through September 30, 2018, only), fixed per diem, RCC method, “full cost” method, CAH method, etc. For RCC and “full cost” payments, the basic payment is established by multiplying the hospital's assigned RCC (not to exceed 100 percent) by the allowed covered charges for medically necessary services. Recipient responsibility (spend-down) and third party liability as identified on the billing invoice or otherwise by the Agency, is deducted from the allowed amount (basic payment) to determine the actual payment for that admission. Other applicable adjustments may also be made. For the “full cost” method, only the federal funds participation (FFP) percentage is paid on the claim after all other adjustments to the allowed amount have been made.

For claims with admission dates on and after January 1, 2010, which qualify under the per diem payment method, the state does not pay for days of service beyond the average length of stay (LOS) attributable to Health Care-Acquired Conditions (HCAC) and are coded with Present on Admission Indicator codes “N” or “U”.

For claims with admission dates on and after January 1, 2010, which qualify under the CAH payment method which uses the Departmental weighted costs to charges (DWCC) rates to calculate payments, under the Ratio of Cost to Charges (RCC) payment method, and under the per case payment method (effective August 1, 2017, through September 30, 2018, only), the state does not pay for services attributable to the HCAC.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

C. GENERAL REIMBURSEMENT POLICIES (cont.)

7. DRG Exempt Hospitals

The following hospitals are exempt from the DRG payment method for Medicaid.

a. Psychiatric Hospitals
Designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals are this type of facility. This currently includes, but is not limited to, Fairfax Hospital, Lourdes Counseling Center, West Seattle Psychiatric Hospital, the psychiatric unit at Children's Hospital and Regional Medical Center, and all other Medicare-certified and State-approved distinct part psychiatric units doing business with the State of Washington.

b. Rehabilitation Units
Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The criteria used to identify exempt hospitals and units are the same as those employed by the Medicare program to identify designated distinct part rehabilitation units.

In addition, services for clients in the Agency's Physical Medicine and Rehabilitation program (PM&R), and who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for PM&R services and placement into the rehabilitation unit.

c. Critical Access Hospital (CAHs) Agency-approved and Medicare-designated CAHs receive Medicaid prospective payment based on Agency/Department Weighted Cost-to-Charge (DWCC). Post-period cost settlement is then performed.

d. Managed Health Care
Payments for clients who receive inpatient care through managed health care programs. If a client is not a member of the plan, reimbursement for admissions to managed health care program hospital will be determined in accordance with the applicable payment methods for hospitals as described in this section and Section D, Section E and/or Section F.

e. Out-of-State Hospitals
For medical services provided, out-of-state hospitals are those facilities located outside of Washington and outside designated bordering cities as described in Section D. For psychiatric services and Involuntary Treatment Act (ITA) services, out-of-state hospitals are those facilities located outside the State of Washington. The Mental Health Division designee is responsible to screen for authorization of care and make payment for authorized services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

C. GENERAL REIMBURSEMENT POLICIES (cont.)

6. DRG Exempt Services

a. Unstable, Low Volume, and Specialty Services DRG Classifications

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, withdrawal management and Substance Using Pregnant People program services, are reimbursed under the per diem payment method unless the hospital is participating in the “full cost”, or cost settlement payment method.

b. AIDS-Related Services

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.)

8. DRG Exempt Services (cont.)

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

d. Bone Marrow and Other Major Organ Transplants

Services provided to clients receiving bone marrow transplants and other major organ transplants are exempt from the DRG payment method and are reimbursed under the RCC method.

e. Substance-Using Pregnant People

For dates of admission before August 1, 2007, hospital-based intensive inpatient care for detoxification and medical stabilization provided to Substance-Using Pregnant People by a certified hospital are exempt from the DRG payment method and are reimbursed under the RCC payment method. See subsection E.1., for information on the payment method for Substance-Using Pregnant People (SUPP) Program, for dates of admission on and after August 1, 2007.

f. Long-Term Acute Care Program Services

Long-Term Acute Care (LTAC) services, and other inpatient services provided by LTAC hospitals, are exempt from DRG payment methods. LTAC services covered under the LTAC rate are reimbursed using a fixed per diem rate. Other covered LTAC services are paid using the RCC method. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient. Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

g. *Medically necessary gender affirming care*

Medically necessary gender affirming care for a client with a diagnosis of gender dysphoria, provided in an inpatient setting at an acute care hospital is exempt from the DRG payment method and reimbursed under the RCC method. Gender affirming care is specific to physical health services.