Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 11-020

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and CHIP Services (CMCS)

Doug Porter, Administrator
Health Care Authority
Post Office Box 428682
Olympia, Washington 98504-2682

JAN 26 2012

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-020

Dear Mr. Porter:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan (SPA) submitted under transmittal number (TN) 11-020. The purpose of this amendment is to update the State plan by decreasing overall Disproportionate Share Hospital payments. In addition to reducing overall DSH payments, this amendment also establishes a new DSH pool, CHPDSH (Children's Health Insurance Program DSH). Hospitals can first become eligible for CHPDSH payments on July 1, 2011.

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.

Medicaid State plan amendment 11-020 is approved effective May 19, 2011. We are enclosing the HCFA-179 and the amended plan pages.

During the review of Washington SPA 11-020, CMS performed an analysis of Health Care Acquired Conditions and Other Provider Preventable Conditions (OPPS). This analysis revealed issues that will require revision through a corrective action plan (CAP). Under separate cover, CMS will release a letter detailing those issues, and provide guidance on timeframes for correction.

If you have any questions, please contact Joe Fico of the National Reimbursement Team at (206) 615-2380.

Sincerely,

[redacted]

Cindy Mann,
Director, CMCS

cc

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

Doug Porter, Administrator
Health Care Authority
Post Office Box 45502
Olympia, WA 98054-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-020

Dear Mr. Porter:

This letter serves as a companion letter to our approval of Washington State Plan Amendment (SPA) Transmittal Number 11-020, submitted on July 28, 2011. Washington submitted this SPA to modify its Disproportionate Share Hospital (DSH) payment distribution methodology and to implement an overall reduction in DSH payments. During our review, the Centers for Medicare & Medicaid Services (CMS) notified the State of a federal requirement that had not yet been addressed: the need to update State plan language to conform to statutes, regulations and CMS policy for the non-payment of Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). Additionally, on September 23, 2011, CMS issued a Request for Additional Information (RAI) that also addressed this need.

As required by 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, implemented at 42 Code of Federal Regulations (CFR) Part 447, Subpart A, the Attachments 4.19-A, 4.19-B and 4.19-D of the State plan must be amended to identify HCAC and OPPCs for which payment will be prohibited. To further clarify these requirements, web links to HCAC and OPPC preprint page instructions and to the minimum set of conditions, including infections and events that States must identify for non-payment, has been provided to your staff. Please note that Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement are listed as conditions for which payment is prohibited, but with exclusions from non-payment for pediatric and obstetric patients.

The State has 90 days from the date of this letter to submit a SPA in order to implement a compliant HCAC and OPPC non-payment policy. Failure to respond will result in the initiation of a formal compliance process. During the 90 days, CMS will provide technical assistance, as needed or required.

If you have questions or concerns, please contact me, or have your staff contact Joe Fico at (206) 615-2380 or via email at joseph.fico@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Ann Myer, State Plan 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: **11-20**

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
May 19, 2011

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 2011 $(6,042,000) **(P&I)**
b. FFY 2012 $(23,009,000) **(P&I)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A Part I pgs 4 – 11, 48 – 50, 52 - 57
pages 12, 15 (P&I)

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

Att. 4.19-A Part I pgs 4 – 11, 48 – 50, 52 - 57
pages 12, 15 (P&I)

10. SUBJECT OF AMENDMENT:

Disproportionate Share Hospital Payments

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

[redacted]

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:
June 28, 2011

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Medicaid Purchasing Administration
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **June 28, 2011**

18. DATE APPROVED: **JAN 2 6 2012**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
MAY 19 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

8/25/11 - State authorized pen and ink changes
9/21/11 - State authorized pen & ink changes

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

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan. Allowed covered charges, where mentioned in this attachment to the state plan, refers to the Agency-covered charges on a claim that are used to determine any kind of reimbursement for medically necessary care.

Accommodation and Ancillary Costs
Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), and operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

Adverse Events
Adverse events (also known as "adverse health events" or "never events" and effective July 1, 2011, known for Medicaid claims as "other provider preventable conditions") 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. These serious reportable events are clearly identifiable, preventable, and serious in their consequences for patients, and frequently their occurrence is influenced by the policies and procedures of the healthcare organization.

Agency
Agency refers to the State Medicaid Agency.

Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)
ADATSA is a program that provides a continuum of care to persons who are indigent and considered unemployable as a result of alcoholism and/or other drug addiction.

Bariatric Surgery Case Rate
The bariatric surgery per case rate is a cost-based rate used to pay a hospital that is prior authorized by the Agency to provide bariatric surgery related services to an eligible medical assistance client for those services.

Base Community Psychiatric Hospitalization Payment Rate
For admissions before August 1, 2007, the base community psychiatric hospitalization payment rate is a minimum per diem allowable calculated for claims for psychiatric services provided to covered patients, to pay hospitals that accept commitments under the state's involuntary treatment act.

Case-Mix Index (CMI)
Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

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, a cost based DRG rate, is a calculated amount based on the statewide-standardized average cost 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 Medicaid Utilization Rate
All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the Agency disproportionate share 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 originally developed for the federal Medicare program 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.

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 on and after August 1, 2007, 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.

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.)

"Full Cost" Payment Program
"Full cost" payment program means a hospital payment program for public hospitals located in the State of Washington that are owned 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.)

B. DEFINITIONS (cont.)

Involuntary Treatment Act (ITA)
The ITA designates mental health professionals to perform the duties of investigating and detaining persons who may be of danger to themselves or others, without the voluntary cooperation of those persons, when necessary.

Long Term Acute Care
Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have exceeded high-cost outlier status. At the point at which that determination is made, the mode of care and reimbursement may switch to LTAC under a fixed per diem rate if authorized by the Medicaid Agency. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

Observation Services
Observation services means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital 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.)

B. DEFINITIONS (cont.)

Operating, Medical Education and Capital Costs
Costs are the Medicare-approved costs as reported on the CMS 2552 and are divided into three components:

- Operating costs include all expenses, except capital and medical education, incurred in providing accommodation and ancillary services;
- Medical education costs are the expenses of a formally organized graduate medical education program;
- Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, and interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, are deleted from the capital component.

PII/MCS
PII/MCS, as used in Paragraph H.2 and H.3 below, means the Agency Limited Casualty Program Psychiatric Indigent Inpatient (PII) or Medical Care Services (MCS) program. 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. MCS was known as General Assistance Unemployable (GAU) through December 31, 2010, and as Disability Lifeline (DL) through October 31, 2011.

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, a cost-based rate, is a calculated amount based on the statewide, standardized, average cost 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.)

RCC
RCC means a hospital ratio of costs-to-charges (RCC) calculated using annual CMS 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues (more detail is available in Supplement 3 to Attachment 4.19-A Part 1, pages 3 and 4).

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 in this attachment, rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) data and State-determined base year(s) claims 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.

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

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.)

4. DRG Low Cost Outlier Payments

Low cost outliers are cases with dates of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. To qualify as a DRG low cost outlier, the allowed charges for the case must be equal to or less than the greater of 10 percent of the applicable DRG payment or $450. Reimbursement for these cases is the case's allowed charges multiplied by the hospital's RCC.

5. DRG Long-Stay Day Outlier Payments

Day Outlier payments are applicable for cases with dates of admission before August 1, 2007. Day outlier payments are included only for long-stay clients, under the age of six in disproportionate share hospitals, and for children under age one in any hospital. (See C.16 Day Outlier payments).

6. Non DRG payment method payments

Hospitals and services exempt from the DRG payment method are reimbursed under the per diem, per case rate, 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, 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 (cont.)

G. BASE COMMUNITY PSYCHIATRIC HOSPITALIZATION PAYMENT RATE

Under the DRG, RCC, and "full cost" methods, and only for dates of admission before August 1, 2007, a base community psychiatric hospital payment rate may apply for psychiatric claims submitted by an in-state hospital that has already treated a patient covered under the state's Involuntary Treatment Act (ITA) in an ITA-certified bed. The base community psychiatric payment rate is a per diem rate.

The base community psychiatric hospitalization payment rate used in conjunction with the DRG, RCC, and "full cost" methods as follows:

(1) The respective DRG, RCC, or "full cost" allowable on a qualifying claim is divided by the length of stay for the claim to determine an allowable per diem amount.

(2) The base community psychiatric hospital payment rate is then compared to that amount.

(3) If the base community psychiatric hospital payment rate is greater, then it is applied to the authorized length of stay for the claim to determine a revised allowable for the claim.

H. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for eligible hospitals. To be eligible for any disproportionate share program, a hospital must meet the minimum requirement of a one-percent Medicaid inpatient utilization rate. A hospital will be considered for one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility criteria for that respective DSH program and has met the State DSH application requirements explained in WAC 388-550-4900 through 388-550-5400 in effect as of July 1, 2009.

The total of all DSH payments will not exceed the State's DSH allotment. To accomplish this goal, it is understood in this State Plan that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed the uncompensated cost of furnishing hospital services to Medicaid eligible individuals and individuals with no insurance or any creditable third party coverage for the services provided.

Beginning in state fiscal year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, hospitals are required to return overpayments to the Agency for redistribution to qualifying hospitals as an integral part of the audit process.

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)

The Agency will not exceed the DSH statewide allotment nor allow a hospital to exceed the DSH limit. The following clarification of the process explains precautionary procedures.

All the Agency DSH programs' payments are prospective payments, and these programs are: LIDSH, PIIDSH, CPDSH, and MCSDSH, including the ADATSA program, SRDSH, SRIADSH, NRIADSH, IMDDSH, and PHDSH. DSH is available only to acute care non-psychiatric hospitals with the exception of IMDDSH, which is distributed to psychiatric hospitals. The IMDDSH is appropriated separately and is in the Mental Health state plan amendment.

The following DSH programs are supplemental payments: PHDSH, LIDSH, SRDSH, SRIADSH, and NRIADSH. Three DSH programs are paid on a per claim basis: CHPDSH, DLDSH and PIIDSH.

If an individual hospital has been overpaid by a specified amount, the Agency will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

If a hospital exceeds its DSH limit, the Agency will recoup the DSH payments in the following program order: PHDSH, SRIADSH, SRDSH, NRIADSH, DLDSH, CHPDSH, PIIDSH, IMDDSH, and LIDSH. For example, if a small rural hospital were receiving payments from all applicable DSH programs, the overpayment adjustment would be made in SRIADSH to the fullest extent possible before adjusting LIDSH payments. If the DSH state-wide allotment is exceeded, the Agency will similarly make appropriate proportionate adjustments in the program order shown above.

Beginning in state fiscal year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, hospitals are required to return overpayments to the Agency for redistribution to qualifying hospitals as an integral part of the audit process.

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)

1. Low-income Disproportionate Share Hospital (LIDSH) Payment

Hospitals will be considered eligible for a LIDSH payment adjustment if funding is legislatively appropriated and if:

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

b. The hospital's Medicaid inpatient utilization rate (as defined in Section 1923(b)(2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or,

c. The hospital's low-income utilization rate (as defined in Section 1923 (b) (3)) exceeds 25 percent;

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

e. The hospital is not in Peer Group E (i.e., a certified public expenditure (CPE) hospital) or an Institution for Mental Disease (IMD).

Hospitals considered eligible under the above criteria will receive disproportionate share payment amounts that in total will equal the funding set by the State's appropriations act for LIDSH. The process of apportioning payments to individual hospitals is as follows:

A single base payment is selected that distributes the total LIDSH appropriation. For each hospital, the Agency divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals, then multiplies the result by the hospital's most recent DRG payment method Medicaid case mix index (CMI), and then by the hospital's base year Title XIX discharges. The Agency then converts the product to a percentage of the sum of all such products for individual hospitals and multiplies this percentage by the legislatively appropriated amount for LIDSH. For DSH program purposes, a hospital's Medicaid CMI is the average diagnosis related group (DRG) weight for all of the hospital's Medicaid DRG-paid claims during the state fiscal year used as the base year for the DSH application.

Each hospital's total DSH payments will not exceed its DSH limit. 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.

Dollars not allocated due to a hospital reaching the DSH limit are reallocated to the remaining hospitals in the LIDSH pool. The payments are made periodically. LIDSH payments are subject to federal regulation and payment limits.

Total funding to the LIDSH program equals $17,204,000 in state fiscal year (SFY) 2010, $16,204,000 in SFY 2011, and $8,522,000 in SFY 2012 and thereafter.

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.)

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

Effective July 1, 1994, hospitals will be considered eligible for a MCSDSH payment if funding is legislatively appropriated and 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 public hospitals located in the State of Washington that are owned by public hospital districts and are not Agency-approved and DOH-certified as a Critical Access Hospital (CAH), the Harborview Medical Center, and the University of Washington Medical Center, the inpatient payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment.

The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. For the excepted hospitals, the payment equals "full cost" using the Medicaid RCCs to determine cost for the medically necessary care. The equivalency factor ensures that MCSDSH payments will equal the State's estimated MCSDSH appropriation level.

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.)

4. Small Rural Disproportionate Share Hospital (SRDSH) Payment

Effective July 1, 2007, hospitals will be considered eligible for a SRDSH payment if funding is legislatively appropriated and if:

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

b. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute beds and located in a city or town with a non-student population of no more than 17,806 in calendar year 2008, as determined by population data reported by the Washington State Office of Financial Management population of cities, towns, and counties used for the allocation of state revenues. This non-student population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the non-student population is increased by two percent;

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

d. The hospital is not in Peer Group E (i.e., a certified public expenditure (CPE) hospital) or an Institution for Mental Disease (IMD).

Hospitals qualifying for SRDSH payments are paid from a legislatively-appropriated pool. The apportionment formula is based on each SRDSH hospital's Medicaid payments.

To determine each hospital's percentage of Medicaid payments, the sum of the Medicaid payments to the individual hospital is divided by the total Medicaid payments made to all SRDSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment subject to hospital-specific DSH limits.

As of July 1, 2007, prior to calculation of the individual hospital's percentage of payments, hospitals with a low profitability margin will have their total payments set at 110 percent of actual payments. A hospital is determined to have a low profitability margin when their profitability margin is less than 110 percent of the average profitability margin for qualifying hospitals.

The Agency will calculate each hospital's net operating margin based on the hospital's base year data and audited financial statements from the hospital.

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.)

4. Small Rural Disproportionate Share Hospital (SRDSH) Payment (cont)

Each hospital's total DSH payments will not exceed its DSH limit. 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.

Dollars not allocated due to a hospital reaching the DSH limit are reallocated to the remaining hospitals in the SRDSH pool. The payments are made periodically. SRDSH payments are subject to federal regulation and payment limits.

Total funding to the SRDSH program equals $3,818,400 per state fiscal year (SFY) beginning SFY 2010.

Beginning in state fiscal year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, hospitals are required to return overpayments to the Agency for redistribution to qualifying hospitals as an integral part of the audit process.

5. Small Rural Indigent Assistance Disproportionate Share Hospital (SRIADSH) Payment

Effective July 1, 2007, hospitals will be considered eligible for a SRIADSH payment if funding is legislatively appropriated and if:

a. The hospital is an in-state (Washington) hospital;
b. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute beds and located in a city or town with a non-student population of no more than 17,806 in calendar year 2008, as determined by population data reported by the Washington State Office of Financial Management population of cities, towns, and counties used for the allocation of state revenues. This non-student population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the non-student population is increased by two percent;
c. The hospital qualifies under Section 1923(d) of the Social Security Act;
d. Effective July 1, 2007, the hospital provided services to charity patients during the calculation base year; and
e. The hospital is not in Peer Group E (i.e., a certified public expenditure (CPE) hospital) or an institution for Mental Disease (IMD).

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.)

5. Small Rural Indigent Assistance Disproportionate Share Hospital (SRIADSH) Payment (cont)

Hospitals qualifying for SRIADSH payments are paid from a legislatively appropriated pool. Beginning July 1, 2007, the apportionment formulas is based on each SRIADSH hospital's calculated costs for qualifying Charity patients during the most currently available state fiscal year.

To determine each hospital's percentage of SRIADSH payments, the sum of individual hospital calculated charity costs is divided by the total charity calculated costs of all SRIADSH hospitals during the most currently available state fiscal year. The percentage is then applied to the total dollars in the pool to determine each hospital's payment, subject to hospital-specific DSH limits.

As of July 1, 2007, prior to calculation of the individual hospital's percentage of calculated charity costs, hospitals with a low profitability margin will have their total calculated charity costs adjusted to 110 percent of calculated charity costs. A hospital is determined to have a low profitability margin when their profitability margin is less than 110 percent of the average profitability margin for qualifying hospitals. The Agency will calculate each hospital's net operating margin based on the hospital's base year data ant audited financial statements from the hospital.

Payments for SRIADSH will be made in conjunction with payments for SRDSH.

Each hospital's total DSH payments will not exceed its DSH limit. 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.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the SRIADSH pool. The payments are made periodically. SRIADSH payments are subject to federal regulation and payment limits.

Beginning in state fiscal year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, hospitals are required to return overpayments to the Agency for redistribution to qualifying hospitals as an integral part of the audit process.

Total funding to the SRIADSH program equals $1,294,000 in state fiscal year (SFY) 2011 and $1,330,000 in SFY 2012 and thereafter. This program is not funded in SFY 2010.

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. DSH PAYMENTS (cont.)

6. Non-Rural Indigent Assistance Disproportionate Share Hospital (NRIADSH) Payment

Effective July 1, 2007, hospitals will be considered eligible for a NRIADSH payment if funding is legislatively appropriated and if:

a. The hospital does not qualify as a Small Rural Hospital as defined in section H.4. of this plan;
b. The hospital qualifies under Section 1923(d) of the Social Security Act;
c. The hospital is not in Peer Group E (i.e., a certified public expenditure (CPE) hospital) or an Institution for Mental Disease (IMD); and
d. The hospital is an in-state (Washington) or designated bordering city hospital that provided charity services to clients during the base year (for DSH purposes, the Agency considers as non-rural any hospital located in a designated bordering city).

Hospitals qualifying for NRIADSH payments are paid from a legislatively appropriated pool. Beginning July 1, 2007, the apportionment formula is based on each NRIADSH hospital's calculated costs of charity care during the most currently available state fiscal year.

To determine each hospital's percentage of NRIADSH payments, the sum of individual hospital calculated charity costs is divided by the total calculated charity costs of all NRIADSH hospitals. The percentage is then applied to the total dollars in the pool to determine each hospital's payment.

As of July 1, 2007, prior to calculation of the individual hospital's percentage of costs for charity care, hospitals with a low profitability margin will have their total calculated charity costs adjusted to 110% of calculated charity costs. A hospital is determined to have a low profitability margin when their profitability margin is less than 110 percent of the average profitability margin for qualifying hospitals. The Agency will calculate each hospital's net operating margins based on the hospital's base year data and audited financial statements from the hospital.

Each hospital's total DSH payments will not exceed its DSH limit. 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.

Dollars not allocated due to a hospital reaching its DSH limit are reallocated to the remaining hospitals in the NRIADSH pool. The payments are made periodically. NRIADSH payments are subject to federal regulation and payment limits.

Total funding to the NRIADSH program equals $11,506,000 in state fiscal year (SFY) 2011 and $11,810,000 in SFY 2012 and thereafter. This program is not funded in SFY 2010.

Beginning in state fiscal year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, hospitals are required to return overpayments to the Agency for redistribution to qualifying hospitals as an integral part of the audit process.

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. DSH PAYMENTS (cont.)

7. Public Hospital Disproportionate Share Hospital (PHDSH) Payment

Effective July 1, 2005, hospitals will be considered eligible for a PHDSH payment if funding is legislatively appropriated and 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 owned and operated by public hospital districts);
b. The hospital qualifies under section 1923 (d) of the Social Security Act; and
c. The hospital is not Agency-approved and DOH-certified as a CAH under Washington State Law and federal Medicare rules.

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

The DSH payments for the 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 funding is legislatively appropriated and 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 nonemergency health coverage and who are encountering a nonemergency medical condition; and
c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

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