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State/Territory Name: Washington

State Plan Amendment (SPA) #: 13-15

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 S2-26-12
Baltimore, Maryland 21244-1850

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

NOV 22 2013

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

RE: WA State Plan Amendment (SPA) Transmittal Number #13-015 – Approval

Dear Ms. Lindeblad:

We have reviewed the proposed amendment to Attachments 4.19-A and B of your Medicaid State plan submitted under transmittal number (TN) 13-015. This amendment revises the inpatient and outpatient hospital supplemental payment process for Level I, II, and III trauma centers.

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 13-015 is approved effective as of July 1, 2013. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' RO NIRT Representative at 208-334-9482 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Cindy Mann
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: 13-15

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, 2013

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 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A Part 1 pages 20, 21, 25, 25a (new)
Att. 4.19-B pages 16a, 17

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19-A Part 1 pages 20, 21, 25
Att. 4.19-B pages 16a, 17

10. SUBJECT OF AMENDMENT:

Trauma Services Rates

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:
9-6-13

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 45504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 6, 2013

18. DATE APPROVED: 11/22/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/01/2013

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:

FORM HCFA-179 (07-92)

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

C. GENERAL REIMBURSEMENT POLICIES (cont.)

8. DRG Exempt Services (cont.)

g. Services provided in DRG classifications that do not have an Agency relative weight assigned.

For dates of admission before August 1, 2007, services provided in DRGs that do not have an Agency relative weight assigned, that would otherwise be paid using the DRG payment method, are reimbursed using the RCC, "full cost", or cost settlement payment method unless a different payment method has been specified.

For dates of admission on and after August 1, 2007, services provided in DRGs that do not have an Agency relative weight assigned, are paid using one of the other payment methods (e.g. RCC, per diem, per case rate, "full cost", or cost settlement).

h. 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 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.

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 trauma facilities for care to Medicaid trauma patients. The supplemental payment to designated hospitals is in the form of lump-sum payments made quarterly.

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

The payment an eligible hospital receives from the quarterly payment pool is determined by first summing each hospital's qualifying payments for trauma cases from the beginning of the service year and expressing this amount as a percentage of total payments made by the Agency to all Level I, II, and III hospitals for qualifying services provided during the service year to date. The beginning of the service year is defined as July 1 – the state fiscal year – for which legislative appropriation is made. Each eligible hospital's payment percentage for the service year-to-date is multiplied by the trauma supplemental funds available for the service year-to-date, and then the Agency subtracts previous quarterly payments made to the individual hospital for the service year-to-date to determine that hospital's portion of the current quarterly payment pool.

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.)

h. Trauma Center Services (cont.)

Effective with dates of service on and after July 1, 2013, the supplemental payments proportion a Level I, II, or III hospital receives will be calculated using the aggregate qualifying trauma care services provided in both fee for service and managed care. Payments for inpatient Medicaid services are not to exceed the upper payment limit (UPL) for federal financial participation for fee for service.

A trauma case qualifies a Level I, II, or III hospital for supplemental trauma payment if the Injury Severity Score (ISS) is 13 or greater for an adult patient or 9 or greater for a pediatric patient (through age 14 only). A transferred trauma case qualifies the receiving hospital for supplemental payment regardless of ISS.

The qualifying ISS for adult and pediatric patients are evaluated periodically and may be adjusted based on the Washington State Department of Health's Trauma Registry data and changes to the Abbreviated Injury Scale (AIS) coding system.

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

i. Inpatient Pain Center Services

Services in Agency-authorized inpatient pain centers are paid using a fixed per diem rate.

9. Transfer Policy

For a hospital transferring a client to another acute care hospital or a facility with sub-acute medical services, for a claim paid using the DRG payment method, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below:

For dates of admission before August 1, 2007, the payment allowed amount to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital, or the appropriate DRG payment allowed amount; and

For dates of admission on and after August 1, 2007, the payment allowed amount to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital plus one day, or the appropriate DRG payment allowed amount.

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.)

16. Day Outliers (cont.)

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate. Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

17. Trauma Care Enhancement

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

The Level I, II, and III trauma center supplemental payment is based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to designated trauma facilities for care to Medicaid trauma patients. The supplemental payment to designated hospitals is in the form of lump-sum payments made quarterly.

The payment an eligible hospital receives from the quarterly payment pool is determined by first summing each hospital's qualifying payments for trauma cases from the beginning of the service year and expressing this amount as a percentage of total payments made by the Agency to all Level I, II, and III hospitals for qualifying services provided during the service year to date. Each eligible hospital's payment percentage for the service year-to-date is multiplied by the trauma supplemental funds available for the service year-to-date, and then the Agency subtracts previous quarterly payments made to the individual hospital for the service year-to-date to determine that hospital's portion of the current quarterly payment pool.

Effective with dates of service on and after July 1, 2013, the supplemental payments proportion a Level I, II, or III hospital receives will be calculated using the aggregate qualifying trauma care services provided in both fee for service and managed care. Payments for inpatient Medicaid services are not to exceed the upper payment limit (UPL) for federal financial participation for fee for service.

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

A trauma case qualifies a Level I, II, or III hospital for supplemental trauma payment if the Injury Severity Score (ISS) is 13 or greater for an adult patient or 9 or greater for a pediatric patient (through age 14 only). A transferred trauma case qualifies the receiving hospital for supplemental payment regardless of ISS.

The qualifying ISS for adult and pediatric patients are evaluated periodically and may be adjusted based on the Washington State Department of Health's Trauma Registry data and changes to the Abbreviated Injury Scale (AIS) coding system.

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.)

18. Adjustment for New Newborn Screening Tests

A payment adjustment is made for new legislatively approved and funded newborn screening tests not paid through other rates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont)

A. Outpatient hospital services (cont)

3. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont.)

A. Outpatient hospital services, Trauma Center Services (cont.)

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 1st, 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.

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.