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State/Territory Name: WA

State Plan Amendment (SPA) #: 18-0029

- 1) Approval Letter
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DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12 Baltimore, MD 21244-1850



Financial Management Group

December 14, 2018

Susan Birch, Director MaryAnne Lindeblad, Medicaid Director Health Care Authority Post Office Box 45502 Olympia, Washington 98504-5010

RE: WA State Plan Amendment (SPA) Transmittal Number #18-0029 - Approval

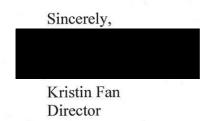
Dear Ms. Birch and Ms. Lindeblad:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0029. This SPA eliminates a separate reimbursement methodology for bariatric surgery from the State plan and transfers reimbursement for this service to the routine DRG system.

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 18-0029 is approved effective as of October 1, 2018. 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 208-861-9838 or Thomas.Couch@cms.hhs.gov.



Enclosures

FORM APPROVED OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	18-0029	Washington
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	October 1, 2018	K.
5. TYPE OF PLAN MATERIAL (Check One):		
	CONSIDERED AS NEW PLAN	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME 6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	n amenament)
1902(a) and 1923(a) of the Social Security Act	a. FFY 2019 \$18,711	
1902(a) and 1925(a) of the Social Security Act	b. FFY 2020 \$18,711	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:		EDED PLAN SECTION
Attachment 4.19-A Part 1 page 40, 41, 42, 43, 44, 45	SUPERS Applicable): Attachment 4.19-A Part 1	
	page 40, 41, 42, 43, 44, 4	14a, 45
10. SUBJECT OF AMENDMENT:		
Elimination of the Per Case Rate		
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 SPE	CIFIED: Exempt
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Ann Myers	2
	Rules and Publications	
13. TYPED NAME:	Division of Legal Services	
MaryAnne Lindeblad	Health Care Authority	
14. TITLE:	626 8th Ave SE MS: 42716	
Director 15. DATE SUBMITTED:	Olympia, WA 98504-2716	
11-19-18		
FOR REGIONAL OI		
17. DATE RECEIVED:	18. DATE APPROVED: DEC 14 2018	
	NE COPY ATTACHED 20. SIGNATURE OF REGIONAL O	EFICIAL ·
19. EFFECTIVE DATE OF APPROVED MCTENIAL 2018	20. SIGNAT DAE OF REGIONAL OF	HOIRE.
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG	
23. REMARKS:		
12/7/18-State authorized a P&I change to blocks #8 and #9.		

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

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

- ✓ Effective for dates of admission on or after July 1, 2013, per diem rates for specialty services will decrease by eleven and fifty one-hundredths (11.50%) from the rates that were established for dates of admission on and after February 1, 2010. This rate adjustment is in accordance with Chapter 74.60 RCW, as amended by the Legislature in 2013. The July 1, 2013, rates will be equal to the July 1, 2009, rates.
- ✓ Effective for dates of admission on or after July 1, 2014, the statewidestandardized average cost was recalculated using the same methods as described above, based on cost information for hospital fiscal years ending in 2013. The Agency applied a budget adjuster so that aggregate inpatient payments would remain constant after the rebased costs were determined.

New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to August 1, 2007. A change in ownership does not necessarily constitute the creation of a new hospital. For their per diem rate, the statewide average rate is used. For new hospitals that have direct medical education costs and a submitted Medicare cost report with at least twelve months of data, the Agency will identify and include the direct medical education cost to the hospital-specific rate. For a new hospital that has direct medical education cost and Medicare cost report submitted to Medicare with less than twelve months of data, the Agency will not identify and include the direct medical education cost to the hospital-specific rate.

k. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

PER CASE RATE

The per case rate methodology is effective August 1, 2007, through September 30, 2018, only; effective October 1, 2018, the per case rate methodology is obsolete.

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

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

The RCC method is based on each hospital's specific RCC. The RCC allowed amount for payment is calculated by multiplying the hospital's allowed covered charges for the claim by the hospital's RCC.

Rates used to pay for services are cost-based using Medicare cost report (CMS form 2552-96) 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.