Washington State Medicaid
Inpatient Hospital Rebasing Project
State Survey Questions

ID	TASK	QUESTIONS	RESPONSES
		Inpatient Utilization & Payments	
1.1		How are hospitals paid for inpatient services? (Indicate which of the following apply) ▪ AP-DRG version_____ ▪ CMS/Medicare DRG ▪ Percent of billed charges ▪ Fixed payment per case ▪ Fixed per diem ▪ ICD-9 procedure ▪ Other (please describe)	
1.2		Of total inpatient payments, indicate the percentage paid under the following payment methodologies:	• AP-DRG or CMS/Medicare DRG _____ % • Percent of billed charges _____ % • Fixed payment per case _____ % • Fixed per diem _____ % • Other Method _____ %

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1.3		How are the following services paid for?	**Neonate Services** **Transplant Services** **Rehab Services** **Psych Services** **HIV Services**
1.4		How are low volume AP-DRGs (those with no relative weight established) paid for?	
1.5		What percentage of total payments do the following services represent?	Neonate Services _____ % Transplant Services _____ % Rehab Services _____ % Psych Services _____ % AP-DRG low volume _____ %

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1.6		Are additional payments made for DSH or GME? If so, how are the additional payment amounts determined?	
1.7		Of total inpatient payments, what percentage do additional payments (for DSH and GME) represent?	
1.8	2	What has been the trend in inpatient acute care hospital billed charges in the last 5 years?	
1.9	2	What has been the inpatient acute care hospital volume trend in the last 5 years?	
1.10	2	What has been the trend in Medicaid payments for inpatient services in the last 5 years?	
1.11	2	Have there been any significant changes in Case Mix Indices in recent years? Explain?	
1.12	2	What portion of inpatient hospital payments have been made for outlier cases?	

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1.13	2	What have been the payment/utilization trends with respect to the following DRG groups? (DRGs Defined?)	
1.14	2	What have been the payment/utilization/methods for RCC claims?	
		DRG-Related Issues	
2.1	3	Which patient classification system is used (i.e., DRG grouper, AP-DRG grouper, etc.)? Which version of the grouper is used?	
2.2	3	How are the DRG[1] conversion factors determined (methods & variables)? Describe?	
2.3	3	Is there a geographic component to the conversion factor setting methodology? Describe?	

[1] For purposes of these questions, the term "DRG" is used is used as a generic term to describe any DRG-Type of payment, regardless of the patient classification system used (i.e., Medicare DRG, AP-DRG, APR-DRG, etc.).

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2.4	3	How are GME (including IME) and DSH factored into the determination of conversion factors? Describe?	
2.5	3	Do conversion factors vary for hospitals with selective contracting? If so, please describe?	
2.6	3	Do conversion factors and the DRG methodology change for border hospitals? If so, please describe?	
2.7	3	What method was used to establish relative weights?	
2.8	3	What is the methodology for rebasing/recalibrating the DRG system?	
2.9		How often is the AP-DRG relative weight recalibrated?	
2.10		How often are conversion factors rebased, updated, or recalculated?	

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2.11	5	What is the payment policy when billed charges are less than DRG payment?	
2.12	6	What is the AP-DRG or DRG outlier payment policy/methodology?	
2.13		How often is the high outlier payment policy updated?	
2.14		Are conversion factors and the high outlier policy updated concurrently?	
2.15	6	How are expected outlier payments considered or factored into the determination of conversion factors?	
2.16	6	What proportion of cases are paid using the outlier methodology?	
2.17	6	Are there interim outlier payment strategies? What are they?	
2.18	6	What methods are used to pay for transfer cases?	

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2.19	6	What is the proportion of payments and cases for which transfer payments are made?	
2.20	6	How are payments to specialty hospitals and long term care hospitals made when patients are transferred from acute care hospitals?	
2.21		Is a hospital peer group conversion used? If so, how are the peer groups defined?	
2.22		Is a blended rate (hospital specific rate and state average rate) used to determine the hospital specific rate/conversion factor?	
		Non-DRG Payment Methodologies	
3.1	3	Describe methods of reimbursement for IP that use an RCC methodology?	
3.2	3	For what services is the RCC methodology used?	

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3.3	3	How are RCCs calculated? What are the data sources that support the calculation?	
3.4	3	How often are RCCs recalculated or updated?	
3.5	3	What are "Allowable Room Rate Charges" or "Room Rate Charges?" How are they incorporated into the RCC calculation or payment methodology?	
3.6		Is there a cap for the "Allowable Room Rate Charge" or "Room Rate Charge"?	
3.7	4	Is a fixed payment per case or per diem methodology used to pay for any services outside of the standard DRG methodology? If so, for what services?	
3.8	4	Describe the fixed payment per case or per diem methodology. How are payment levels determined?	

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3.9		Is there a high outlier policy for fixed payment per case or fixed per diem payment methods? If so, how are outlier payment amounts determined?	
3.10	4	What are the advantages or disadvantages of fixed payment per case methodologies over DRGs?	
3.11	4	What are the advantages or disadvantages of fixed per diem methodologies over DRGs?	
3.12	4	What are the advantages or disadvantages of RCC-based methodologies over DRGs?	
3.13	4	What are the advantages or disadvantages of selective contracting over DRGs?	
		Critical Access Hospitals	
4.1		How many CAH hospitals are there statewide? What percentage of hospitals participate in the CAH program?	

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4.2		Of total inpatient payments, what percentage do CAH payments represent?	
4.3	3/9	What method does the state use to identify CAH hospitals?	
4.4	3/9	How does the state pay for inpatient CAH services?	
4.5	3/9	Is the State's payment methodology for CAHs different from non-CAH general acute care hospitals, and if so, how?	
4.6	3/9	If the State pays for CAH services under its general inpatient hospital methodology, does it make any special adjustments to this methodology based on CAH status? Describe?	
4.7	3/9	Is CAH status recognized under Medicaid managed care arrangements? If so, describe payment methodology.	
4.8	3/9	If payments to CAHs are cost-based, how does the State determine costs?	

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4.9	3/9	If RCCs are used to pay for CAHs, how often are the RCCs updated?	
4.10	3/9	Does the State perform cost settlements for CAHs?	
4.11	3/9	Has the State observed any decreases or increases in the number of critical access hospitals statewide? What are the reasons for changes in CAH status?	
4.12	3/9	How many CAHs are in the state currently?	
		Trauma Services	
5.1		How many designated trauma centers are there statewide? What percentage of hospitals have designated trauma centers?	
5.2		Of total inpatient payments, what percentage do payments to trauma centers represent?	
5.3	9	What are the policies and methods for Medicaid supplemental trauma care payments?	

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5.4	9	Does the State make special payments for Medicaid trauma care services?	
5.5	9	How does the State calculate these payments (e.g., an add-on by claim or lump sum by hospital)?	
5.6	9	What is the specific methodology used to determine payment?	
5.7	9	How often are these payments made?	
5.8	9	Is there a limit on the amount of these payments either by hospital or statewide (e.g., limited by an annual amount approved by the legislature)?	
5.9	9	How does the State define trauma care services – diagnosis codes? Injury Severity Score? Other?	
5.10	9	What are these specific diagnosis or procedure codes?	
5.11	9	Does the State limit trauma care payments to specific facility trauma levels?	

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5.12	9	How have the volume of trauma care services and Medicaid trauma care payments changed over time?	
5.13	9	Does the State have any estimates of Medicaid cost coverage for its trauma care services? What are they?	
5.14	9	Are hospitals eligible for other trauma care payments (i.e., trauma care fund used for the uninsured)?	
5.15	9	How are these special payments funded (i.e. tobacco tax, etc.)?	
		Border Hospitals	
6.1	3	What criteria are used to identify border hospitals?	
6.2	3	Are there different reimbursement methodologies for border hospitals? If so, what are they?	
6.3		If the payment methodologies used to pay border hospitals are not different, are border hospitals paid a discounted rate?	

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6.4	3	Are any border hospitals reimbursed based on RCC methodologies?	
		Selective Contracting	
7.1	8	Does the state selectively contract with a limited number of hospitals for all or certain inpatient services?	
7.2		What percentage of hospitals are included in the State's selective contracting program?	
7.3	8	What services are subject to selective contracting?	
7.4	8	What are the selective contracting payment approaches to IP services?	
7.5	8	On what basis does the state pay hospitals with which it selectively contracts? (e.g. confidential negotiated rates, RCC method, DRGs)	
7.6	8	If the state uses an RCC method, is payment limited by customary charges?	

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7.7	8	Is a facility-wide RCC used or departmental RCCs?	
7.8	8	What is the source of the RCCs?	
7.9	8	How often are the RCCs used for payment updated?	
	8	**Centers of Excellence**	
8.1	8	Does the state use a Centers of Excellence approach for contracting for certain tertiary and quaternary services?	
8.2	8	Describe IP Centers of Excellence programs?	
8.3	8	Does the state have performance criteria that hospitals must meet to be eligible for contracting, such as minimum number of procedures, etc.? Describe?	
8.4	8	Does the state require hospitals designated as Centers of Excellence to routinely report performance statistics?	

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8.5	8	On what basis does the state pay hospitals that are designated as Centers of Excellence, e.g. RCC, DRG, global package rate, etc.	
8.6	8	Does the global package rate for transplants include professional services and any pre- or post-transplant services?	
		IP Psychiatric Services	
9.1	7	Does the state pay for inpatient psychiatric services on a different basis than acute medical/surgical services?	
9.2	7	What is the basis of payment for inpatient psychiatric services, e.g., per diem, ratio of cost-to charges (RCC) method, etc.	
9.3	7	Is the state planning to implement a payment system based on Medicare's Inpatient Psychiatric Facility PPS?	
9.4	7	What is the basis for identifying a case as a psychiatric stay, e.g. psychiatric diagnosis, a psychiatric DRG, etc?	

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9.5	7	What is the basis of payment for a patient with psychiatric diagnosis or DRG in a general acute care hospital that does not have a distinct part psychiatric unit?	
9.6		Is an organization such as Regional Support Networks used for paying inpatient psych claims?	
		Children's Hospitals	
10.1		Are children's hospitals paid according to a different methodology than regular acute care hospitals?	
10.2		If not, does the state provide higher payment rates to children's hospitals?	
		Managed Care Plan	
11.1		How are Medicaid recipients enrolled in managed care plans?	

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11.2		How do managed care plans set rates for paying inpatient hospitals – are Medicaid rates used, or do plans directly negotiate payment rates with hospitals?	
		State Demographics	
12.1		Ho many Medicaid recipients do you have?	
12.2		What is your state's population?	