# RULE-MAKING ORDER

**CR-103P (May 2009)**
**(Implements RCW 34.05.360)**

**Agency:** Health Care Authority, Washington Apple Health

**Permanent Rule Only**

**Effective date of rule:**
**Permanent Rules**
☒ 31 days after filing.
☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**
☐ Yes    ☒ No    If Yes, explain:

**Purpose:**

The agency is amending WAC 182-551-1510 to add new language that reflects a two percent payment reduction for hospice providers who did not comply with the Medicare Quality Data Reporting Program. Amendments are necessary to implement CMS requirements under 42 U.S.C. Sec. 1395f(i)(5)(A)(i). Housekeeping changes are also included.

**Citation of existing rules affected by this order:**
Repealed:
Amended:     182-551-1510
Suspended:

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160; 42 U.S.C. Sec. 1395f(i)(5)(A)(i)

**Other authority:**

**PERMANENT RULE (Including Expedited Rule Making)**
Adopted under notice filed as WSR 16-24-056 on December 2, 2016.
Describe any changes other than editing from proposed to adopted version:  None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:                                    phone  (    ) _____
Address:                                 fax      (    ) _____
                                         e-mail  _____

**Date adopted:**  January 11, 2017

**NAME (TYPE OR PRINT)**
Wendy Barcus

**SIGNATURE**

**TITLE**
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE:  January 11, 2017
TIME:  1:38 PM

WSR 17-03-073

**(COMPLETE REVERSE SIDE)**

**Note: If any category is left blank, it will be calculated as zero. No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

| | | | | | |
|---|---|---|---|---|---|
| **Federal statute:** | New _____ | Amended _____ | Repealed _____ |
| **Federal rules or standards:** | New _____ | Amended 1 | Repealed _____ |
| **Recently enacted state statutes:** | New _____ | Amended _____ | Repealed _____ |

**The number of sections adopted at the request of a nongovernmental entity:**

New _____          Amended _____          Repealed _____

**The number of sections adopted in the agency's own initiative:**

New _____          Amended _____          Repealed _____

**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New _____          Amended _____          Repealed _____

**The number of sections adopted using:**

| | | | | | |
|---|---|---|---|---|---|
| **Negotiated rule making:** | New _____ | Amended _____ | Repealed _____ |
| **Pilot rule making:** | New _____ | Amended _____ | Repealed _____ |
| **Other alternative rule making:** | New _____ | Amended 1 | Repealed _____ |

WAC 182-551-1510  **Rates methodology and payment method for hospice agencies.**  This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The medicaid agency uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC 182-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

(a) Wage component;

(b) Wage index; and

(c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the medicaid agency bases payment rates on the core-based statistical area (CBSA) county location. CBSAs are identified in the medicaid agency's provider guides.

(4) The medicaid agency pays hospice agencies for services (not room and board) at a daily rate methodology as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence.

(b) Payments for routine home care ((~~(RHC)~~)) are based on a two-tiered payment methodology.

(i) Days one through sixty are paid at the base ((~~RHC~~)) routine home care rate.

(ii) Days sixty-one and after are paid at a lower ((~~RHC~~)) routine home care rate.

(iii) If a client discharges and readmits to a hospice agency's program within sixty calendar days of that discharge, the prior hospice days will continue to follow the client and count towards the client's eligible days in determining whether the hospice agency may bill at the base or lower ((~~RHC~~)) routine home care rate.

(iv) If a client discharges from a hospice agency's program for more than sixty calendar days, a readmit to the hospice agency's program will reset the client's hospice days.

(c) Hospice services are eligible for an end-of-life service intensity add-on ((~~(SIA)~~)) payment when the following criteria are met:

(i) The day on which the services are provided is ((~~an RHC~~)) a routine home care level of care;

(ii) The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;

(iii) The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and

(iv) The service is not provided by the social worker via telephone.

(d) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(5) The medicaid agency:

(a) Pays for routine ((~~hospice~~)) home care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(6) Hospice agencies must bill the medicaid agency for their services using hospice-specific revenue codes.

(7) For hospice clients in a nursing facility:

(a) The medicaid agency pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no more than the nursing facility's current medicaid daily rate.

(8) The medicaid agency:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(9) The daily rate for authorized out-of-state hospice services is the same as for in-state non-CBSA hospice services.

(10) The medicaid agency reduces hospice payments by two percent for providers who did not comply with the annual medicare quality data reporting program as required under 42 U.S.C. Sec. 1395f(i)(5)(A)(i). The payment reduction is effective for the fiscal reporting year in which the provider failed to submit data required for the annual medicare quality reporting program.

(a) The two percent payment reduction applies to routine home care, including the service intensity add-on, continuous home care, inpatient respite care, and general inpatient care.

(b) The two percent payment reduction does not apply to pediatric palliative care, the hospice care center daily rate, and the nursing facility room and board rate.

(c) Any provider affected by the two percent payment reduction will receive written notification.

(d) Any provider affected by the two percent payment reduction may appeal the rate reduction per WAC 182-502-0220.

(11) The client's notice of action (award) letter states the amount the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount that the client is required to pay, if any; and

(b) Must show the client's monthly required payment on the hospice claim. (Hospice providers may refer to the medicaid agency's provider guides for how to bill a hospice claim.) If a client has a required payment amount that is not reflected on the claim and the medicaid agency reimburses the amount to the hospice agency, the amount is subject to recoupment by the medicaid agency.