PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: March 01, 2018
TIME: 9:29 AM

WSR 18-06-036

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 17-18-095 **; or**

☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**

☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**

☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject)
WAC 182-550-2900 Payment limits – Inpatient hospital services
WAC 182-550-3000 Payment method
WAC 182-550-3840 Payment adjustment for potentially preventable readmissions

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
April 10, 2018	10:00 AM	Health Care Authority Cherry Street Plaza **Sue Crystal Room 106A** 626 8th Ave, Olympia, WA 98504	Metered public parking is available street side around building. A map is available at: www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than April 11, 2018 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 42716, Olympia WA 98504-2716
Email: arc@hca.wa.gov
Fax: 360) 586-9727
Other:
By (date) April 10, 2018

Assistance for persons with disabilities:
Contact Amber Lougheed
Phone: 360) 725-1349
Fax: 360) 586-9727
TTY: 800) 848-5429 or 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) April 6, 2018

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is repealing WAC 182-550-3840 and restoring previous rule language regarding 14-day readmissions to WAC 182-550-2900 and WAC 182-550-3000. The agency is making these changes because it has determined that restoring the 14-day readmission rule is the most clinically sound and cost-effective approach to managing readmissions.

Reasons supporting proposal: See Purpose.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Katie Pounds	PO Box 42716, Olympia, WA 98504-2716	(360) 725-1346
Implementation:	Grant Stromsdorfer	PO Box 45500, Olympia, WA 98504-5500	(360) 725-1678
Enforcement:	Grant Stromsdorfer	PO Box 45500, Olympia, WA 98504-5500	(360) 725-1678

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

☒ No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

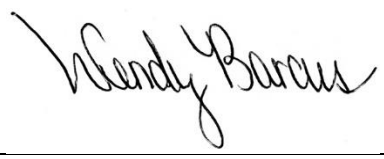
If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The updates to WAC 182-550-2900 and WAC 182-550-3000 and the repeal of WAC 182-550-3840 do not impose additional compliance costs or requirements on providers.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: March 1, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 15-24-021, filed 11/19/15, effective 1/1/16)

WAC 182-550-2900 Payment limits—Inpatient hospital services. (1) To be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the medicaid agency; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of that hospital, as defined in WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) The agency does not pay for any of the following:

(a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

(d) Additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the agency or mental health designee under WAC 182-550-2600, as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received prior authorization for an extended LOS from the agency or mental health designee as specified in WAC 182-550-4300(4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. A mental health designee may also perform those utilization reviews to evaluate an extended LOS.

(e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(f) Two separate inpatient hospitalizations if a client is readmitted to the same or affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines that one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000.

(g) A client's day(s) of absence from the hospital or distinct unit.

((~~(g)~~)) (h) A nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.

((~~(h)~~)) (i) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.

((~~(i)~~)) (j) An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before thirty-nine

weeks gestation, including induction and cesarean section, if medically necessary under WAC 182-533-0400(20).

(3) This section defines when the agency considers payment for an interim billed inpatient hospital claim.

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged before the next sixty calendar day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the agency is not the primary payer:

(i) The agency pays an interim billed nonpsychiatric claim when the criteria in (a) of this subsection are met; and

(ii) Either of the following:

(A) Sixty calendar days have passed from the date the agency became the primary payer; or

(B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(c) For psychiatric claims, (a)(i) and (b)(i) of this subsection do not apply.

(4) The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less upon the client's formal release from the hospital or distinct unit.

(5) To be eligible for payment, a hospital or distinct unit must bill the agency using an inpatient hospital claim:

(a) Under the current national uniform billing data element specifications:

(i) Developed by the National Uniform Billing Committee (NUBC);

(ii) Approved or modified, or both, by the Washington state payer group or the agency; and

(iii) In effect on the date of the client's admission.

(b) Under the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) Under the agency's published billing instructions and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the agency considers and pays an initial interim billed hospital claim and any subsequent interim billed hospital claims;

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and

(g) With the appropriate NUBC revenue code specific to the service or treatment provided to the client.

(6) When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by C.F.R. Sec. 447.271.

(7) The agency allows hospitals an all-inclusive administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care. The agency allows this day rate only when an appropriate placement outside the hospital is not available.

(8) The agency pays for observation services according to WAC 182-550-6000, 182-550-7200, and other applicable rules.

(9) The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:

(a) Client participation (e.g., spenddown);

(b) Any third-party liability amount, including medicare part A and part B; and

(c) Any other adjustments as determined by the agency.

(10) The agency pays hospitals less for services provided to clients eligible under state-administered programs, as provided in WAC 182-550-4800.

(11) All hospital providers must present final charges to the agency according to WAC 182-502-0150.

AMENDATORY SECTION (Amending WSR 15-24-096, filed 12/1/15, effective 1/1/16)

WAC 182-550-3000 Payment method. (1) The medicaid agency uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 182-550-4300 and 182-550-4400.

(2) The agency assigns a DRG code to each claim for an inpatient hospital stay using 3M™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

(i) Ratio of costs-to-charges (RCC); and

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(4) An inpatient claim payment includes all hospital covered services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) The inpatient hospital stay;

(b) Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim;

(c) Any hospital covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000
Per Diem	Hospital-specific daily rate for the service (psych, rehab, detox, or CUP) times covered allowable days	182-550-2600 and 182-550-3381
Single Case Rate	Hospital specific bariatric case rate per stay	182-550-3470
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ancillary charges that are allowable and covered for administrative days	182-550-3381

(6) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) A claim qualifies as a high outlier (see WAC 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a Washington apple health program on one or more days of the hospital stay;

(d) A client has third-party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges; ((~~or~~))

(f) A client is discharged from an inpatient hospital stay and, within fourteen calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or the agency's designee performs a retrospective utilization review (see WAC 182-550-1700) on the initial admission and all readmissions to determine which inpatient hospital stays qualify for payment;

(g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition). The agency or its designee performs a retrospective utilization review to determine if:

(i) Both admissions are appropriate and qualify for individual payments; or

(ii) The claims for these admissions must be combined to be reimbursed as one payment; or

(h) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

(b) The agency will apply the inpatient adjustment factor when the agency determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

(9) The agency does not pay for a client's day(s) of absence from the hospital.

(10) The agency pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 182-550-2900.

(11) The agency applies to the allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(12) The agency pays hospitals in designated bordering cities for allowed covered services as described in WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described in WAC 182-550-4000.

(14) The agency's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the agency would have paid using medicare payment principles.

(15) When hospital ownership changes, the agency's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(16) Hospitals participating in the Washington apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by the agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

(19) Participating hospitals must permit the agency to conduct periodic audits of their financial records, statistical records, and any other records as determined by the agency.

(20) The agency limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(21) For a client's hospital stay that involves regional support network (RSN)-approved voluntary inpatient or involuntary inpatient hospitalizations, the hospital must bill the agency for payment. When the hospital contracts directly with the RSN, the hospital must bill the RSN for payment.

(22) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the agency may manually price the claim at the hospital's psychiatric per diem rate.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-550-3840	Payment adjustment for potentially preventable readmissions.