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 02, 2018
TIME: 9:15 AM

WSR 18-06-048

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 17-17-087 **; 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 182-550-3830 Adjustments to inpatient rates
WAC 182-550-7300 OPPS – Payment limitations

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 amending WAC 182-550-3830, Adjustments to inpatient rates, to make changes to the timing of adjusting inpatient rates. The agency is amending WAC 182-550-7300, OPPS – Payment limitations, to strike subsection (5) that limits the agency's payment to the total billed charges.

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 WACs 182-550-3830 and 182-550-7300 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 2, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 15-10-014, filed 4/23/15, effective 5/24/15)

WAC 182-550-3830 Adjustments to inpatient rates. (1) The medicaid agency updates all of the following components of a hospital's specific diagnosis-related group (DRG) factor and per diem rates ((~~between rebasing periods~~)) at rebase:

(a) ((~~Effective July 1st of each year, the agency updates all of the following:~~

~~(i)~~)) Wage index adjustment;

((~~(ii)~~)) (b) Direct graduate medical education (DGME); and

((~~(iii)~~)) (c) Indirect medical education (IME).

((~~(b)~~)) (2) Effective January 1, 2015, the agency updates the sole community hospital adjustment.

((~~(2)~~)) (3) The agency does not update the statewide average DRG factor between rebasing periods, except:

(a) To satisfy the budget neutrality conditions in WAC 182-550-3850; and

(b) When directed by the legislature.

((~~(3)~~)) (4) The agency updates the wage index to reflect current labor costs in the core-based statistical area (CBSA) where a hospital is located. The agency:

(a) Determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(b) Multiplies the amount in (a) of this subsection by the most recent wage index information published by the Centers for Medicare and Medicaid Services (CMS) when the rates are set; then

(c) Adds the nonlabor portion of the base rate to the amount in (b) of this subsection to produce a hospital-specific wage adjusted factor.

((~~(4)~~)) (5) DGME. The agency obtains DGME information from the hospital's most recently filed medicare cost report that is available in the CMS health care cost report information system (HCRIS) dataset.

(a) The hospital's medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(b) If a hospital's medicare cost report is not available on HCRIS, the agency may use the CMS Form 2552-10 to calculate DGME.

(c) If a hospital has not submitted a CMS medicare cost report in more than eighteen months from the end of the hospital's cost reporting period, the agency considers the current DGME costs to be zero.

(d) The agency calculates the hospital-specific DGME by dividing the DGME cost reported on worksheet B, part 1 of the CMS cost report by the adjusted total costs from the CMS cost report.

((~~(5)~~)) (6) IME. The agency sets the IME adjustment equal to the "IME adjustment factor for Operating PPS" available in the most recent CMS final rule impact file on CMS's web site as of May 1st of the rate-setting year.

((~~(6)~~)) (7)(a) Effective January 1, 2015, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.25 if the hospital meets the criteria in this subsection.

(b) The agency considers an in-state hospital to qualify for the rate enhancement if all of the following conditions apply. The hospital must:

(i) Be certified by CMS as a sole community hospital as of January 1, 2013;

(ii) Have a level III adult trauma service designation from the department of health as of January 1, 2014;

(iii) Have less than one hundred fifty acute care licensed beds in fiscal year 2011; and

(iv) Be owned and operated by the state or a political subdivision.

(v) Not participate in the certified public expenditures (CPE) payment program defined in WAC 182-550-4650.

AMENDATORY SECTION (Amending WSR 14-14-049, filed 6/25/14, effective 7/26/14)

WAC 182-550-7300 OPPS—Payment limitations. (1) The medicaid agency limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient fee schedule published on the agency's web site, subject to the following limitations:

(a) To receive payment for services, providers must bill claims according to national correct coding initiative (NCCI) standards. When a unit limit for services is not stated in the outpatient fee schedule, the agency pays for services according to the program's unit limits stated in applicable WAC and published provider guides.

(b) The average resource, including units of service, are factored into the enhanced ambulatory patient group (EAPG) weight determination, and the allowable units of service for EAPGs is equal to one.

(2) The following service categories are included in the EAPG payment for significant procedure(s) on the claim and do not receive separate payments under EAPG:

(a) Services classified as the same or clinically related to the main significant procedure;

(b) Routine ancillary services;

(c) Chemotherapy services grouped as class I, class II, or minor; and

(d) Pharmacotherapy services grouped as class I, class II, or minor.

(3) The agency reduces the EAPG payment by fifty percent based on the default EAPG grouper settings for services subject to one or more of the following discounts:

(a) Multiple procedures;

(b) Repeat ancillary services; or

(c) A terminated procedure.

(4) The agency limits outpatient services billing to one claim per episode of care. If any line of the claim is denied, or a service that was provided was not stated on the initial submitted claim, the agency requires the entire claim to be adjusted.

((~~(5) The agency limits payments to the total billed charges.~~))