RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: April 11, 2018
TIME: 9:14 AM

WSR 18-09-022

Agency: Health Care Authority

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 182-550-3830, Adjustments to inpatient rates, to make changes to the timing of inpatient rates adjustments. 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.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-3830, 182-550-7300
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 18-06-048 on March 2, 2018 (date).

Describe any changes other than editing from proposed to adopted version: NA

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

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

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Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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 on the agency's own initiative:

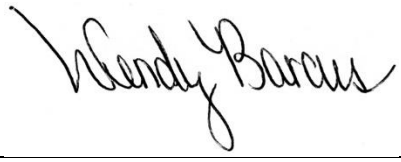
	New	____	Amended	____	Repealed	____

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

	New	____	Amended	2	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	2	Repealed	____

Date Adopted: April 11, 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.~~))