RULE-MAKING ORDER
PERMANENT RULE ONLY

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

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FILED

DATE: May 30, 2018
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WSR 18-12-043

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) July 1, 2018 **(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 WACs 182-550-3600 and 182-550-3700 to align with Medicare changes to outlier pricing. The agency is amending WAC 182-550-3800 to reflect changes in the rebasing process. These changes are being made due to audit findings by the Office of the Washington State Auditor and in response to provider inquiries regarding the grouper version used by the agency. The agency is amending WAC 182-550-4800 to remove specification of the all-patient refined-diagnostic-related group (APR-DRG) grouper version.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-3600, 182-550-3700, 182-550-3800, 182-550-4800
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 18-09-112 on April 18, 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Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended		Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended		Repealed	____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	4	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	4	Repealed	____

Date Adopted: May 30, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 14-12-047, filed 5/29/14, effective 7/1/14)

WAC 182-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. (1) The rules in this section apply when an eligible client transfers from an acute care hospital or distinct unit to any of the following:

(a) Another acute care hospital or distinct unit;

(b) A skilled nursing facility (SNF);

(c) An intermediate care facility (ICF);

(d) Home care under the medicaid agency's home health program;

(e) A long-term acute care facility (LTAC);

(f) Hospice (facility-based or in the client's home);

(g) A hospital-based, medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 182-550-3000); or

(h) A nursing facility certified under medicaid but not medicare.

(2) The medicaid agency pays a transferring hospital the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) The prorated DRG payment, which the agency calculates by:

(i) Using the average length of stay (ALOS) for the assigned DRG:

(A) The agency uses the 3M national average length of stay for paying inpatient claims.

(B) The agency publishes ALOS values on its web site;

(ii) Dividing the hospital's allowed payment amount for the assigned DRG by the ALOS in (b)(i) of this subsection;

(iii) Determining the client length of stay as all medically necessary days at the transferring hospital, plus one day; and

(iv) Multiplying the number in (b)(ii) of this subsection by the length of stay determined in (b)(iii) of this subsection.

(3) The agency applies the outlier payment method if a transfer case qualifies as a high outlier. To qualify for a high outlier, the costs (ratio of cost-to-charges multiplied by covered allowed charges) for the transfer must exceed the outlier threshold. The threshold is the ((~~DRG allowed amount (hospital-specific rate multiplied by DRG relative weight)~~)) prorated DRG amount plus forty thousand dollars. The prorated amount is the lesser of:

(a) The per diem DRG allowed amount (hospital's rate multiplied by relative weight for the DRG code assigned to the claim by the agency) divided by the average length of stay (for the DRG code assigned by the agency for the claim) multiplied by the client's length of stay plus one day; or

(b) The total DRG payment allowed amount calculation for the claim.

(4) The agency does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(5) The agency pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the agency's maximum payment to a discharging hospital.

(6) The agency pays an intervening hospital a per diem payment based on the method described in subsection (2) of this section.

(7) The transfer payment policy described in this section does not apply to claims grouped into DRG classifications the agency pays

based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(8) The agency applies the following to the payment for each claim:

(a) All applicable adjustments for client responsibility;

(b) Any third-party liability;

(c) Medicare payments; and

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

AMENDATORY SECTION (Amending WSR 14-12-047, filed 5/29/14, effective 7/1/14)

WAC 182-550-3700 DRG high outliers. (1) The medicaid agency identifies a diagnosis-related group (DRG) high outlier claim based on the claim's estimated costs. The agency allows a high outlier payment for claims paid using the DRG payment method when high outlier criteria are met.

(a) To qualify as a DRG high outlier claim, the estimated costs for the claim must be greater than the outlier threshold effective for the date of admission. The outlier threshold amount is depicted in the following table:

Dates of Admission	Pediatric	Nonpediatric
February 1, 2011 - July 31, 2012	Base DRG * 1.50	Base DRG * 1.75
August 1, 2012 - June 30, 2013	Base DRG * 1.429	Base DRG * 1.667
July 1, 2013 - June 30, 2014	Base DRG * 1.563	Base DRG * 1.823
July 1, 2014, and after	Base DRG + $40,000	Base DRG + $40,000

(b) The agency calculates the estimated costs of the claim by multiplying the total submitted charges, minus the nonallowed charges on the claim, by the hospital's ratio of costs-to-charges (RCC).

(c) When a transferring hospital submits a transfer claim to the agency, the high outlier criteria used to determine whether the claim qualifies for high outlier payment is the prorated DRG ((~~allowed~~)) amount for the claim before the transfer payment ((~~reduction~~)).

(2) The agency calculates the high outlier payment by multiplying the hospital's estimated cost above threshold (CAT) by the outlier adjustment factor. The outlier adjustment factors, which vary by dates of admission and inpatient payment policy, are depicted in the table at the end of this subsection.

(a) For inpatient claims paid under the all-patient-diagnosis-related group (AP-DRG), the agency uses a separate outlier adjustment factor for:

(i) Pediatric services, including all claims submitted by children-specialty hospitals;

(ii) Burn services; and

(iii) Nonpediatric services.

(b) For inpatient claims paid under the all-patient refined-DRG (APR-DRG), the agency uses a separate outlier adjustment factor for a:

(i) Severity of illness (SOI) of one or two; or

(ii) SOI of three or four.

AP-DRG Dates of Admission	Pediatric	Burn	Nonpediatric
Before August 1, 2012	CAT * 0.95	CAT * 0.90	CAT * 0.85

August 1, 2012 - June 30, 2013	CAT * 0.998	CAT * 0.945	CAT * 0.893
July 1, 2013 - June 30, 2014	CAT * 0.912	CAT * 0.864	CAT * 0.816
APR-DRG Dates of Admission	**SOI 1 or 2**	**SOI 3 or 4**	
July 1, 2014, and after	CAT * 0.80	CAT * 0.95	

(3) For state-administered programs (SAP), the agency applies the hospital-specific ratable to the outlier adjustment factor.

(4) This subsection contains examples of outlier claim payment calculations.

DRG SOI	DRG Allowed Amount	Threshold[1]	Cost[2]	Outlier Percent	Ratable	Base DRG	Outlier[3]	Claim Payment[4]
1	$10,000	$50,000	$100,000	0.80	n/a	$10,000	$40,000	$50,000
3	$10,000	$50,000	$100,000	0.95	n/a	$10,000	$47,500	$57,500

[1] Threshold = $40,000 + base DRG

[2] Cost = Billed charges - noncovered charges - denied charges

[3] Outlier = (cost - threshold) * outlier percent

[4] Claim payment = base DRG + outlier

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 182-550-3000(8), the agency may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the outlier adjustment factors described in this section.

(6) The agency applies the following to the payment for each claim:

(a) All applicable adjustments for client responsibility;

(b) Any third-party liability;

(c) Medicare payments; and

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

AMENDATORY SECTION (Amending WSR 14-12-047, filed 5/29/14, effective 7/1/14)

WAC 182-550-3800 Rebasing. The medicaid agency redesigns (rebases) the medicaid inpatient payment system as needed. The base inpatient conversion factor and per diem rates are only updated during a detailed rebasing process, or as directed by the state legislature. Inpatient payment system factors such as the ratio of costs-to-charges (RCC), weighted costs-to-charges (WCC), and administrative day rate are rebased on an annual basis. As part of the rebasing, the agency does all of the following:

(1) Gathers data. The agency uses the following data resources considered to be the most complete and available at the time:

(a) One year of fee-for-service (FFS) paid claim data from the agency's medicaid management information system (MMIS). The agency excludes:

(i) Claims related to state programs and paid at the Title XIX reduced rates from the claim data; and

(ii) Critical access hospital claims paid per WAC 182-550-2598; and

(b) The hospital's most current medicare cost report data from the health care cost report information system (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS). If the hospital's medicare cost report from HCRIS is not available, the agency uses the medicare cost report provided by the hospital.

(c) FFS and managed care encounter data.

(2) Estimates costs. The agency uses one of two methods to estimate costs. The agency may perform an aggregate cost determination by multiplying the ratio of costs-to-charges (RCC) by the total billed charges, or the agency may use the following detailed costing method:

(a) The agency identifies routine and ancillary cost for operating capital, and direct medical education cost components using different worksheets from the hospital's medicare cost report;

(b) The agency estimates costs for each claim in the dataset as follows:

(i) Accommodation services. The agency multiplies the average hospital cost per day reported in the medicare cost report data for each type of accommodation service (e.g., adult and pediatric, intensive care unit, psychiatric, nursery) by the number of days reported at the claim line level by type of service; and

(ii) Ancillary services. The agency multiplies the RCC reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, or clinic) by the allowed charges reported at the claim line level by type of service; and

(c) The agency uses the following standard cost components for accommodation and ancillary services for estimating costs of claims:

(i) Routine cost components:

(A) Routine care;
(B) Intensive care;
(C) Intensive care-psychiatric;
(D) Coronary care;
(E) Nursery;
(F) Neonatal ICU;
(G) Alcohol/substance abuse;
(H) Psychiatric;
(I) Oncology; and
(J) Rehabilitation.

(ii) Ancillary cost components:

(A) Operating room;
(B) Recovery room;
(C) Delivery/labor room;
(D) Anesthesiology;
(E) Radio, diagnostic;
(F) Radio, therapeutic;
(G) Radioisotope;
(H) Laboratory;
(I) Blood administration;
(J) Intravenous therapy;
(K) Respiratory therapy;
(L) Physical therapy;
(M) Occupational therapy;
(N) Speech pathology;
(O) Electrocardiography;
(P) Electroencephalography;
(Q) Medical supplies;
(R) Drugs;
(S) Renal dialysis/home dialysis;

(T) Ancillary oncology;
(U) Cardiology;
(V) Ambulatory surgery;
(W) CT scan/MRI;
(X) Clinic;
(Y) Emergency;
(Z) Ultrasound;
(AA) NICU transportation;
(BB) GI laboratory;
(CC) Miscellaneous; and
(DD) Observation beds.

(3) Specifies resource use with relative weights. The agency uses national relative weights designed by 3M™ Corporation as part of its all-patient refined-diagnostic related group (APR-DRG) payment system. The agency periodically reviews and determines the most appropriate APR-DRG grouper version to use.

(4) Calculates base payment factors. The agency calculates the average, or base, DRG conversion factor and per diem rates. The base is calculated as the maximum amount that can be used, along with all other payment factors and adjustments described in this chapter((~~, to maintain aggregate payments across the system~~)). The agency models the rebased system to be budget neutral on a prospective basis, including global adjustments to the budget target determined by the agency. The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients. The agency will publish base rate factors on its web site.

(5) ((~~Determines~~)) To maintain budget neutrality, the agency makes global adjustments as needed.

(a) Claims paid under the DRG, rehab per diem, and detox per diem payment methods were reduced to support an estimated three million five hundred thousand dollar increase in psychiatric payments to acute hospitals.

(b) Claims for acute hospitals paid under the psychiatric per diem method were increased by a factor to inflate estimated system payments by three million five hundred thousand dollars.

(c) Effective for dates of admission on and after October 1, 2017, the agency increased psychiatric per diem rates as directed by the legislature. The increase applies to any hospital with two hundred or more psychiatric bed days.

(i) The agency prioritized the increase for hospitals not currently paid based on provider-specific costs using a similar methodology to set rates for existing inpatient facilities utilizing cost report information for hospital fiscal years ending in 2016.

(ii) The distribution of funds for each fiscal year is as follows:

(A) Free-standing psychiatric hospitals receive 68.15 percent of the statewide average cost per day.

(B) All other hospitals receive the greater of 78.41 percent of their provider-specific cost, or their current medicaid psychiatric per diem rate.

(iii) The agency set the increased rates to assure that the distribution of funds does not exceed the amounts provided by the legislature.

(iv) The agency conducts annual reviews for updated cost information to determine whether new and existing providers meet the two hundred or more bed criteria.

(v) The agency will apply the same cost percentage criteria for future rebasing of the psychiatric per diem rates.

(6) Determines provider specific adjustments. The following adjustments are applied to the base factor or rate established in subsection (4) of this section:

(a) Wage index adjustments reflect labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(i) The agency determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(ii) The amount in (a)(i) of this subsection is multiplied by the most recent wage index information published by CMS at the time the rates are set; then

(iii) The agency adds the nonlabor portion of the base rate to the amount in (a)(ii) of this subsection to produce a hospital-specific wage adjusted factor.

(b) Indirect medical education factors are applied to the hospital-specific base factor or rate. The agency uses the indirect medical education factor established by medicare on the most currently available medicare cost report that exists at the time the rates are set; and

(c) Direct medical education amounts are applied to the hospital-specific base factor or rate. The agency determines a percentage of direct medical education costs to overall costs using the most currently available medicare cost report that exists at the time the rates are set.

(7) The final, hospital-specific rate is calculated using the base rate established in subsection (4) of this section along with any applicable adjustments in subsections (5) and (6) of this section.

AMENDATORY SECTION (Amending WSR 14-12-047, filed 5/29/14, effective 7/1/14)

WAC 182-550-4800 Hospital payment methods—State-administered programs. This section does not apply to out-of-state hospitals unless they are border hospitals (critical or noncritical).

(1) The medicaid agency:

(a) Pays for services provided to a client eligible for a state-administered program (SAP) based on SAP rates;

(b) Establishes SAP rates independently from the process used in setting the medicaid payment rates;

(c) Calculates a ratable each year to adjust each hospital's SAP rates for their percentage of community-based dollars to the total revenues for all hospitals;

(d) Calculates an equivalency factor (EF) to keep the SAP payment rates at the same level before and after the medicaid rates were rebased.

(2) The agency has established the following:

(a) SAP diagnosis-related group (DRG) conversion factor (CF) for claims grouped under DRG classifications services;

(b) SAP per diem rates for claims grouped under the following specialty service categories:

(i) Chemical-using pregnant (CUP) women;

(ii) Detoxification;

(iii) Physical medicine and rehabilitation (PM&R); and

(iv) Psychiatric;

(c) SAP per case rate for claims grouped under bariatric services; and

(d) SAP ratio of costs-to-charges (RCC) for claims grouped under transplant services.

(3) This subsection describes the SAP DRG CF and payment calculation processes used by the agency to pay claims using the DRG payment method. The agency pays for services grouped to a DRG classification provided to clients eligible for a SAP based on the use of a DRG CF, a DRG relative weight, and a maximum service adjustor. This process is similar to the payment method used to pay for medicaid and CHIP services grouped to a DRG classification.

(a) The agency's SAP DRG CF calculation process is as follows:

(i) The hospital's specific DRG CF used to calculate payment for a SAP claim is the medicaid DRG CF multiplied by the applicable EF multiplied by the ratable;

(ii) For hospitals that do not have a ratable or an EF, the SAP CF is the hospital's specific medicaid CF multiplied by the average EF and the average ratable; and

(iii) For noncritical border hospitals, the SAP DRG CF is the lowest in-state medicaid DRG CF multiplied by the average ratable and the average EF.

(b) The agency calculates the SAP DRG EF as follows:

(i) The hospital-specific current SAP DRG CF is divided by the rebased medicaid DRG CF and then divided by the ratable factor to compute the preliminary EF.

(ii) The current SAP DRG payment is determined by multiplying the hospital specific SAP DRG CF by the AP-DRG version 23 relative weight.

(iii) The current aggregate DRG payment is determined by summing the current SAP DRG payments for all hospitals.

(iv) The hospital projected SAP DRG payment is determined by multiplying the hospital specific current SAP DRG CF by the APR-DRG relative weights ((~~version 31.0~~)) and the maximum service adjustor.

(v) The projected aggregate DRG payment is determined by summing the projected SAP program DRG payments for all hospitals.

(vi) The aggregate amounts derived in (b)(iii) and (v) of this subsection are compared to identify a neutrality factor that keeps the projected aggregate SAP DRG payment (based on DRG-APR relative weights ((~~version 31.0~~))) at the same level as the ((~~current~~)) previous aggregate SAP DRG payment (based on AP-DRG relative weights version 23.0).

(vii) The neutrality factor is multiplied by the hospital specific preliminary EF to determine the hospital specific final EF that is used to determine the SAP DRG conversion factors for the rebased system implementation.

(c) The agency calculates the DRG payment for services paid under the DRG payment method as follows:

(i) The agency calculates the allowed amount for the inlier portion of the SAP DRG payment by multiplying the SAP DRG CF by the DRG relative weight and the maximum service adjustor.

(ii) SAP claims are also subject to outlier pricing. See WAC 182-550-3700 for details on outlier pricing.

(4) This subsection describes how the agency calculates the SAP per diem rate and payment for CUP, detoxification, PM&R, and psychiatric services.

(a) The agency calculates the SAP per diem rate for in-state and critical border hospitals by multiplying the hospital's specific medicaid per diem by the ratable and the per diem EF.

(b) The agency calculates the SAP per diem rate for noncritical border hospitals by multiplying the lowest in-state medicaid per diem rate by the average ratable and the average per diem EF.

(c) For hospitals with more than twenty nonpsychiatric SAP per diem paid services during SFY 2011, the agency calculates a per diem EF for each hospital using the individual hospital's claims as follows:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments by the total number of days associated with the payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payments (same claims used in (c)(i) of this subsection).

(iii) The agency divides the hospital estimated SAP average payment per day in (a) of this subsection by the hospital medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (c)(iii) of this subsection by the hospital specific ratable factor to determine the EF.

(d) For hospitals with twenty or less nonpsychiatric SAP per diem paid services during SFY 2011, the EF is an average for all hospitals. The agency uses the following process to determine the average EF:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments for all hospitals by the total number of days associated with the aggregate payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payment (same claims used in (d)(i) of this subsection).

(iii) The agency divides the SAP average per day in (a) of this subsection by the medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (d)(iii) of this subsection by the hospital specific ratable factor to determine the EF. The EF is an average based on claims for all the hospitals in the group.

(e) A psychiatric EF is used to keep SAP psychiatric rates at the level required by the Washington state legislature. The agency's SAP psychiatric rates are eighty-five and four one hundredths of a percent (85.04%) of the agency's medicaid psychiatric rates. The factor is applied to all hospitals.

(f) The agency calculates the SAP per diem allowed amount for CUP, detoxification, PM&R, and psychiatric services by multiplying the hospital's SAP per diem rate by the agency's allowed patient days.

(g) The agency does not apply the high outlier or transfer policy to the payment calculations for CUP, detoxification, PM&R, and psychiatric services.

(5) This subsection describes the SAP per case rate and payment processes for bariatric surgery services.

(a) The agency calculates the SAP per case rate for bariatric surgery services by multiplying the hospital's medicaid per case rate for bariatric surgery services by the hospital's ratable.

(b) The per case payment rate for bariatric surgery services is an all-inclusive rate.

(c) The agency does not apply the high outlier or transfer policy to the payment calculations for bariatric surgery services.

(6) The agency calculates the SAP RCC by multiplying the medicaid RCC by the hospital's ratable.

(7) The agency establishes annually the hospital-specific ratable factor used in the calculation of SAP payment rate based on the most current hospital revenue data available from the department of health (DOH). The agency uses the following process to determine the hospital ratable factor:

(a) The agency adds the hospital's medicaid revenue, medicare revenue, charity care, and bad debts as reported in DOH data.

(b) The agency determines the hospital's community care dollars by subtracting the hospital's low-income disproportionate share hospital (LIDSH) payments from the amount derived in (a) of this subsection.

(c) The agency calculates the hospital net revenue by subtracting the hospital-based physician revenue (based on information available from the hospital's medicare cost report or provided by the hospitals) from the DOH total hospital revenue report.

(d) The agency calculates the preliminary hospital-specific ratable by dividing the amount derived in (b) of this subsection by the amount derived in (c) of this subsection.

(e) The agency determines a neutrality factor by comparing the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the preliminary ratable to the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the prior year ratable. The neutrality factor is used to keep the projected SAP payments at the same current payment level.

(f) The agency determines the final hospital-specific ratable by multiplying the hospital-specific preliminary ratable by the neutrality factor.

(g) The agency applies to the allowable for each SAP claim all applicable adjustments for client responsibility, any third-party lia-

bility, medicare payments, and any other adjustments as determined by the agency.

(8) The agency does not pay an SAP claim paid by the DRG method at greater than the billed charges.

(9) SAP rates do not apply to the critical access hospital (CAH) program's weighted cost-to-charges, to the long-term acute care (LTAC) program's per diem rate, or to the certified public expenditure (CPE) program's RCC (except as the RCC applies to the CPE hold harmless described in WAC 182-550-4670).