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 filing these rules to implement a population-based, data-driven approach to affect inpatient hospital readmission rates and related costs. The anticipated result is a more efficient use of health care dollars. By improving the quality of care provided during an inpatient admission, improving discharge planning, improving community provider connections to deliver post-discharge care, and assuring post-discharge care coordination, preventable readmissions will be avoided.

Citation of existing rules affected by this order:

Repealed:

Amended: WAC 182-550-3000, WAC 182-550-3840

Suspended:

Statutory authority for adoption: RCW 41.05.021, RCW 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 15-19-159 on September 23, 2015.

Describe any changes other than editing from proposed to adopted version: N/A

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: December 1, 2015

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: December 01, 2015
TIME: 8:02 AM

WSR 15-24-096

(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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	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New _____ Amended _____ Repealed _____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New _____ Amended _____ Repealed _____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 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	

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

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

Payment Method	General Description of Payment Formula	WAC Reference
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 its designee performs a retrospective utilization review (see WAC 182-550-1700) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) 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 both admissions are appropriate and qualify for individual payments;~~

~~(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.

NEW SECTION

WAC 182-550-3840 Payment adjustment for potentially preventable readmissions. (1) The medicaid agency adjusts the payment rate to a hospital with an excessive number of potentially preventable readmissions (PPRs), using the criteria described in subsection (4) of this section. The agency calculates the number of excess PPRs using a risk-adjusted comparison, as described in subsection (5) of this section, between the actual and expected number of PPRs attributable to a hospital, and prospectively reduces the payment.

(2) Payment reductions under this section do not apply to critical access hospitals under WAC 182-550-2598; however, critical access hospital claims are included in the PPR analysis.

(3) The following definitions and those found in chapter 182-500 WAC apply to this section:

(a) "Actual PPR chains" means the number of PPR chains attributable to a hospital, based on the PPR analysis.

(b) "Excess PPR chains" means the difference between a hospital's actual PPR chains and the expected PPR chains, not to be less than 0.

(c) "Expected PPR chains" means the number of PPR chains expected for a hospital, based on the hospital's mix of services provided and clients served in the PPR analysis.

(d) "Excess readmission payments" means a hospital's number of excess readmissions multiplied by the average payments per PPR chain.

(e) "Initial admission" means an admission to a hospital that is not identified as a PPR that is followed by a PPR for the same recipient within thirty days, as determined by the PPR software under standard settings.

(f) "Nonqualifying admission" means an admission excluded from the determination of readmissions by the PPR software under standard settings. Nonqualifying admissions exclude initial admissions, only admissions, and PPRs.

(g) "Only admission" means an admission that is not a PPR, an initial admission, or other nonqualifying admission, as determined by the PPR software under standard settings.

(h) "Potentially preventable readmission (PPR)" means a readmission meeting the criteria in subsection (4) of this section that follows a prior discharge from a hospital within thirty days for the same recipient, as determined by the PPR software under standard settings. A PPR can occur at the same hospital as the initial readmission or at a different hospital.

(i) "Potentially preventable readmission chain" or "PPR chain" means the collection of one or more PPRs attributable to an initial admission.

(j) "PPR analysis" means the historical claims data processed by the PPR software under standard settings used to determine each hospital's excess PPR chains, as described in subsection (5) of this section.

(k) "PPR software" means the software created and maintained by the 3M™ Corporation and currently used by the agency to identify PPRs. This software is programmed to include admission inclusion and exclu-

sion criteria and factors in an adjustment for pediatric admissions and those admissions with a mental health diagnosis code, but are not classified as a mental health admission.

(l) "Readmission reduction factor" means a prospective reduction to inpatient payment rates based on the excess readmissions payments divided by the total hospital inpatient payments in the PPR analysis. The agency will consider a cap on this reduction to the inpatient payment rate each year.

(4) Readmission criteria. A PPR is an inpatient readmission within thirty days after discharge that is clinically related to the initial admission, as defined by the PPR software using standard settings. A PPR meets the following criteria:

(a) The readmission is potentially preventable through appropriate care consistent with accepted standards in the prior discharge or during the postdischarge follow-up period;

(b) The readmission is for a condition or procedure related to the care provided during the prior discharge or during the period immediately after the prior discharge;

(c) The PPR chain has one or more readmissions that are clinically related to the initial admission. The first readmission is within thirty days after the initial admission, and the thirty-day time frame begins again at the discharge of the most recent readmission; and

(d) The readmission is to the same or to any other hospital.

(e) For the purposes of determining PPRs, certain services and circumstances are excluded from the analysis including, but not limited to:

(i) Leukemia;

(ii) Lymphoma;

(iii) Chemotherapy;

(iv) Neonatal admission;

(v) Hospitalization with a discharge status of "left against medical advice";

(vi) Admission to an acute care hospital for clients assigned to the base APR DRG for rehabilitation, aftercare, and convalescence;

(vii) Same-day transfer to an acute care hospital for nonacute care (for example: Hospice care);

(viii) Malignancy and selected disorders or diseases with chemotherapy or radiotherapy procedures (for example: Connective tissue or coagulation and platelet disorders); and

(ix) Out-of-state admission.

(5) Methodology to determine excess readmissions.

(a) The agency's analysis is based on the 3M™ Health Information Systems Potentially Preventable Readmissions Classification System under standard settings currently used by the agency.

(b) The following readmissions are excluded from the PPR analysis prior to processing the claims data through the PPR software:

(i) Enrollees in state-only programs;

(ii) Dually eligible medicare/medicaid enrollees;

(iii) Mental health and chemical dependency claims covered by the division of behavioral health and recovery (DBHR); and

(iv) Claims occurring at out-of-state, noncritical border hospitals.

(c) Nonqualifying admissions identified by the PPR software under standard settings are excluded from the determination of excess PPR chains.

(d) The following claims are also excluded from the determination of excess PPR chains:

(i) Trauma claims qualifying for supplemental payments for approved trauma service centers under WAC 182-550-5450;

(ii) Newborn cases with the mother's patient information reported in the claim;

(iii) Newborn jaundice cases; and

(iv) Transplant diagnosis-related group (DRG) initial admissions or admissions within one hundred eighty days of a transplant DRG.

(e) The agency will prospectively apply a readmission reduction factor to inpatient rates for dates of service provided on January 1, 2016, through June 30, 2016, based on a PPR analysis consisting of the following claims data:

(i) PPR analysis will consist of fee-for-service (FFS) and managed care claims data, including claims denied under the legacy readmission policy under WAC 182-550-3000, and excluding the claims described in (b) of this subsection.

(ii) PPR analysis claim services dates will consist of discharge dates within state fiscal year 2014 (July 1, 2013, through June 30, 2014), with the following exceptions:

(A) PPR analysis will include PPRs with a discharge date after state fiscal year 2014 that were in a PPR chain with an initial admission discharge date in state fiscal year 2014.

(B) PPR analysis will exclude PPRs with a discharge date in state fiscal year 2014 that were in a PPR chain with an initial admission discharge date before state fiscal year 2014.

(iii) A readmission reduction factor for each hospital is based on the hospital's excess readmission payments divided by the total hospital inpatient payments in the PPR analysis.

(f) The agency will annually update the readmission reduction factors on July 1st, starting on July 1, 2016, based on a PPR analysis consisting of the following claims data:

(i) PPR analysis will consist of FFS and managed care claims data, including claims denied under the legacy readmission policy under WAC 182-550-3000, and excluding the claims described in (b) of this subsection.

(ii) PPR analysis claim services dates will consist of discharge dates within the calendar year prior to the July 1st effective date (for readmission reduction factors effective July 1, 2016, the PPR analysis will be based on claims with discharge dates in calendar year 2015), with the following exceptions:

(A) PPR analysis will include PPRs with a discharge date after the calendar year that were in a PPR chain where the initial admission discharge date was in the calendar year.

(B) PPR analysis will exclude PPRs with a discharge date in the calendar year that were in a PPR chain where the initial admission discharge date was before the calendar year.

(iii) A readmission reduction factor for each hospital is based on the hospital's excess readmission payments divided by the total hospital inpatient payments in the PPR analysis.