



# 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 amending these rules to replace the single routine home care (RHC) per diem rate with a two-tiered payment model for RHC days, add a service intensity add-on payment, and include housekeeping changes. Amendments are necessary to implement new CMS requirements for RHC rates.

**Citation of existing rules affected by this order:**

Repealed:  
 Amended: 182-551-1510  
 Suspended:

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160, 42 CFR 418 Subpart G

**Other authority:**

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 16-11-101 on May 18, 2016.  
 Describe any changes other than editing from proposed to adopted version: None

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:** June 23, 2016

**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: June 23, 2016**  
**TIME: 11:04 AM**

**WSR 16-14-009**

**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:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	<u>1</u>	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	<u>  </u>	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	_____	Amended	<u>1</u>	Repealed	_____

**WAC 182-551-1510 Rates methodology and payment method for hospice agencies.** This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The medicaid agency uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC 182-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

- (a) Wage component;
- (b) Wage index; and
- (c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the medicaid agency bases payment rates on the ~~((metropolitan))~~ core-based statistical area ~~((MSA))~~ (CBSA) county location. ~~((MSAs))~~ CBSAs are identified in the medicaid agency's provider guides.

~~(4) ((Payment rates for:~~

~~(a) Routine and continuous home care services are based on the county location of the client's residence.~~

~~(b) Inpatient respite and general inpatient care services are based on the MSA county location of the providing hospice agency.~~

~~(5))~~ The medicaid agency pays hospice agencies for services (not room and board) at a daily rate ~~((calculated))~~ methodology as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence ~~((+or))~~.

(b) Payments for routine home care (RHC) are based on a two-tiered payment methodology.

(i) Days one through sixty are paid at the base RHC rate.

(ii) Days sixty-one and after are paid at a lower RHC rate.

(iii) If a client discharges and readmits to a hospice agency's program within sixty calendar days of that discharge, the prior hospice days will continue to follow the client and count towards the client's eligible days in determining whether the hospice agency may bill at the base or lower RHC rate.

(iv) If a client discharges from a hospice agency's program for more than sixty calendar days, a readmit to the hospice agency's program will reset the client's hospice days.

(c) Hospice services are eligible for an end-of-life service intensity add-on (SIA) payment when the following criteria are met:

(i) The day on which the services are provided is an RHC level of care;

(ii) The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;

(iii) The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and

(iv) The service is not provided by the social worker via telephone.

(d) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

~~((+6))~~ (5) The medicaid agency:

(a) Pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death;  
(b) Does not pay room and board for the day of death; and  
(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

~~((7))~~ (6) Hospice agencies must bill the medicaid agency for their services using hospice-specific revenue codes.

~~((8))~~ (7) For hospice clients in a nursing facility:

(a) The medicaid agency pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no more than the nursing facility's current medicaid daily rate.

~~((9))~~ (8) The medicaid agency:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

~~((10))~~ (9) The daily rate for authorized out-of-state hospice services is the same as for in-state (~~non-MSA~~) non-CBSA hospice services.

~~((11))~~ (10) The client's notice of action (award) letter states the amount (~~of participation~~) the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount (~~of the client's participation if the client has~~) that the client is required to pay, if any; and

(b) Must show the client's monthly (~~participation~~) required payment on the hospice claim. (Hospice providers may refer to the medicaid agency's provider guides for how to bill a hospice claim.) If a client has a (~~participation~~) required payment amount that is not reflected on the claim and the medicaid agency reimburses the amount to the hospice agency, the amount is subject to recoupment by the medicaid agency.