



PROPOSED RULE MAKING

CR-102 (June 2004)

(Implements RCW 34.05.320)

Do **NOT** use for expedited rule making

Agency: Department of Social and Health Services, Health and Recovery Services Administration

- Preproposal Statement of Inquiry was filed as WSR 09-04-072 ; or
- Expedited Rule Making--Proposed notice was filed as WSR _____ ; or
- Proposal is exempt under RCW 34.05.310(4).

- Original Notice
- Supplemental Notice to WSR
- Continuance of WSR

Title of rule and other identifying information: (Describe Subject)

The department is amending:

- WAC 388-502-0150 Time limits for providers to bill MAA.
- WAC 388-550-2800 Payment methods and limits—Inpatient hospital services for Medicaid and State Children’s Health Insurance Program (SCHIP) clients.
- WAC 388-550-3000 Payment method—Diagnosis related groups (DRG).
- WAC 388-550-3010 Payment method—Per diem payment.
- WAC 388-550-3020 Payment method—Bariatric surgery—Per case payment.
- WAC 388-550-3460 Payment method—Per diem rate.
- WAC 388-550-3900 Payment method—Bordering city hospitals and critical border hospitals.
- WAC 388-550-4000 Payment method—Emergency services—Out-of-state hospitals.

Hearing location(s):

Office Building 2 - Auditorium
 (DSHS Headquarters)
 1115 Washington
 Olympia, WA 98504
 Public parking at 11th and Jefferson. A map is available at:
<http://www1.dshs.wa.gov/msa/rpau/RPAU-OB-2directions.html>
 or by calling 360-664-6094.

Date: **May 26, 2009** Time: **10:00 a.m.**

Submit written comments to:

Name: DSHS Rules Coordinator
 Address: PO Box 45850, Olympia WA, 98504-5850
 Delivery: 4500 – 10th Ave. SE, Lacey, Washington 98503
 E-mail: DSHSRPAURulesCoordinator@dshs.wa.gov
 Fax: (360) 664-6185

by
5 p.m. on May 26, 2009

Assistance for persons with disabilities: Contact Jennisha Johnson, DSHS Rules Consultant by May 12, 2009

TTY (360) 664-6178 or (360) 664-6094 or
by e-mail at johnsjl4@dshs.wa.gov

Date of intended adoption: Not sooner than May 27, 2009
(Note: This is **NOT** the **effective** date)

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

See “**ATTACHMENT**”

Reasons supporting proposal: The department must meet the legislature’s targeted budget expenditure levels for payment of hospital and hospital-related services provided to medical assistance clients.

Statutory authority for adoption: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530

Statute being implemented: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500

Is rule necessary because of a:

- Federal Law? Yes No
 - Federal Court Decision? Yes No
 - State Court Decision? Yes No
- If yes, CITATION:

DATE

March 30, 2009

NAME (type or print)

Stephanie Schiller

SIGNATURE

TITLE

DSHS Rules Coordinator

CODE REVISER USE ONLY

**OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED**

DATE: March 31, 2009

TIME: 5:24 PM

WSR 09-08-117

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Name of proponent: (person or organization) Department of Social and Health Services

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Kathy Sayre	PO Box 45505, Olympia WA 98504-5504	(360) 725-1342
Implementation.... Carolyn Adams	PO Box 45510, Olympia WA 98504-5510	(360) 725-1854
Enforcement..... Carolyn Adams	PO Box 45510, Olympia WA 98504-5510	(360) 725-1854

Has a small business economic impact statement been prepared under chapter 19.85 RCW?

Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ()

fax ()

e-mail

No. Explain why no statement was prepared.

These rules do not impact small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name: Carolyn Adams

Address: Health and Recovery Services Administration

PO Box 45510

Olympia, WA 98504-5510

phone (360) 725-1854

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e-mail adamscr@dshs.wa.gov

No: Please explain:

ATTACHMENT to CR-102

Amending WAC 388-502-0150 and WAC 388-550-2800, 3000, 3010, 3020, 3460, 3900, and 4000

The proposed changes update and clarify hospital-related and provider-related sections and are intended to address the anticipated levels of funding from the legislature, inform providers of program changes, and clarify and update current language. These rules:

- Add language putting providers on notice that the department will make adjustments to existing inpatient hospital rates and/or payment methods, by applying an “inpatient adjustment factor,” when directed by the legislature to achieve targeted budget expenditure levels;
- Add language regarding the department’s intent to apply the inpatient adjustment factor in a proportional manner across the inpatient hospital rates and payment methods;
- Add language that makes a delivery by cesarean section without complications and comorbidities payable at the same rate as a vaginal birth with complicated diagnosis;
- Expand the types of facilities and/or programs to which an acute care hospital or distinct unit can transfer an eligible client and receive a prorated diagnosis related group (DRG) payment from the department;
- Add clarifying language that the department uses the per diem payment method to pay for hospital stays that have insufficient data available to determine stable relative weights and for other specified specialty services;
- Add language that the department may adjust the DRG conversion factor when directed by the legislature to achieve budgetary targets;
- Add language that the department may adjust the per diem rate when directed by the legislature to achieve budgetary targets;
- Add language that the department may adjust a per case payment when directed by the legislature to achieve budgetary targets;
- Put in rule how per diem rates are determined for chronic pain services;
- Remove “emergency services” from the title of WAC 388-550-4000 and clarify that the section applies to both emergency and nonemergency services provided by out-of-state hospitals;
- Add language that the department may adjust the outlier threshold or the percentages of outlier adjustment factors when directed by the legislature to achieve budgetary targets; and
- Reduce the total period allowed for resubmission or modification of a claim, other than a prescription drug or major trauma claim, from thirty-six months to twenty-four months from the date of service, effective with dates of services or admission on and after July 1, 2009;
- Add language specifying a three-hundred sixty-five-day limit for resubmission or modification of a claim for major trauma services, consistent with the limit set in WAC 388-550-5450 and 388-531-2000; and
- Update, clarify, and rearrange current language for improved readability.

AMENDATORY SECTION (Amending WSR 00-14-067, filed 7/5/00, effective 8/5/00)

WAC 388-502-0150 Time limits for providers to bill ((MAA)) the department. Providers ((may)) must bill the ~~((medical assistance administration (MAA)))~~ department for covered services provided to eligible clients((~~-~~)) as follows:

(1) ((MAA)) The department requires providers to submit initial claims and adjust prior claims in a timely manner. ((MAA)) The department has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims and claims for major trauma services, see subsections (7) and (8) of this section; ((and))

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to ((MAA)) the department as described in ((MAA's)) the department's current published billing instructions.

(3) Providers must submit ((their)) the initial claim to ((MAA)) the department and have an internal control number (ICN) assigned by ((MAA)) the department within three hundred sixty-five calendar days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders ((MAA)) the department to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) ((MAA)) The department may grant exceptions to the time limit of three hundred sixty-five ~~((=day time limit))~~ calendar days for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retroactive period; or

(b) The provider proves to ((MAA's)) the department's satisfaction that there are other extenuating circumstances.

(5) ((MAA)) The department requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to ((MAA's)) the department's billing limits.

(6) When a client is covered by both medicare and ((MAA)) medicaid, the provider must bill medicare for the service before billing ((medicaid)) the initial claim to the department. If medicare:

(a) Pays the claim the provider must bill ((MAA)) the department within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, ((MAA)) the department requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) ((MAA allows providers to)) The following applies to claims with a date of service or admission before July 1, 2009:

(a) Within thirty-six months of the date the service was provided to the client, a provider may resubmit, modify, or adjust any claim, other than a prescription drug claim or a claim for major trauma services, with a timely ICN ((within thirty-six months of the date the service was provided to the client)). This applies to any claim, other than a prescription drug claim or a claim for major trauma services, that met the time limits for an initial claim, whether paid or denied. ((MAA)) The department does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(b) After thirty-six months from the date the service was provided to the client, a provider cannot refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(8) ((The thirty-six-month period described in subsection (7) of this section does not apply to overpayments that a provider must refund to the department. After thirty-six months, MAA does not allow a provider to refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check)) The following applies to claims with a date of service or admission on or after July 1, 2009:

(a) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(b) After twenty-four months from the date the service was provided to the client, the department does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the department by a negotiable financial instrument, such as a bank check.

(9) ((MAA)) The department allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within fifteen months of the date the service was provided to the client. After fifteen months, ((MAA)) the department does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) ((MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements of this section, resulting in the claim not being paid by MAA)) The department allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and

sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the department. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the department.

(13) If a provider fails to bill a claim according to the requirements of this section and the department denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

AMENDATORY SECTION (Amending WSR 07-14-018, filed 6/22/07, effective 8/1/07)

WAC 388-550-2800 Payment methods and limits--Inpatient hospital services for medicaid and SCHIP clients. The term "allowable" used in this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department pays hospitals for medicaid and SCHIP inpatient hospital services using the rate setting methods identified in the department's approved state plan as follows:

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Diagnosis related group (DRG) negotiated conversion factor	Hospitals participating in the medicaid hospital selective contracting program under waiver from the federal government	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed ((amount)) amount, minus the third-party payment amount and any client responsibility amount.

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
DRG cost-based conversion factor	Hospitals not participating in or exempt from the medicaid hospital selective contracting program	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed ((amount)) <u>amount</u> , minus the third-party payment amount and any client responsibility amount.
Ratio of costs-to-charges (RCC)	Some services exempt from DRG payment methods	The allowable minus the third-party payment amount and any client responsibility amount.
((Costs-to-charges rate with a "hold harmless" settlement provision)) <u>Ratio of costs-to-charges (RCC) subject to cost settlement</u>	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	((For the "hold harmless" settlement, the lesser of the billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount.)) The payment made is the federal share ((only)) <u>of costs after deducting any third party payment amount and any client responsibility amount.</u>
Single case rate	Hospitals eligible to provide bariatric surgery to medical assistance clients	Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the single case rate allowed amount minus the third-party payment amount and any client responsibility amount.
Fixed per diem rate	Long-term acute care (LTAC) hospitals	Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the per diem allowed amount minus the third-party payment amount and any client responsibility amount.
Per diem rate	Some providers/services exempt from the DRG payment methods	Per diem allowed amount, and for some services a high outlier amount, minus the third-party ((payer)) <u>payment</u> amount and any client responsibility amount.

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Cost settlement	DOH-approved critical access hospitals (CAHs)	The allowed amount, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.
Medicaid base community psychiatric hospitalization rate	Nonstate-owned free-standing psychiatric hospitals located in Washington state	Paid according to applicable payment method in WAC 388-550-2650 for medicaid and SCHIP clients, minus the third-party payment amount and any client responsibility amount.

See WAC 388-550-4800 for payment methods used by the department for inpatient hospital services provided to clients eligible under state-administered programs. The department's policy for payment on state-administered program claims that involve third-party liability (TPL) and/or client responsibility payments on claims is the same policy indicated in the table in subsection (1) ~~((in))~~ of this section. However, to determine the department's payment on the claim, state-administered program rates, not medicaid or SCHIP rates, apply when comparing the lesser of either the billed amount minus the third-party payment and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount.

(2) In response to direction from the legislature, the department may change any one or more payment methodologies outlined in chapter 388-550 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 department in the biennial appropriations act. In response to this legislative direction, the department 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 department and applied to existing inpatient hospital rates in order to meet targeted expenditure levels as directed by the legislature.

(b) The department will apply the inpatient adjustment factor when the department determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The department will apply any such inpatient adjustment factor to each affected rate in a proportional manner.

(3) The department's annual aggregate medicaid and SCHIP payments to each hospital for inpatient hospital services provided to medicaid and SCHIP clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR Sec. 447.271). The department recoups annual aggregate medicaid and SCHIP payments that are in excess of the usual and

customary charges.

~~((+3+))~~ (4) The department's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the department would have paid using medicare payment principles.

~~((+4+))~~ (5) When hospital ownership changes, the department's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v) (1) (O).

~~((+5+))~~ (6) Hospitals participating in the department's medical assistance program must annually submit to the department:

(a) A copy of the hospital's CMS medicare cost report (form 2552-96) 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 388-550-4900 for the requirements for a hospital to qualify for a DSH payment.

~~((+6+))~~ (7) Reports referred to in subsection ~~((+5+))~~ (6) 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 department.

~~((+7+))~~ (8) The department requires hospitals to follow generally accepted accounting principles.

~~((+8+))~~ (9) Participating hospitals must permit the department to conduct periodic audits of their financial records, statistical records, and any other records as determined by the department.

~~((+9+))~~ (10) The department 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.

~~((+10+))~~ (11) For a client's hospital stay that involves both regional support network (RSN)-approved voluntary inpatient and involuntary inpatient hospitalizations, the hospital must bill the department for payment, unless the hospital contracts directly with the RSN. In that case, the hospital must bill the RSN for payment.

~~((+11+))~~ (12) Refer to subsection (1) of this section for how the department adjusts inpatient hospital claims for third party payment amounts and any client responsibility amounts.

AMENDATORY SECTION (Amending WSR 07-14-055, filed 6/28/07, effective 8/1/07)

WAC 388-550-3000 Payment method--DRG. (1) The department uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) The department uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. The department periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes all covered hospital services provided to a client during days the client is eligible, but is not

limited to:

(a) An inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, 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 (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient hospital stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's specific DRG conversion factor. See WAC 388-550-3450. The total allowed amount also includes any high outlier amount calculated for claims. (~~See WAC 388-550-3450 and 388-550-4600(4)~~).

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific DRG conversion factor rate used in calculating the DRG payment.

(6) The department's DRG payment to a hospital may be adjusted when one or more of the following occur:

(a) For dates of admission before August 1, 2007, a claim qualifies as a DRG high-cost or low-cost outlier, and for dates of admission on and after August 1, 2007, a claim qualifies as a DRG high outlier (see WAC 388-550-3700);

(b) A client transfers;

(i) Before July 1, 2009, from one acute care hospital or distinct unit to another acute care hospital or distinct unit; or

(ii) On and after July 1, 2009 from one acute care hospital or distinct unit to:

(A) Another acute care hospital or distinct unit;

(B) A skilled nursing facility (SNF);

(C) An intermediate care facility;

(D) Home care under the department'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 388-550-3600); or

(H) A nursing facility certified under medicaid but not

medicare.

(c) A client is not eligible for a medical assistance program on one or more ~~((of the))~~ 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 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 seven calendar days, is readmitted as an inpatient to the same hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for DRG payment. Upon the department's retrospective review, an outlier payment may be made if the department determines the claim for combined hospital stays qualifies as a high-cost outlier or high outlier. See WAC 388-550-3700 for DRG high-cost outliers and high outliers.

~~((+6))~~ (7) For dates of admission on and after July 1, 2009, the department pays inpatient claims assigned by the all-patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.

(8) The department does not pay for a client's day(s) of absence from the hospital.

~~((+7))~~ (9) The department pays an interim billed hospital claim or covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

~~((+8))~~ (10) The department applies to the payment for each claim all applicable ~~((claim payment))~~ adjustments for client responsibility, any third party liability, medicare, ~~((etc., to the payment))~~ and any other adjustments as determined by the department.

(11) The department pays hospitals in designated bordering cities for allowed covered services as described in WAC 388-550-3900.

(12) The department pays out-of-state hospitals for allowed covered services as described in WAC 388-550-4000.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

WAC 388-550-3010 Payment method--Per diem payment. (1) Effective for dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay some covered inpatient hospital services as specified in this section and WAC 388-550-4300, 388-550-4400, and 388-550-3460.

(2) The per diem payment method is effective for dates of admission before, on, and after August 1, 2007, for the following:

(a) Long term acute care (LTAC) ~~((7))~~;

(b) Hospital administrative day ~~((7))~~ bed; and

(c) Hospital swing bed ~~((is effective for dates of admission~~

before, and on and after, August 1, 2007)).

((+2)) (3) The department uses the all-patient diagnosis related group (AP-DRG) grouper ((software)) to assign a DRG classification to each inpatient hospital stay. The department ((periodically evaluates which version of the AP-DRG grouper software to use and updates the grouper version. This update is normally completed once every three years during inpatient payment system rebasing)) uses the per diem payment method to pay for hospital stays that have insufficient data available to determine stable relative weights and other specialty services identified in WAC 388-550-3460.

((+3)) (4) A per diem payment includes, but is not limited to:

(a) A hospital covered service(s) provided to a client during the client's inpatient hospital stay.

(b) An outpatient hospital covered service(s), including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital ((stay)) admission. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

((+4)) (5) The department ((has established)) establishes an average length of stay (ALOS) for each DRG classification during the rebasing process. The DRG ALOS is used as a benchmark to authorize and pay for inpatient hospital stays that are exempt from the DRG payment method. See WAC 388-550-4300(6).

((+5)) (6) The department's per diem payments to ((hospitals)) a hospital may be adjusted when one or more of the following occur:

(a) A claim qualifies as a per diem high outlier claim (see WAC 388-550-3700). The outlier provision does not include a claim grouped to a DRG classification in a specialty service category. The specialty ((services)) service categories include psychiatric, rehabilitation, detoxification, and CUP program services. Long term acute care (LTAC), administrative days and swing bed days do not qualify for high outlier payment((+)).

(b) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay((+)).

(c) A client has third party liability coverage at the time of

admission to the hospital or distinct unit(~~(7)~~).

(d) A client is eligible for medicare, and medicare has made a payment for the hospital charges(~~(7 or)~~).

(e) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital or a different hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which, if any, inpatient hospital stay(s) qualify for payment. An outlier payment may be made if the department determines the claim for the combined hospital stays qualifies as a high outlier. (See WAC 388-550-3700 for high outliers.)

(f) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the per diem rate payments.

~~((7))~~ (7) The department does not pay for a client's day(s) of absence from the hospital.

~~((7))~~ (8) The department 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 388-550-2900.

~~((8))~~ (9) The department applies to the payment for each claim, all applicable ((claim payment)) adjustments for client responsibility, any third party liability, medicare, ((etc., to the payment)) and any other adjustments as determined by the department.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

WAC 388-550-3020 Payment method--Bariatric surgery--Per case payment. (1) The department pays designated department-approved hospitals for prior authorized bariatric surgery when the criteria in WAC 388-550-2301 are met. Claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) do not qualify for outlier payments.

~~(2) ((For dates of admission before and on and after August 1, 2007,))~~ The department pays for claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) using a per case rate. See WAC 388-550-3470.

(3) The department applies to the payment for each claim, all applicable ((claim payment)) adjustments for client responsibility, any third party liability, medicare, ((etc., to the payment)) and any other adjustments as determined by the department.

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific per case rate.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

WAC 388-550-3460 Payment method--Per diem rate. (1) For dates of admission before August 1, 2007 the department established per diem rates for:

(a) Inpatient chronic pain management as ~~((indicated))~~ specified in WAC 388-550-2400;

(b) Long term acute care (LTAC) hospitals as ~~((indicated))~~ specified in WAC 388-550-2595;

(c) Community psychiatric inpatient hospitalization as ~~((indicated))~~ specified in WAC 388-550-2650; and

(d) Administrative day status, and nursing facility swing bed day status, as ~~((indicated))~~ specified in WAC 388-550-4500 as it existed before July 1, 2009 or WAC 388-550-4550 for these services effective for dates of admission on and after July 1, 2009.

(2) For dates of admission on and after August 1, 2007, the department continues to pay per diem ~~((s))~~ rates for the services identified in subsection (1), except for the community psychiatric inpatient hospitalization per diem indicated in subsection (1)(c).

(3) For dates of admission on and after August 1, 2007, with the exception of community psychiatric inpatient services, the department establishes per diem rates for specialty services that are generally based on statewide standardized average cost per day amounts, which are then adjusted to reflect the unique characteristic of hospitals in the state of Washington for payment purposes.

(a) The department calculates separate statewide standardized per diem rates for the following categories:

(i) Rehabilitation services--Rehabilitation claims are identified as all claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals and freestanding rehabilitation hospitals including distinct part units;

(ii) Detoxification services--Detoxification claims are identified as all claims from hospital-based detoxification units, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.

(iii) CUP women program services--Chemically using pregnant (CUP) women program services are identified as any claims with units of service (days) submitted to revenue code 129 in the claim record.

(b) The department calculates hospital-specific per diem rates for all medicaid services provided by free-standing psychiatric hospitals, and all psychiatric services provided by acute care hospitals, including distinct part units.

(c) To determine statewide standardized cost per day amounts for rehabilitation, detoxification and CUP women program services, the department uses the estimated costs of the claims identified for each category based on the department's cost finding process for the system. These claims include any statistical outliers.

These statewide standardized amounts serve as the basis for calculating per diem rates for each hospital for each service. The department then makes adjustments to the cost amounts for each hospital to factor out differences related to approved medical education programs.

(i) For each in-state acute care hospital, excluding critical access hospitals (CAHs) and LTAC hospitals, the department estimates operating and capital costs for each of the three specialty services.

(ii) The department then adjusts these costs to remove the indirect costs associated with approved medical education programs.

Medicare publishes separate indirect medical education factors for operating and capital components, so these adjustments are made separately for both of these components. These factors are intended to reflect the indirect costs incurred by hospitals in support of approved graduate medical education programs.

(A) For hospital-specific operating costs, the department adjusts the labor portion of the hospital-specific operating costs by the most ~~((currently available))~~ current hospital-specific medicare wage index established and published by medicare ~~((that exists))~~ at the time of the medicaid rebasing; then adds the nonlabor portion to the result; then divides the result by (1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor established by medicare that exists at the time of the medicaid rebasing); then divides that result by the hospital-specific medicaid case-mix index; then

(B) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific medicare capital indirect medical education factor); then divides the result by the hospital-specific medicaid case-mix; then

(iii) The department then sums the costs and days for all included hospitals for each service, and calculates each ~~((services+))~~ service's statewide standardized weighted average cost per day amounts, weighted based on number of days.

(d) Once the department establishes the statewide standardized amounts, hospital-specific per diem rates for each specialty service are calculated.

(i) Starting with the statewide standardized operating amount, the department multiplies the labor portion of the amount ~~((to determine the labor portion, the department used the factor established by medicare multiplied by the statewide operating standardized amount))~~ by the most ~~((currently available))~~ current hospital-specific medicare wage index established and published by medicare ~~((that exists))~~ at the time of the medicaid rebasing ~~((, as published by medicare))~~. (To determine the labor portion, the department uses the factor established by medicare multiplied by the statewide operating standardized amount.) This adjustment is made to reflect wage differences incurred by hospitals in different regions of the state. The department then adds the nonlabor portion to the result.

(ii) The department-adjusted operating and capital amounts reflect the indirect costs associated with approved teaching programs. The department adjusts for the indirect costs by multiplying the operating and capital amounts by (1.0 plus the most currently available hospital-specific medicare indirect medical

education factor in the medicare final rule for the operating and capital components). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(iii) The department then adds to the operating and capital amounts the hospital-specific direct medical education cost per day (hospital-specific direct medical education cost per day adjusted for hospital-specific case-mix index).

(iv) Finally, the department adjusts the facility-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(e) Specialty service claims are not eligible for high outlier payments. See WAC 388-550-3700.

(4) For dates of admission on and after August 1, 2007, the department establishes hospital-specific per diem rates for psychiatric services provided by instate noncritical access hospitals that are free-standing psychiatric hospitals, acute care hospitals with psychiatric distinct part units, or other acute care hospitals.

(a) The department identifies psychiatric claims for hospitals meeting the criteria in this subsection as all claims from free-standing psychiatric hospitals, and all claims with a psychiatric diagnosis (i.e., assigned to a psychiatric AP-DRG classification) at the acute care hospitals. The department includes all claims from freestanding psychiatric hospitals, regardless of AP-DRG assignment.

(b) To determine a facility-specific payment rate per day for psychiatric services, the department uses the greater of the estimated costs per diem of the:

(i) Hospital's inpatient psychiatric claims in the base year dataset; or

(ii) Statewide average of the estimated costs of the hospital's inpatient psychiatric claims (as described in subsection (4)(a)) in the base year claims including adjustments for regional wage differences and for differences in medical education costs.

(c) The department calculates average cost per day amounts for each hospital and then makes adjustments to the average cost per day amounts to reflect changes in the indirect medical education factor and hospital-specific wage index between the base year and the implementation year.

(d) Finally, the department adjusts the hospital-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(5) For dates of admission on and after August 1, 2007, for hospitals not meeting the criteria in subsection (4), the department calculates per diem rates using the same method used for

rehabilitation, detoxification and CUP women program payments described in this section, except that the department uses only the psychiatric claims from those facilities identified as qualifying for hospital-specific rates.

(6) For dates of admission on and after August 1, 2007, for freestanding rehabilitation facilities, the department uses the per diem rate established for rehabilitative services rather than a facility-specific rate.

(7) For dates of admission on and after August 1, 2007, for claims that are classified into AP-DRG classifications that do not have enough claims volume to establish stable relative weights, and that are not specialty claims as described in this section, the department also uses a per diem rate.

(a) These types of claims are less homogeneous than the specialty claims described in this section, and the costs of these claims are more variable than the costs of those that are included under the DRG payment method. The department conducts significant analyses to establish per diem rates based on groupings that would distinguish between higher cost per day claims and lower cost per day claims. As part of this analysis, the department analyzes costs per day based on the following criteria for groupings, which are not mutually exclusive:

(i) Neonatal claims, based on assignment to major diagnostic category (MDC) 15;

(ii) Burn claims based on assignment to MDC 22;

(iii) AP-DRG assignments that include primarily medical procedures;

(iv) AP-DRG assignments that include primarily surgical procedures;

(v) Cranial procedure claims, based on specific cranial procedure AP-DRG classifications, and

(vi) MDC assignment.

(b) Based on the analyses of cost per day amounts for each grouping criteria identified in subsection (7)(a), the department identified four nonspecialty service groupings appropriate for establishing per diem payments. These are:

(i) Neonatal claims, based on assignment to MDC 15;

(ii) Burn claims based on assignment to MDC 22;

(iii) AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified in this subsection; and

(iv) AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified in this subsection.

(c) For each service group, except for burn cases, the department calculates a per diem rate for each hospital based on the aggregate statewide weighted average cost per day for the service after adjusting costs for regional wage differences and differences in graduate medical education program costs. (~~((Unstable burn claim))~~) For burn cases, per diem rates are based on the average operating and capital cost per day (~~((of unstable burn claims at))~~) for Harborview Medical Center, which (~~((treats))~~) had the vast majority of burn cases in the state.

(d) The per diem calculations are based on the estimated costs of the claims for each service group in the base year, including both fee-for-service and healthy options claims data. After

determining the statewide weighted average cost per day after these adjustments, the department calculates the per diem rate for each hospital for each service group by adjusting the statewide weighted average cost per day amount for each hospital based on its hospital-specific wage index and medical education program costs.

(e) Because of the variability of the cost of claims in unstable AP-DRG classifications, the department developed an outlier policy for these per diem payments, similar to the outlier methodology recommended for the DRG payment method.

(f) Claims that are not in the specialty service groupings indicated in subsection (3)(a) and (b), may qualify for a high outlier payment if the claim qualifies under the high outlier criteria. See WAC 388-550-3700.

(8) For dates of admission on and after August 1, 2007, for inpatient chronic pain services, the department establishes per diem rates based on allowed charges data that the department obtains from the hospital. The department determines the hospital per diem rate by identifying costs and dividing the total cost by the number of days associated with the cost.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

WAC 388-550-3900 Payment method--Bordering city hospitals and critical border hospitals. (~~((1) For dates of admission before August 1, 2007, under the diagnosis-related group (DRG) payment method:~~

~~(a) The department calculates the cost-based conversion factor (CBCF) of a bordering city hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.~~

~~(b) For a bordering city hospital with no medicare cost report (Form 2552-96) for the rebasing year, the department assigns the department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.~~

~~(2) For dates of admission before August 1, 2007, the department calculates:~~

~~(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.~~

~~(b) For a bordering city hospital with no medicare cost report submitted to the department, its RCC is based on the Washington in-state average RCC.~~

~~(3) For dates of admission before August 1, 2007, the department pays a bordering city hospital using the same payment methods as for an in-state hospital for allowed covered charges related to medically necessary services identified on an outpatient hospital claim.~~

~~(4) For dates of admission on and after August 1, 2007, with the exception of outpatient payment to hospitals previously paid under the outpatient prospective payment system (OPPS) methodology and critical border hospitals located in bordering cities, the department pays bordering city hospitals for allowed covered charges related to medically necessary services based on the~~

~~inpatient and outpatient hospital rates and payment methods used to pay out-of-state hospitals. See WAC 388-550-4000.~~

~~(5) For dates of admission on and after August 1, 2007, the department pays a critical border hospital for allowed covered charges related to medically necessary services identified on an inpatient hospital claim:~~

~~(a) Under one of the inpatient DRG, RCC, per diem, or per case rate payment methods that are similar to the methods used to pay instate hospitals;~~

~~(b) Using a DRG conversion factor, per diem, or per case rate based on the statewide standardized average that will result in payment that does not exceed the payment that would be made to any instate hospital for the same service, including medical education components of payments; and~~

~~(c) Using a hospital's specific RCC rate based on the hospital's annual medicare cost report information for the applicable period. For a critical border hospital that does not submit a medicare cost report to the department, the department determines which instate hospital has the lowest RCC rate and uses that rate as the critical border hospital's RCC rate.~~

~~(6) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. Those rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital. Bordering city hospitals' base period claims data is analyzed during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies as a critical border hospital.~~

~~(7) For dates of admission on and after August 1, 2007, the department pays a critical border hospital for allowed covered charges related to medically necessary services identified on an outpatient hospital claim using the outpatient hospital payment methods and payment criteria identified in WAC 388-550-6000 and 388-550-7200. The department limits payment to bordering city hospitals that are noncritical border hospitals to the lesser of the billed charges or the calculated payment amount.~~

~~(8) The department makes applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to claim payments)) The department uses the payment methods described in this section to pay bordering city hospitals and critical border hospitals for inpatient and outpatient claims. Bordering city hospitals and critical border hospitals are defined in WAC 388-550-1050.~~

(1) Bordering city hospitals--Inpatient hospital claim payment methods.

(a) For dates of admission before August 1, 2007, under the diagnosis related group (DRG) payment method:

(i) The department calculates the cost-based conversion factor (CBCF) of a bordering city hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department assigns the department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(b) For dates of admission before August 1, 2007, under the ratio of costs-to-charges (RCC) payment method:

(i) The department calculates the RCC in accordance with WAC 388-550-4500.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department bases the RCC on the Washington instate average RCC.

(c) For dates of admission on and after August 1, 2007:

(i) The department calculates the payment for allowed covered charges related to medically necessary services, using the lowest of the instate inpatient hospital rates without graduate medical education (GME) (excluding DWCC rates that are paid to instate critical access hospitals) for the DRG conversion factor, the per diem, per case, and RCC payment methods; and

(ii) The department pays the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(2) Bordering city hospitals--Outpatient hospital claim payment methods for allowed covered charges related to medically necessary services.

(a) For bordering city hospitals paid according to the outpatient prospective payment system (OPPS), refer to WAC 388-550-7000 through 388-550-7600. The department uses the following types of payment methods used in OPPS:

(i) Ambulatory payment classification (APC) method (the primary payment method for OPPS) (WAC 388-55-7200):

(A) Before August 1, 2007, the department determines the OPPS conversion factor using the methods described in WAC 388-550-7500.

(B) On and after August 1, 2007, the department pays using the lowest instate OPPS conversion factor.

(ii) OPPS maximum allowable fee schedule (WAC 388-550-7200).

(iii) Hospital outpatient RCC rate (WAC 388-550-4500).

(A) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(B) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(b) For bordering city hospitals exempt from OPPS, the department uses the following payment methods:

(i) Outpatient maximum allowable fee schedule (WAC 388-550-6000); and

(ii) Hospital outpatient RCC rate (WAC 388-550-4500).

(c) When the RCC payment method described in WAC 388-550-4500 is used to pay for outpatient services provided:

(i) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(ii) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(d) When the maximum allowable fee schedule method is used to pay for outpatient services provided, the department pays the lesser of the:

(i) Billed charges; or

(ii) Calculated payment amount.

(3) Designated critical border hospitals.

(a) Beginning August 1, 2007, the department designated

certain qualifying hospitals located out-of-state as critical border hospitals. A designated critical border hospital must:

(i) Be a bordering city hospital as described in WAC 388-550-1050; and

(ii) Have submitted at least ten percent of the total nonemergency inpatient hospital claims that have been paid to bordering city hospitals for the prior state fiscal year (SFY) for clients eligible for Washington state medicaid and state-administered programs. Nonemergency inpatient hospital claims are defined as those that do not include emergency room charges (revenue code 045X series).

(b) The department analyzes bordering city hospitals' base period claims data during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies or continues to qualify as a critical border hospital.

(4) Critical border hospitals--Inpatient hospital claim payment methods. The department pays inpatient critical border hospital claims with dates of services on and after August 1, 2007, as follows:

(a) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. The rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital.

(b) The department pays inpatient critical border hospital claims using the same payment methods and rates as for instate hospital claims, including DRG, RCC, per diem, outliers, and per case rate, subject to the following:

(i) Inpatient payment rates used to pay critical border university hospitals for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an instate university hospital;

(ii) Inpatient payment rates used to pay critical border Level 1 trauma centers for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an instate Level 1 trauma center; and

(iii) Inpatient payment rates used to pay critical border hospitals not listed in (A) and (B) of this subsection for inpatient hospital claims cannot exceed the highest corresponding instate inpatient payment rate for instate hospitals that are not designated as:

(A) Critical access hospitals (CAHs);

(B) University hospitals; or

(C) Level 1 trauma centers.

(5) Critical border hospitals--Outpatient hospital claim payment methods. The department pays outpatient critical border hospital claims with dates of services on and after August 1, 2007, using the same payment methods as for instate outpatient hospital claims, including the APC method using the hospital's OPSS conversion factor, maximum allowable fee schedule method, and the hospital outpatient RCC rate method (refer to WAC 388-550-7000 through 388-550-7600 and WAC 388-550-4500), subject to the following:

(a) Outpatient rates used to pay critical border university hospitals for outpatient claims cannot exceed the highest corresponding rate for an instate university hospital.

(b) Outpatient rates used to pay critical border Level 1

trauma centers for outpatient claims cannot exceed the highest corresponding rate for an instate Level 1 trauma center.

(c) Outpatient rates used to pay the critical border hospitals not listed in (i) and (ii) of this subsection for outpatient claims cannot exceed the highest corresponding rate for instate hospitals that are not designated as:

(i) Critical access hospitals (CAH);

(ii) University hospitals; or

(iii) Level 1 trauma centers.

(6) Critical border hospitals are eligible to receive payment for graduate medical education (GME). All other bordering city hospitals are not eligible to receive payment for GME.

(7) The department makes:

(a) Claim payment adjustments, including but not limited to, third party liability, medicare, and client responsibility; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

WAC 388-550-4000 Payment method--(~~Emergency services--~~) Out-of-state hospitals. ((The department pays for emergency services that are covered by the department and provided to eligible medical assistance clients as follows:)) This section describes the payment methods the department uses to pay hospitals located out-of-state for providing services to eligible Washington state medical assistance clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC 388-501-0175. Payment methods that apply to bordering city hospitals, including critical border hospitals, are described in WAC 388-550-3900.

(1) (~~For dates of admission~~) Emergency hospital services before August 1, 2007(~~, the department pays~~).

(a) ~~For~~ inpatient hospital claims for emergency services provided in out-of-state hospitals(~~(7)~~) with dates of admission before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) (~~The~~) Weighted average of ratio of costs-to-charges (RCC) ratios for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(b) ~~For~~ outpatient hospital claims for emergency services provided in out-of-state hospitals(~~(7)~~) with the first date of service before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) (~~The~~) Weighted average of hospital outpatient (~~hospital~~) RCC rates for instate hospitals multiplied by the allowed covered charges for medically necessary services.

(2) (~~For dates of admission~~) Emergency hospital services on and after August 1, 2007(~~, the department pays~~).

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals ((under the inpatient diagnostic related group (DRG), ratio of costs-to-charges (RCC), per diem, and per case rate payment methods, whether or not the hospital has submitted a medicare cost report (Form 2552-96) to the department for the rebasing year.)) with dates of admission on and after August 1, 2007, the department:

(i) Pays ((an out-of-state hospital and bordering city hospital that is not a critical border hospital, using the lowest of the instate inpatient hospital rates, and excludes payment for medical education (out-of-state hospitals are not eligible to receive payment for medical education). This rate is the same rate calculated for all rural hospitals in Washington for the same service (excluding DWCC rates that are paid to instate critical access hospitals)) using the same methods used to pay instate hospitals:

(A) Diagnosis related group (DRG) (WAC 388-550-3000);

(B) Per diem (WAC 388-550-3010);

(C) DRG and per diem outliers (WAC 388-550-3700); and

(D) Ratio of costs-to-charges (RCC) (WAC 388-550-4500).

(ii) Pays ((a department designated critical border hospital according to WAC 388-550-3900)) using the lowest instate inpatient hospital rate corresponding to the payment method used in (a) (i) of this subsection.

(iii) Limits payment to out-of-state hospitals ((and bordering city hospitals that are noncritical border hospitals)) to the lesser of the:

(A) Billed charges; or ((the))

(B) Calculated payment amount.

(b) ((Pays)) For outpatient hospital claims for emergency services provided in out-of-state hospitals ((that are)) with dates of service on or after August 1, 2007, the department pays an out-of-state hospital using one or both of the following methods:

(i) ((Bordering city hospitals, including critical border hospitals previously paid under the outpatient prospective payment system (OPPS) methodology for dates of admission before August 1, 2007, in accordance with WAC 388-550-7200; and

(ii) Out-of-state hospitals, including bordering city hospitals not previously paid under the OPPS methodology, the lesser of)) The maximum allowable fee schedule method described in WAC 388-550-6000, and limits payment when the maximum allowable fee schedule method is used to the lesser of the:

(A) Billed charges; or

(B) ((The instate average hospital outpatient rate times the allowed covered charges for medically necessary services)) Calculated payment amount.

(ii) The hospital outpatient RCC method described in WAC 388-550-4500. When using the RCC payment method, the department pays the lowest instate hospital outpatient RCC rate, excluding departmental weighted costs-to-charges (DWCC) rates that are paid to instate critical access hospitals.

(c) Out-of-state hospitals are not eligible to receive payment for graduate medical education (GME).

(3) The department makes:

(a) Claim payment adjustments, including but not limited to client responsibility, third party liability, and medicare; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

(4) Nonemergency services. The department does not pay for nonemergency hospital services provided to a medical assistance client ~~((s))~~ in a hospital located out-of-state ~~((hospitals))~~ unless the ~~((facility))~~ hospital is contracted and/or prior authorized by the department or the department's designee, for the specific service provided.

~~((i))~~ (a) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.

~~((ii))~~ (b) Authorized services are paid according to subsections (1) ~~((and))~~, (2), and (3) of this section.

(c) Bariatric surgery performed in a designated department-approved hospital is paid a per case rate and must be prior authorized by the department (see WAC 388-550-3020).

~~((4) The department makes all applicable claim payment adjustments for clients responsibility, third party liability, medicare, etc., to claim payments.))~~