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)

WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. (Amend)
WAC 388-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers. (Amend)
WAC 388-550-4500 Payment method—Inpatient RCC rate, administrative day rate, hospital outpatient rate, and swing bed rate (Amend)
WAC 388-550-4550 Administrative day rate and swing bed day rate. (New)
WAC 388-550-7050 OPPS definitions. (Amend)
WAC 388-550-7100 OPPS—Exempt hospitals. (Amend)
WAC 388-550-7450 OPPS Budget Target Adjustor (New)
WAC 388-550-7500 OPPS conversion factor. (Amend)
WAC 388-550-7600 OPPS payment calculation. (Amend)

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

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

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

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
Stephanie E Schiller

TITLE
DSHS Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: March 31, 2009
TIME: 5:27 PM

WSR 09-08-118

(COMPLETE REVERSE SIDE)

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 98504-510	(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
fax (360) 753-9152
e-mail adamscr@dshs.wa.gov

☐ No: Please explain:

Attachment to CR-102

Amending WAC 388-550-3600, 3700, 4500, 7050, 7100, 7500, and 7600
Adding new sections WAC 388-550-4550 and 388-550-7450

The proposed changes update and clarify hospital-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:

- Update and clarify how the department pays a hospital when an acute care hospital or distinct unit transfers a client to another acute care hospital or distinct unit, or when a client transfers from an acute care hospital or distinct unit to another acute care hospital or distinct unit or other places as identified in the rule;
- Remove "neonatal" from the list of DRG service categories for claims that group to a medical, surgical, or burn diagnosis related services (DRG) category; remove "prepay" from "retrospective prepay utilization review" and clarify that the department may perform these reviews;
- Define "outpatient adjustment factor" and add that the inpatient adjustment factor does not apply to hospitals paid under the certified public expenditure (CPE) payment method, except to payments for repriced claims adjusted according to WAC 388-550-4670(2)(a)(ii); update and clarify how the department calculates and uses the ratio of costs-to-charges (RCC) payment method to pay inpatient hospital claims;
- Remove language for "administrative day rate and swing bed rate" from WAC 388-550-4500 and place it into a new section;
- Add language that the department may change the method for calculating OPPS rates to achieve the legislature's targeted expenditure levels for outpatient hospital services;
- Add language that 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;
- Update the definitions for "budget target adjustor," outpatient code editor (OCE), and "outpatient prospective payment system (OPPS) conversion factor";
- Add definitions for "nationwide rate," and "outpatient prospective payment system (OPPS) rate";
- Add language that incorporates into rule which hospitals are no longer exempted from the outpatient prospective payment system (OPPS) method and that the department pays all covered outpatient hospital services, except for those provided in critical access hospitals (CAHs), under the OPPS methodology;
- Add a new section "OPPS budget target adjustor" that describes the budget target adjustor and how the department calculates the OPPS budget target adjustor;
- Clarify how the department calculates the hospital-specific OPPS rates;
- Add language that the department may change the method for calculating OPPS payments to achieve the legislature's targeted expenditure levels; and
- Update and clarify current language for improved readability.

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

WAC 388-550-3600 Diagnosis-related group (DRG) payment--Hospital transfers. ((~~The department applies the following payment rules when an eligible client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit:~~

~~(1) The department does not pay a hospital for a nonemergency case when the hospital transfers the client to another hospital.~~

~~(2) The department pays a hospital that transfers emergency cases to another hospital, the lesser of:~~

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

~~(b) For dates of admission:~~

~~(i) Before August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average length of stay.~~

~~(ii) On or after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem rate by dividing the hospital's DRG allowed amount for payment for the appropriate DRG by that DRG's statewide average length of stay for the AP-DRG classification as determined by the department.~~

~~(3) The department uses:~~

~~(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and~~

~~(b) The department's length of stay data to determine the number of medically necessary days for a client's hospital stay.~~

~~(4) The department:~~

~~(a) Pays the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment; and~~

~~(b) Applies the outlier payment methodology if a transfer case qualifies:~~

~~(i) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and~~

~~(ii) For dates of admission on or after August 1, 2007, as a high outlier.~~

~~(5) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.~~

~~(a) The department's maximum payment to the discharging hospital is the full DRG payment.~~

~~(b) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (2) of this~~

~~section.~~

~~(6) The department makes all applicable claim payment adjustments to claims for client responsibility, third party liability, medicare, etc~~)) (1) The rules in this section apply when an eligible client transfers from an acute care hospital or distinct unit:

(a) Before July 1, 2009, to another acute care hospital or distinct unit; and

(b) On or after July 1, 2009, to one of the following:

(i) Another acute care hospital or distinct unit;

(ii) A skilled nursing facility (SNF);

(iii) An intermediate care facility (ICF);

(iv) Home care under the department's home health program;

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

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

(vii) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3000); or

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

(2) The department pays a hospital that transfers an emergency case to another acute care hospital, including an acute physical medicine and rehabilitation (acute PM&R) facility or distinct unit, an acute psychiatric facility or distinct unit, and a long-term acute care facility, the lesser of:

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

(b) A prorated DRG payment when the client's stay at the transferring hospital is less than the average length of stay (LOS) for the AP-DRG classification as determined by the department.

(3) The department pays a transferring hospital as follows:

(a) For dates of admission before August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average LOS.

(b) For dates of admission on and after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average LOS (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(4) The department uses:

(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and

(b) The department's LOS data to determine the number of medically necessary days for a client's hospital stay.

(5) When a post-acute care hospital transfer occurs to one of the locations listed in subsection (1)(b)(ii) through (viii) of this section, the department pays the transferring hospital the lesser of:

(a) The appropriate DRG payment; or

(b) For dates of admission on and after July 1, 2009, a per

diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average length of stay (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(6) The department applies the outlier payment methodology if a transfer case qualifies:

(a) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and

(b) For dates of admission on or after August 1, 2007, as a high-cost outlier.

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

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

(9) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(10) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (3) of this section.

(11) The transfer payment policy described in this section does not apply to claims grouped into AP-DRG classifications that are paid based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(12) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, 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 388-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers. This section applies to inpatient hospital claims paid under the diagnosis-related group (DRG) payment methodology, and for dates of admission on and after August 1, 2007. It also applies to inpatient hospital claims paid under the per diem payment methodology.

(1) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of twenty-eight thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(b) The client's admission date on the claim is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of thirty-three thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(2) For dates of admission before August 1, 2007, if the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date on or after January 1((~~, 2001 or after~~)).

(3) For dates of admission before August 1, 2007, the department determines payment for medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and ((~~in-state~~)) claims from instate children's hospitals, are paid seventy-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) In-state children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

((~~Three examples for DRG high-cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after, and before August 1, 2007).~~))

Examples for DRG high-cost outlier claim qualification and payment calculation (Admission dates are January 1, 2001, or after, and before August 1, 2007.)((~~:~~))

Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	Allowed Charges > $33,000?	Allowed Charges > Three times App. DRG Payment?	DRG High-Cost Outlier Payment	Hospital's Individual RCC Rate
$17,000	$5, 000	$15,000	No	Yes	N/A	64%
*33,500	5,000	15,000	Yes	Yes	**$5,240	64%
10,740	35,377	106,131	No	No	N/A	64%

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%)
*$33,500	Allowed charges
- $33,000 $500	The greater amount of 3 x ((~~app.~~)) <u>applicable</u> DRG pymt ($15,000) or $33,000
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/((~~nonin-state~~))<u>noninstate</u> children's) (75% x 64% = 48%)
$240	Outlier portion
+ $5,000	Applicable DRG payment
**$5,240	Outlier payment

(4) For dates of admission before August 1, 2007, DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(6) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (5)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (5)(b)(i) or (ii), whichever is greater.

(7) For dates of admission before August 1, 2007, the department determines payment for a medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) For dates of admission before August 1, 2007, DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) For dates of admission before August 1, 2007<u>,</u> the department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (2) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(10) For dates of admission before August 1, 2007 the department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) For dates of admission before August 1, 2007, the department's total payment for a day outlier ((~~claims~~)) claim is the applicable DRG payment plus the day outlier or administrative days payment.

(12) For dates of admission before August 1, 2007, a client's outlier claim is either a day outlier or a high-cost outlier, but not both.

(13) For dates of admission on and after August 1, 2007, the department does not identify a claim as a low cost outlier or day outlier. Instead, these claims are processed using the applicable payment method described in this chapter. The department may review claims with very low costs.

(14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the ((~~department determined~~)) department's estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars, and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under the DRG payment method, the department identifies a high outlier claim based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable base DRG allowed amount for payment.

(15) For dates of admission on and after August 1, 2007, the department may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable DRG service categories, i.e., medical, surgical, burn, and neonatal. These service categories are described in subsection

(16) of this section.

(a) The department identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the noncovered charges for the claim, multiplied by the hospital's ratio of costs-to-charges (RCC) related to the admission. ((~~To qualify as a high outlier claim, when~~)) Except as specified in (b) of this subsection, a claim that is grouped to a medical, surgical, or burn((~~, or neonatal~~)) DRG service category((~~,~~)) qualifies as a high outlier when the claim's estimated cost ((~~amount must be~~)) is greater than both the fixed outlier threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable per diem base allowed amount for payment.

(b) For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under medical, surgical, burn, and neonatal services categories, the department identifies high outlier claims based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost ((~~amount~~)) must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable per diem base allowed amount for payment.

(c) The department ((~~performs~~)) may perform retrospective ((~~prepay~~)) utilization reviews on all per diem outlier claims that exceed the department determined DRG average length of stay (LOS). If the department determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.

(16) For dates of admission on and after August 1, 2007, the term "unstable" is used generically to describe an AP-DRG classification that has fewer than ten occurrences (low volume), or that is unstable based on the statistical stability test indicated in this subsection, and to describe such claims in the major service categories of per diem paid claims identified in this section. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the population's estimated standard deviation.

Specifically, this formula is:

$N = (Z^2 * S^2)/R^2$, where

- The Z statistic for 90 percent confidence is 1.64
- S = the standard deviation for the AP-DRG classification, and
- R = acceptable error range, per sampling unit

If the actual number of claims within an AP-DRG classification is less than the calculated N size for that classification during relative weight recalibration, the department designates that DRG classification as unstable for purposes of calculating relative weights. And as previously stated, for relative weight recalibration, the department also designates any DRG classification having less than ten claims in total in the claims sample used to recalibrate the relative weights, as low volume and unstable.

The DRG classifications assigned to the per diem payment

method, that are in one of the ((~~following~~)) major ((~~services~~)) service categories in subsection (16)(a) through (d) of this section, qualify for ((~~determination to ascertain~~)) examination if a high outlier payment is appropriate. The department specifies those DRG classifications to be paid the per diem payment method because the DRG classification has low volume and/or unstable claims data for determination of an AP-DRG relative weight. A claim in a ((~~DRB~~)) DRG classification that falls into one of the following major services categories that the department designates for per diem payment, may receive a per diem high outlier payment when the claim meets the high outlier criteria as described in subsection (15) of this section:

(a) Neonatal claims, based on assignment to medical diagnostic category (MDC) 15;

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

(c) AP-DRG groups that include primarily medical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection; and

(d) AP-DRG groups that include primarily surgical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection.

(17) For dates of admission on and after August 1, 2007, the high outlier claim payment processes for the general assistance-unemployable (GA-U) program are the same as those for the medicaid or SCHIP DRG paid and per diem paid claims, except that the DRG rates and per diem rates are reduced, and the percent of outlier adjustment factor applied to the payment may be reduced. The high outlier claim payment process for medicaid or SCHIP DRG paid and per diem paid claims is as follows:

(a) The department determines the claim estimated cost amount that is used in the determination of the high outlier claim qualification and the high outlier threshold for the calculation of outlier adjustment amount. The claim estimated cost is equal to the total submitted charges, minus the noncovered charges reported on the claim, multiplied by the hospital's inpatient ratio of costs-to-charges (RCC) related to the admission.

(b) The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is:

(i) For DRG paid claims grouped to nonneonatal or nonpediatric DRG classifications, and for DRG paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base DRG payment allowed amount;

(ii) For DRG paid claims grouped to neonatal or pediatric DRG classifications, and for DRG paid claims that are from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base DRG payment allowed amount;

(iii) For nonspecialty service category per diem paid claims grouped to nonneonatal and nonpediatric DRG classifications, and for nonspecialty service category per diem paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base per diem payment

allowed amount; and

(iv) For nonspecialty service category per diem paid claims grouped to neonatal and pediatric DRG classifications, and for all nonspecialty service category per diem paid claims from Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base per diem payment allowed amount;

(c) The high outlier payment allowed amount is equal to the difference between the department's estimated cost of services associated with the claim, and the high outlier threshold for payment indicated in (b)(i) through (iv) of this subsection, respectively, the resulting amount being multiplied by a percent of outlier adjustment factor. The percent of outlier adjustment factor is:

(i) Ninety-five percent for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications. Hospitals paid with the payment method used for out-of-state hospitals are paid using the percent of outlier adjustment factor identified in (c)(iii) of this subsection. All high outlier claims at Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center receive a ninety-five percent of outlier adjustment factor, regardless of AP-DRG classification assignment;

(ii) Ninety percent for outlier claims that fall into burn-related AP-DRG classifications;

(iii) Eighty-five percent for all other AP-DRG classifications; and

(iv) Used as indicated in WAC 388-550-4800 to calculate payment for state-administered programs' claims that are eligible for a high outlier payment.

(d) The high outlier payment allowed amount is added to the calculated allowed amount for the base DRG or base per diem payment, respectively, to determine the total payment allowed amount for the claim.

DRG high outlier

Three examples for medicaid or SCHIP DRG high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Minus Noncovered Charges	Base DRG Payment Allowed Amount[1]	175% of Base DRG Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than $50,000?[2]	Department Determined Estimated Costs Are Greater Than 175% of Base DRG Payment Allowed Amount?	Total DRG High Outlier Claim Payment Allowed Amount[3,4]	Hospital's Individual RCC Rate
$95,600	$28,837	$50,465	Yes	Yes	$38,761	65%
$64,500	$28,837	$50,465	No	Yes	$28,837	65%
$77,000	$28,837	$50,465	Yes	No	$28,837	65%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$95,600 x 65% = $62,140 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria (in this example $50,000), then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

$62,140 - $50,465 = $11,675 x 85% = $9,924 = High outlier portion allowed amount

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment amount

$28,837 + $9,924 = $38,761

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than $50,000. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 65% = $41,925 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($41,925 - $50,465 = ($8,540)) x 85% = ($7,259), which is converted to $0. Also, $41,925 is not greater than $50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$28,837 + $0 = $28,837

Example three: The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$77,000 x 65% = $50,050 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = high outlier portion allowed amount, if greater than $0, otherwise $0.

($50,050 - $50,465 = ($415)) x 85% = ($353), which is converted to $0. Also, $50,050 is greater than $50,000, but not greater than $50,465, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$28,837 + $0 = $28,837

Per Diem High Outlier

Three examples for medicaid and SCHIP per diem high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Less Total Noncovered Charges	Base Per Diem Payment Allowed Amount[1]	175% of Base Per Diem Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than $50,000?[2]	Department Determined Estimated Costs Are Greater Than 175% of Base Per Diem Payment Allowed Amount?	Total Per Diem High Outlier Claim's Payment Allowed Amount[3,4]	Hospital's Individual RCC Rate
$100,000	$25,000	$43,750	Yes	Yes	$47,313	70%
$64,000	$25,000	$43,750	No	Yes	$25,000	70%
$75,000	$35,000	$61,250	Yes	No	$35,000	70%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 (rate) x 25 (days) = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$100,000 x 70% = $70,000 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($70,000 - $43,750 = $26,250) x 85% = $22,313 = High outlier portion allowed amount

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$25,000 + $22,313 = $47,313

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than $50,000. Example dollar amounts are approximated and not based on real claims data:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 25 = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 70% = $45,150 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($45,150 - $43,750 = $1,400), but $45,150 is not greater than $50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$25,000 + $0 = $25,000

Example three: (The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data):

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 35 = $35,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$75,000 x 70% = $52,500 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater tan $0, otherwise $0.

($52,500 - $61,250 = (8,750)) x 85% = ($7,438), which is

converted to $0. Also, $52,500 is greater than $50,000, but not greater than $61,250, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$35,000 + $0 = $35,000

(18) ((~~The department makes all applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to the payment~~)) 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 any of the high outlier thresholds and to any of the percentages of outlier adjustment factors described in this section.

(19) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, 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 388-550-4500 Payment method--((~~Inpatient RCC rate, administrative day rate, hospital outpatient rate, and swing bed rate~~)) Ratio of costs-to-charges (RCC). (1) ((~~The inpatient~~)) Ratio of costs-to-charges (RCC) ((~~allowed amount is the hospital's covered charges on a claim multiplied by the hospital's inpatient RCC rate. The department limits this RCC allowed amount for payment to the hospital's allowable usual and customary charges.~~

~~(a) The department calculates a hospital's RCC rate by dividing allowable costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.~~

~~(b) The department bases the RCC rate calculation on data from the hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.~~

~~(c) The department updates a hospital's inpatient RCC rate annually after the hospital sends its "as filed" hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and to the department.~~

~~(i) In situations where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the RCC rate based on a department-determined method.~~

~~(ii) Prior to calculating the RCC rate, the department excludes department nonallowed costs and nonallowable revenues. Costs and revenues attributable to a change in ownership are one example of what the department does not allow in the calculation process.~~

~~(2) The department limits a hospital's RCC payment to one hundred percent of its allowed covered charges.~~

~~(3) The department establishes the basic inpatient hospital RCC allowed amount by multiplying the hospital's assigned RCC rate by the allowed covered charges for medically necessary services. The department deducts client responsibility and third-party liability (TPL), and makes other applicable payment program adjustments to the basic allowed amount to determine the actual payment due.~~

~~(4) For dates of admission:~~

~~(a) Before August 1, 2007, the department uses the RCC payment method to pay:~~

~~(i) DRG-exempt hospitals identified in WAC 388-550-4300; and~~

~~(ii) Any hospital for DRG-exempt services identified in WAC 388-550-4400. See the services identified in WAC 388-550-4400 (2)(g), (h), and (k) for an exception to this policy.~~

~~(b) For dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay:~~

~~(i) Transplant services identified in WAC 388-550-4400;~~

~~(ii) DRG and per diem payment method high outlier payments;~~

~~(iii) Long term acute care (LTAC) hospital services not covered under the LTAC per diem rate; and~~

~~(iv) Other services specified by the department.~~

~~(5) For dates of admission before August 1, 2007, the department pays instate and bordering city hospitals that lack sufficient medicare cost report data to establish a hospital specific RCC, using the weighted average in-state:~~

~~(a) RCC rate for applicable inpatient services identified in WAC 388-550-4300 and 388-550-4400; and~~

~~(b) Outpatient rate as provided in WAC 388-550-6000.~~

~~(6) The department pays out-of-state hospitals for covered services as described in WAC 388-550-4000.~~

~~(7) The department identifies all in-state hospitals that have hospital specific RCC rates, and calculates the weighted average in-state RCC rate annually by dividing the department-determined total allowable costs of these hospitals by the department-determined total patient-related revenues associated with those costs.~~

~~(8) The department allows hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.~~

~~(a) Upon request, the department's nursing facility rate-setting staff provides the department's hospital rate-setting staff with the statewide weighted average nursing facility medicaid payment rate each year to update the all-inclusive administrative day rate on November 1.~~

~~(b) The department does not pay for ancillary services provided during administrative days.~~

~~(c) The department identifies administrative days during the length of stay review process after the client's discharge from the hospital.~~

~~(d) The department pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can~~

~~be made.~~

~~(9) The department calculates the weighted average in-state hospital outpatient rate annually by multiplying the weighted average in-state RCC rate by the outpatient adjustment factor.~~

~~(10) For hospitals that have their own hospital specific inpatient RCC rate, the department calculates the hospital's specific hospital outpatient rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor.~~

~~(11) The outpatient adjustment factor:~~

~~(a) Must not exceed 1.0; and~~

~~(b) Is updated annually. At the time the outpatient adjustment factor is updated, the hospital outpatient rate for the hospital is adjusted.~~

~~(12) The department establishes the basic hospital outpatient allowed amount for a claim as provided in WAC 388-550-6000 and 388-550-7200. The department deducts any client responsibility and any third-party liability (TPL), and makes any other applicable payment program adjustments to the allowed amount to determine the actual payment due.~~

~~(13) The department allows hospitals a swing bed day rate for those days when a client is receiving department-approved nursing service level of care in a swing bed. The department's aging and disability services administration (ADSA) determines the swing bed day rate.~~

~~(a) The department does not allow payment for acute inpatient level of care for swing bed days when a client is receiving department-approved nursing service level of care in a swing bed.~~

~~(b) The department's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 388-550-6000 and 388-550-7200, and may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.~~

~~(c) The department allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving department-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The department does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim~~)) is defined in WAC 388-550-1050. The department uses:

(a) The RCC payment method to pay hospitals for hospital services that are exempt from the diagnosis related group (DRG), per diem, ambulatory payment classification (APC), maximum allowable fee schedule, and per case payment methods.

(b) The term "ratio of costs-to-charges" to refer to the factor (rate) applied to a hospital's allowed covered charges to determine estimated costs for medically necessary services.

(2) The department:

(a) Determines the payment due a hospital under the RCC payment method for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC rate by the allowed covered charges for medically necessary services.

(ii) Outpatient claims by multiplying the hospital's outpatient RCC rate by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection any:

(i) Client responsibility amount;

(ii) Third-party liability (TPL) amount; and

(iii) Other applicable payment program adjustment.

(c) Limits the RCC payment to the hospital's allowable usual and customary charges.

(3) For inpatient hospital dates of admission before August 1, 2007, the department uses the RCC payment method to pay for inpatient hospital services that are:

(a) Provided in a hospital located in the state of Washington (see WAC 388-550-4000 for out-of-state hospital payment methods and WAC 388-550-3900 for payment methods to designated bordering city and critical border hospitals);

(b) Provided in a diagnosis related group (DRG)-exempt hospital identified in WAC 388-550-4300; and

(c) Identified in WAC 388-550-4400 as DRG-exempt services (see WAC 388-550-4400(2)(g), (h), and (k) for exceptions).

(4) For inpatient hospital dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay for:

(a) Organ transplant services identified in WAC 388-550-4400(4)(h);

(b) High outlier qualifying claims (see WAC 388-550-3700(14) and (15);

(c) Hospital services not covered under the LTAC per diem rate (see WAC 388-550-2596);

(d) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments (see WAC 388-550-4650(5)); and

(e) Any other hospital service identified and published by the department as being paid by the RCC payment method.

(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 the inpatient RCC payments made for the services in subsection (4) of this section, except as provided in subsection (6) of this section.

(6) For hospitals paid under the certified public expenditure (CPE) payment method, the inpatient adjustment factor referred to in subsection (5) of this section does not apply, except to payments for repriced claims adjusted according to WAC 388-550-4670(2)(a)(ii).

(7) The department calculates each instate and critical border hospital's RCC rate as follows. The department:

(a) Divides each hospital's allowable costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.

(b) Excludes, prior to calculating the RCC rate, department nonallowed costs and nonallowed revenue, such as costs and revenues attributable to a change in ownership.

(c) Bases the RCC rate calculation on data from the hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital. The "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) Updates a hospital's inpatient RCC rate annually after the

hospital sends its "as filed" hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and the department. In the case where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the RCC rate based on a department-determined method.

(e) Limits a noncritical access hospital's RCC payment to one hundred percent of its allowed covered charges.

(f) Determines an RCC rate, when a hospital is formed as a result of a merger (refer to WAC 388-550-4200), by combining the previous hospital's medicare cost reports and following the process in (a) of this subsection. The department does not use partial year cost reports for this purpose.

(g) Determines a new instate hospital's RCC rate by calculating and using the average RCC rate for all current noncritical access hospitals located in Washington state. The department annually calculates a weighted average instate RCC rate by identifying all instate hospitals with specific RCC rates and dividing the department-determined total patient-related revenues associated with those costs.

(8) The department calculates each hospital's outpatient RCC rate annually.

(a) The department calculates a hospital's outpatient RCC rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor (OAF).

(b) The department determines the weighted average instate hospital outpatient RCC rate by multiplying the instate weighted average inpatient RCC rate by the outpatient adjustment factor.

(9) The outpatient adjustment factor:

(a) Is the ratio between the outpatient and inpatient RCC payments, established in 1998 through negotiation with hospital providers;

(b) Is updated annually to adjust for cost and charge inflation;

(c) Must not exceed 1.0; and

(d) Is differentiated from the OPPS outpatient adjustment factor (defined in WAC 388-550-1050), and applies to hospitals exempt from OPPS.

NEW SECTION

WAC 388-550-4550 Administrative day rate and swing bed day rate. (1) **Administrative day rate.** The department allows hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(a) The department uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1 of each year.

(b) The department does not pay for ancillary services provided during administrative days.

(c) The department identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can be made.

(2) **Swing bed day rate.** The department allows hospitals a swing bed day rate for those days when a client is receiving department-approved nursing service level of care in a swing bed. The department's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The department does not pay a hospital the rate applicable to the acute inpatient level of care for those days of a hospital stay when a client is receiving department-approved nursing service level of care in a swing bed.

(b) The department's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 388-550-6000 and 388-550-7200. These ancillary services may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The department allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving department-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The department does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

WAC 388-550-7050 OPPS--Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the department's outpatient prospective payment system (OPPS):

"Ambulatory payment classification (APC)" means a grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Budget target" means the amount of money appropriated by the legislature or through the department's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjustor" means ((~~the department specific multiplier~~)) a department-established component of the APC payment calculation applied to all payable ambulatory payment classifications (APCs) to allow the department to reach and not exceed the established budget target.

"Discount factor" means the percentage applied to additional significant procedures when a claim has multiple significant

procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"National payment rate (NPR)" means a rate for a given procedure code, published by the centers for medicare and medicaid (CMS), that does not include a state or location specific adjustment.

"Nationwide rate" see "national payment rate."

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program ((~~published by 3M Health Information Systems~~)) that the department uses for classifying and editing claims in ambulatory payment classification (APC) based OPPS.

"Outpatient prospective payment system (OPPS)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient prospective payment system (OPPS) conversion factor" ((~~means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation~~)) see "outpatient prospective payment system (OPPS) rate."

"Outpatient prospective payment system (OPPS) rate" means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by centers for medicare and medicaid services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

"Status indicator (SI)" means a ((~~one-digit identifier~~)) code assigned to each medical procedure or service by the ((~~outpatient code editor (OCE) software~~)) department that contributes to the selection of a payment method.

"SI" see **"status indicator."**

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

WAC 388-550-7100 OPPS--Exempt hospitals. (1) The department ((~~exempts~~)) exempted the following hospitals from the initial implementation of the department's outpatient prospective payment system (OPPS)((~~. (Refer to other sections in chapter 388-550 WAC for outpatient payment methods the department uses to pay hospital providers that are exempt from the department's OPPS.)~~

~~(1)~~)) in 2004:

(a) Cancer hospitals;

((~~(2)~~)) (b) Critical access hospitals (CAHs);

((~~(3)~~)) (c) Free-standing psychiatric hospitals;

((~~(4)~~)) (d) Pediatric hospitals;

((~~(5)~~)) (e) Peer group A hospitals;

((~~(6)~~)) (f) Rehabilitation hospitals; and

((~~(7)~~)) (g) Veterans' and military hospitals.

(2) Effective for dates of service on and after July 1, 2009:

(a) Only CAHs remain exempt from OPPS; and

(b) The department pays all covered outpatient hospital services (except for those provided in CAHs), under the OPPS methodology.

(3) Refer to the applicable sections in chapter 388-550 WAC for outpatient payment methods used to pay hospitals exempted from OPPS (see subsections (1) and (2) of this section).

NEW SECTION

WAC 388-550-7450 OPPS budget target adjustor. (1) The outpatient prospective payment system (OPPS) budget target adjustor is a component of the ambulatory payment classification (APC) payment calculation. The budget target adjustor allows the department to reach but not exceed the established budget target. The same OPPS budget target adjustor value is applied to payments for all hospitals.

(2) The department calculates the OPPS budget target adjustor using:

(a) A payment system model developed by the department;

(b) The department's budget target;

(c) The department's outpatient fee schedule;

(d) Addendum B to 42 CFR Part 410 (medicare's hospital outpatient regulations and notices); and

(e) The wage index established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS budget target adjustor is set for the upcoming year.

(3) In response to direction from the legislature, the department may change the method for calculating the OPPS budget target adjustor to achieve the legislature's targeted expenditure levels for outpatient hospital services. 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.

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

WAC 388-550-7500 OPPS ((~~conversion factor~~)) rate. (1) The department calculates ((~~the~~)) hospital-specific outpatient prospective payment system (OPPS) ((~~conversion factors by modeling, using the centers for medicare and medicaid services (CMS) addendum B and wage index information available and published at the time the OPPS conversion factors are set for the upcoming year~~)) rates using:

(a) A payment method model established by the department; and

(b) The latest wage index information established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(2) The department may adjust OPPS rates to pay for graduate medical education (GME) costs. The department obtains the GME information from a hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.

(a) The hospital's "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year. In the case where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the hospital's OPPS rate.

(b) The department may not pay GME expenses for hospitals in specified categories, and hospitals that meet, or fail to meet, conditions specified in statute or WAC.

(3) In response to direction from the legislature, the department may change the method for calculating OPPS rates to achieve the legislature's targeted expenditure levels for outpatient hospital services. 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.

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

WAC 388-550-7600 OPPS payment calculation. (1) The department follows the discounting and modifier policies of the centers for medicare and medicaid services (CMS). The department calculates the ambulatory payment classification (APC) payment as follows:

APC payment =
National payment rate x Hospital OPPS ((~~conversion factor~~))

rate x
Discount factor (if applicable) x Units of service (if applicable) x
Budget target adjustor

(2) The total OPPS claim payment is the sum of the APC payments plus the sum of the lesser of the billed charge or allowed charge for each non-APC service.

(3) The department pays hospitals for claims that involve clients who have third-party liability (TPL) insurance, the lesser of either the:

(a) Billed amount minus the third-party payment amount; or

(b) Allowed amount minus the third-party payment amount.

(4) In response to direction from the legislature, the department may change the method for calculating OPPS payments to achieve the legislature's targeted expenditure levels for outpatient hospital services. 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.