



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Health & Recovery Services Administration

P.O. Box 45080, Olympia, Washington 98504-5080

April 21, 2009

Claudia Sanders, Senior V.P., Policy Development
Andrew Busz, Director, Financial Policy
Washington State Hospital Association
300 Elliott Avenue West, Ste 300
Seattle, WA 98119

Dear Ms. Sanders and Mr. Busz,

Thank you for your letter dated March 16, 2009, in which the Washington State Hospital Association (WSHA) reviewed proposed amendments from the Department of Social and Health Services, Health and Recovery Services Administration (HRSA), to sections in chapter 388-550 WAC. Your comments have been summarized below and HRSA's responses follow:

1) WSHA comments on proposed changes to WAC 388-550-2800(2), 388-550-3000(5), 388-550-3010(5)(f), 388-550-3020(4), 388-550-3700(17)(c) and (18), and 388-550-7500(3) relating to calculating and applying various adjustments factors to hospital payments when the department determines expenditures will exceed the legislature's targeted expenditure levels:

- The language related to the percentage reduction in inpatient forecasted expenditures is "much too vague and gives the department too much discretion to reduce payment levels to the hospitals." WSHA would like the department to wait until the legislative language is clear and the budget has been approved.
- The department could continue to make repeated adjustments to the rates over the course of the biennium as a reaction to the changing forecast and caseload levels without clear legislative direction.
- Language may be drafted not consistent with the state's own administrative procedure act which does require rule writing to make clear methods behind payment rates.
- Lack of a review mechanism to ensure reductions do not exceed a level explicitly approved by the legislature.

HRSA response: The department will only make adjustments to the rates with clear legislative direction as defined in WAC 388-550-2800(2). The methodology to be used to achieve the adjustments has been specified in the inpatient rate WAC section. HRSA's hospital payment methods have been prospective since 1985 with the exception of payment methods for certified public expenditure (CPE) hospitals and critical access hospitals (CAH).

2) WSHA comments on proposed changes to WAC 388-550-3000(6) and 388-550-3600(1)(b) regarding prorating the diagnostic related group (DRG) payments:

- It arbitrarily redefines what constitutes an inpatient stay.
- It undermines the concept that patients are to be cared for in the most clinically appropriate and cost effective setting.

HRSA response: The number of patient status codes has been increased to prevent duplicate payments for the appropriate care for each client. The transfer methodology has not changed.

- The change may have much greater financial impact on hospitals than estimated by the state, especially if the same changes are adopted by the Healthy Options plans.

HRSA response: The department encourages the hospitals to confer with the Healthy Options plans on these concerns.

- The inclusion of hospice and home health is especially problematic.

HRSA response: The state will be relying on the patient status codes submitted by the hospitals on the UB-04 claim form to reflect the location to which the discharge has been made.

3) The draft deletes the language in the existing subsection (6) where a hospital would obtain outlier payment in cases where the department combines two separately billed inpatient stays into one. Would like language reinstated or an explanation why it was deleted.

HRSA response: This language should not have been omitted. It is now found in subsection (6)(f):

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

4) WSHA comments on proposed changes to WAC 388-550-3000(7) regarding the uncomplicated cesarean section deliveries equal to a complicated vaginal delivery:

- This amounts to an average reduction of nearly one thousand dollars in payment in each delivery.

HRSA response: The marginal savings to hospitals with vaginal rate improvements will offset the losses in cesarean sections. Additional savings and improved quality will be realized to the state and clients with improved vaginal rates through fewer NICU admissions, and reduced respiratory distress noted in elective cesarean sections. Efficient hospitals that address cesarean sections and elective inductions earlier than nonefficient hospitals will benefit from these changes.

- The payment reduction penalizes hospitals for what are cultural and societal issues.

HRSA response: Through the hospital survey of delivery policies and programs, we note many hospitals trying to improve the quality of deliveries and reduce nonmedically necessary cesarean sections and elective inductions. This would imply that some hospitals recognize that elective surgery and elective inductions for convenience are a quality issue and not just a cultural or social issue.

- The change could affect privileging requirements and the availability of obstetrical services for medical patients.

HRSA response: The department notes that Madigan and Swedish have strong policies for cesarean sections and elective inductions, respectively, without affecting credentialing.

- The approach in the WAC is significantly different from the original HRSA proposal.

HRSA response: The initial HRSA proposal failed to consistently pay all hospitals using the same method.

5) WSHA comments on proposed changes to WAC 388-550-7100(2) regarding moving the non-OPPS hospitals to OPPS hospitals:

- Medicare and most other plans have made special provisions for these hospitals.
- Other programs, such as TRICARE and Uniform Medical Plan, exempt these hospitals from OPPS.
- This could have devastating financial consequences for these hospitals and impact the availability of their specialized services.

HRSA response: The department is aware that certain hospitals are concerned about the financial effects of the change from non-OPPS to OPPS. The department continues to be willing to work with those hospitals on issues that arise in this regard. At this time, however,

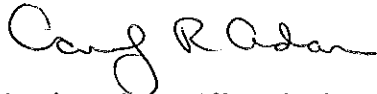
the department is not aware of any convincing rationale for adhering to an alternative payment methodology for the hospitals that have not previously been governed by OPPS.

Thank you for participating in HRSA's rule-making process. The Washington State Register numbers for these proposed rules are WSR 09-08-117 and WSR 09-08-118. The public hearing for these rules is scheduled for May 26, 2009. Please visit:

<http://www.dshs.wa.gov/pdf/ms/rpau/102-09-08-117.pdf> and

<http://www.dshs.wa.gov/pdf/ms/rpau/102-09-08-118.pdf> .

Sincerely,

A handwritten signature in cursive script that reads "Carolyn Adams".

Carolyn Adams, Office Chief
Division of Rates and Finance
Health and Recovery Services Administration
Department of Social and Health Services