

WSHA Comments on Draft WAC Changes

WAC 388-550-2800 Payment methods and limits – Inpatient hospital services for medicaid and SCHIP clients

Section (2) contains new language authorizing the department to calculate and apply various adjustment factors to apply to hospital payments when the department determines expenditures will exceed the legislature's targeted expenditure levels. We strongly object to this language being adopted into rule without additional definitional detail. It is much too vague and gives the department too much discretion to reduce payment levels to hospitals. If it is not possible to make this change in anticipation of legislative action without containing more detail, we would ask the department to refrain from adopting rules now and wait until the budget has been approved.

As drafted, the language gives the department widespread discretion to make changes without any public scrutiny of its methodology or assumptions. It would allow the department to make repeated adjustments to rates over the course of the biennium as a reaction to changing forecast and caseload levels without clear legislative direction or the need to issue new rules. We question if the language as drafted is consistent with the state's own administrative procedure act which, while allowing adoption of specific payment factors without rule writing, does require rule writing to make clear methods behind payment rates. Hospitals are already facing significant reductions in payment from the other adopted policies, and it is critical that there be a review mechanism to ensure reductions do not exceed a level explicitly approved by the legislature.

WAC 550-3000 Payment Method – DRG

Section (5) contains new language authorizing the department to calculate and apply various adjustment factors to apply to hospital payments when the department determines expenditures will exceed the legislature's targeted expenditure levels. We strongly object to this language being adopted into rule without additional definitional detail. It is much too vague and gives the department too much discretion to reduce payment levels to hospitals. If it is not possible to make this change in anticipation of legislative action without containing more detail, we would ask the department to refrain from adopting rules now and wait until the budget has been approved.

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Section (6) reflects a significant change to DRG payment when a discharge is made to home health, hospice, or various types of non-acute care facilities such as skilled nursing and long-term care facilities. It expands the existing practice for prorating the DRG payment and paying less when a patient is transferred to another acute care hospital or distinct part unit. This essentially redefines the concept of what constitutes a full inpatient stay. We have four objections to this change.

- (1) **It arbitrarily redefines what constitutes an inpatient stay.** Medicaid inpatient payment was rebased to pay fairly according to the relative costs of providing care for specific types of inpatient stays. To apply a new definition to what constitutes a full stay is to change the rules in order to reduce payment. A rebasing and recalculation of payment based on the state's new definitions must take place if payment is to be fair, equitable, and credible.
- (2) **It undermines the concept that patients are to be cared for in the most clinically appropriate and cost effective setting.** Currently patients are discharged when they no longer require an acute level of care based on clinical criteria. This change would penalize hospitals when they make arrangements for appropriate post acute care such as home health and skilled nursing services. As a result, this change runs counter to current initiatives to reduce lengths of stay and arrange for appropriate community care that may prevent and reduce readmissions.
- (3) **The change may have much greater financial impact on hospitals than estimated by the state.** WSHA and member hospitals have performed impact projections of the proposed change and are finding a financial impact much greater than what was in the state's estimates, especially if the same changes are adopted by the Healthy Option plans.
- (4) **The inclusion of hospice and home health is especially problematic.** These services do not provide a continuation of hospital based services, but instead provide distinctly different alternative services. In addition, hospitals are often

unaware if patients are selecting to receive home health or hospice care following discharge, and these are not accurately reflected on patient bills.

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

Section (7) specifies that payment to hospitals for uncomplicated Cesarean section deliveries will be equal to that of a complicated vaginal delivery. This amounts to an average reduction of nearly one-thousand dollars in payment for **each** of these deliveries. We agree with the department's efforts to promote C-sections when appropriate as a quality improvement initiative, but this payment reduction arbitrarily punishes hospitals for what are cultural and societal issues. The decision on type of delivery is based on the patient's medical condition and made by the obstetrician and the patient rather than the hospital. This change could affect privileging requirements and the availability of obstetrical services for Medicaid patients. The approach is significantly different than the original HRSA proposal in the governor's budget and the impact to hospitals is of much greater magnitude. WSHA has been working with the state and intends to continue working to reduce the frequency of inappropriate C-sections, but strongly objects to this approach.

WAC 388-550-3010 Payment method – Per diem payment.

Section (5) (f) contains new language authorizing the department to calculate and apply various adjustment factors to apply to hospital payments when the department determines expenditures will exceed the legislature's targeted expenditure levels. We strongly object to this language being adopted into rule without additional definitional detail. It is much too vague and gives the department too much discretion to reduce payment levels to hospitals. If it is not possible to make this change in anticipation of legislative action without containing more detail, we would ask the department to refrain from adopting rules now and wait until the budget has been approved.

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from the other adopted policies, and it is critical that there be a review mechanism to ensure reductions do not exceed a level explicitly approved by the legislature.

WAC 388-550-3020 Payment method – Bariatric surgery – Per case payment.

Section (4) contains new language authorizing the department to calculate and apply various adjustment factors to apply to hospital payments when the department determines expenditures will exceed the legislature's targeted expenditure levels. We strongly object to this language being adopted into rule without additional definitional detail. It is much too vague and gives the department too much discretion to reduce payment levels to hospitals. If it is not possible to make this change in anticipation of legislative action without containing more detail, we would ask the department to refrain from adopting rules now and wait until the budget has been approved.

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WAC 388-550-3600 Diagnosis related group (DRG) payment – Hospital transfers.

Section (1) (b) reflects a significant change to DRG payment when a discharge is made to home health, hospice, or various types of non-acute care facilities such as skilled nursing and long-term care facilities. It expands the existing practice for prorating the DRG payment and paying less when a patient is transferred to another acute care hospital or distinct part unit. This essentially redefines the concept of what constitutes a full inpatient stay. We have four objections to this change.

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WAC 388-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers.

Sections (17) (c) and (18) contain new language authorizing the department to calculate and apply various adjustment factors to apply to hospital payments when the department determines expenditures will exceed the legislature's targeted expenditure levels. We strongly object to this language being adopted into rule without additional definitional detail. It is much too vague and gives the department too much discretion to reduce payment levels to hospitals. If it is not possible to make this change in anticipation of legislative action without containing more detail, we would ask the department to refrain from adopting rules now and wait until the budget has been approved.

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WAC 388-550-7100 OPPS--Exempt hospitals

Section (2) removes the exception from OPPS payment that currently applies to cancer hospitals, free-standing psychiatric hospitals, peer group A (small rural non-critical access hospitals), pediatric hospitals, rehabilitation hospitals, and veterans and military hospitals. These hospitals have historically been understood as unique as to the nature, mix, and volume of their services, and have different cost structures than larger hospitals with a more standard mix. Medicare and most other plans have made special provisions for these hospitals. Medicare has in place a permanent “hold harmless” provision for cancer and pediatric hospitals that protects them from significant reductions under OPPS. Other programs, such as TRICARE and Uniform Medical Plan, exempt them outright from OPPS.

We strongly urge the state not to apply OPPS to these hospitals without also putting in place an appropriate “hold harmless” provision, transitional payment, or payment adjustor. If this is not done, it could have devastating financial consequences for these hospitals and impact the availability of their specialized services. Our estimate of the potential impact of the change is considerably higher than the state’s estimate, again signaling the importance of allowing some adjustments.

WAC 550-7500 OPPS rate

Section (3) contains new language authorizing the department to calculate and apply various adjustment factors to apply to hospital payments when the department determines expenditures will exceed the legislature’s targeted expenditure levels. We strongly object to this language being adopted into rule without additional definitional detail. It is much too vague and gives the department too much discretion to reduce payment levels to hospitals. If it is not possible to make this change in anticipation of legislative action without containing more detail, we would ask the department to refrain from adopting rules now and wait until the budget has been approved.

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