New Section

WAC 182-550-3850 Budget Neutrality Adjustment and Measurement.

(1) The medicaid agency measures the effectiveness of budget neutral rebasing by applying a budget neutrality adjustment factor to the base payment rates for both inpatient and outpatient hospitals as needed to maintain aggregate payments under rebased payment systems. The agency performs budget neutrality adjustments and measurement as follows:

(2) The agency develops a budget neutrality adjustment factor (BNAF) to apply to the system at the date of implementation.

(a) The agency publishes the budget neutrality factor on the agency's website and publishes conversion factors and rates which reflect the adjustment.

(b) The following rates and factors are not adjusted by the BNAF:

(i) Ratio of costs-to-charges (RCC);

(ii) Critical access hospital (CAH) weighted costs-to-charges (WCC);

(iii) Per-case rates;

(iv) Administrative day rates;

(v) Long-term acute care (LTAC);

(vi) Chemical-using pregnant women (CUP);

(vii) Outlier parameters;

(viii) Outpatient services paid at the resource-based relative value scale (RBRVS) fee;

(ix) Outpatient corneal transplants; and

(x) Diabetic education;

(3) The agency measures budget neutrality on an ongoing basis after rebased system implementation as follows:

(a) The agency gathers inpatient and outpatient claims and encounter data from the rebased system implementation date to the end of the measurement period.

(i) The first measurement period is the initial six months following rebased payment system implementation.

(ii) Additional measurement periods occur no more frequently than quarterly thereafter.

(iii) The agency performs a final measurement period for data received through June 30, 2016.

(b) The agency sums the aggregate payment amounts separately for inpatient and outpatient services. Reductions due to third-party liability (TPL), client responsibility, and client spenddown are removed from the payment summary.

(c) The agency processes all claims and encounters using the rates, factors, and policies which were in effect on June 30, 2014, with the following exceptions:

(i) Any increases awarded by RCW 74.09.611 (2) are applied to inpatient services;

(ii) The RCC effective on the date of service is used;

(iii) Outpatient services paid using the RBRVS are updated;

(iv) Ambulatory payment classification (APC) relative weights are updated to reflect the most recent relative weights supplied by CMS; and

(v) The outpatient budget target adjuster (BTA) will be adjusted to offset the inflation factor applied to OPPS in the CMS OPPS final rule.

(d) Payment amounts calculated under subsection (3)(c) of this section will be aggregated separately for inpatient and outpatient services.

(4) The agency will modify the BNAF to reflect aggregate changes in the overall payment system as follows:

(a) If the amount calculated in (3)(b) is between ninety-nine percent and one hundred and one percent of the amount calculated in (3)(d), no adjustment will be made to the BNAF currently in effect;

(b) If the amount calculated in (3)(b) is greater than one hundred and one percent of the amount calculated in (3)(d), the BNAF will be adjusted to reach a target expenditure of one hundred and one percent;

(c) If the amount calculated in (3)(b) is less than ninety-nine percent of the amount calculated in (3)(d), the BNAF will be adjusted to reach a target expenditure decrease of ninety-nine percent.

(5) The agency applies adjustments to the BNAF to rates prospectively at the beginning of the calendar quarter following the measurement.

(6) The agency issues a settlement to each hospital for payment differences on fee-for-service claims paid during the measurement period.

(a) The agency applies the prospective BNAF calculated in subsection (3) to the claims data calculated in (2)(b);

(b) The settlement amount is the difference between the amount calculated in (2)(b) and the amount calculated in (5)(a).

WAC 182-550-7000 Outpatient prospective payment system (OPPS)—General. (1) The ~~department's~~ medicaid agency's outpatient prospective payment system (OPPS) uses an ambulatory payment classification (APC) based reimbursement ~~methodology~~ method as its primary reimbursement method. The ~~department~~ agency ~~is basing~~ bases its OPPS on the centers for medicare and medicaid services (CMS) prospective payment system for hospital outpatient department services.

(2) For a complete description of the CMS outpatient hospital prospective payment system, including the assignment of status indicators (SIs), see 42 C.F.R., Chapter IV, Part 419. The Code of Federal Regulations (C.F.R.) is available from the C.F.R. web site and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

[WSR 11-14-075, recodified as § 182-550-7000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7000, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7000, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7200 OPPS—Billing requirements and payment method. (1) This section describes hospital provider billing requirements and the payment methods the ~~department~~ medicaid agency uses to pay for covered outpatient hospital services provided by hospitals not exempted from the outpatient prospective payment system (OPPS).

(2) Providers must bill according to national correct coding initiative (NCCI) standards. The centers for medicare and medicaid services (CMS) maintains NCCI policy. NCCI standards are based on:

(a) Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual;

(b) Current standards of medical and surgical coding practice;

(c) Input from specialty societies; and

(d) Analysis of current coding practices.

~~The centers for medicare and medicaid services (CMS) maintains NCCI policy.~~

AMBULATORY PAYMENT CLASSIFICATION (APC) METHOD

(3) The ~~department~~ agency uses the APC method when ~~(~~CMS~~)~~ has established a national payment rate to pay for covered services. The APC method is the primary payment ~~methodology~~ method for OPPS. Examples of services paid by the APC ~~methodology~~ method include, but are not limited to:

(a) Ancillary services;

(b) Medical visits;

(c) Nonpass-through drugs or devices;

(d) Observation services;

(e) Packaged services subject to separate payment when criteria are met;

(f) Pass-through drugs;

(g) Significant procedures ~~that are~~ not subject to multiple procedure discounting (except for dental-related services);

(h) Significant procedures ~~that are~~ subject to multiple procedure discounting; and

(i) Other services ~~as~~ identified by the ~~department~~agency.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(4) The ~~department~~ agency uses the outpatient fee schedule published ~~in~~on the ~~department's billing instructions~~ agency's website to pay for covered:

(a) Services ~~that are~~ exempted from the APC payment ~~methodology~~ method or services for which there are no established weight(s);

(b) Procedures ~~that are~~ on the CMS inpatient-~~-~~only list;

(c) Items, codes, and services ~~that are~~ not covered by medicare;

(d) Corneal tissue acquisition;

(e) Devices that are pass-throughs (see WAC ~~388-550-7050~~ 182-550-1050 for definition of pass-throughs); and

(f) Dental clinic services.

HOSPITAL OUTPATIENT RATE

(5) The ~~department~~ agency uses the hospital outpatient rate described in WAC ~~388-550-3900~~182-550-3900 and ~~388-550-4500~~ 182-550-4500 to pay for the services listed in subsection (4) of this section for which the ~~department~~ agency has not established a maximum allowable fee.

[WSR 11-14-075, recodified as § 182-550-7200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. WSR 10-08-023, § 388-550-7200, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7200, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7200, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7300 OPPS—Payment limitations. (1) The ~~department~~ medicaid agency limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient fee schedule ~~and~~ published ~~in~~ on the ~~department's hospital billing instructions~~agency's website, subject to the following:

(a) To receive payment for services, providers must bill claims according to national correct coding initiative (NCCI) standards. See WAC ~~388-550-7200(2)~~182-550-7200(2) for more information on NCCI standards. When a unit limit for services is not stated in the outpatient fee schedule, ~~department~~ the agency pays for services according to the program's unit limits stated in applicable WAC and published ~~issuances~~provider guides.

(b) Because the agency may factor multiple units for services ~~may be factored~~ into the ambulatory payment classification (APC) weight, ~~department~~ the agency pays for services according to the unit limit stated in the outpatient fee schedule when the limit is not the same as the program's unit limit stated in applicable WAC and published ~~issuances~~provider guides.

(2) The ~~department~~ agency does not pay separately for covered services ~~that are~~ packaged into the APC rates. These services are paid through the APC rates.

(3) The ~~department~~agency:

(a) Limits payment for surgical dental services ~~payment~~ to the ambulatory ~~surgical services~~ surgery centers fee schedule and pays:

(i) The first surgical procedure at the applicable ambulatory surgery center group rate; and

(ii) The second surgical procedure at fifty percent of the ambulatory surgery center group rate.

(b) Considers all surgical procedures not identified in subsection (a) to be bundled.

(4) The ~~department~~ agency limits outpatient services billing to one claim per episode of care. If there are late charges, or if any line of the claim is denied, the ~~department~~ agency requires the entire claim to be adjusted.

[WSR 11-14-075, recodified as § 182-550-7300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. WSR 10-08-023, § 388-550-7300, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100,

§ 388-550-7300, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7300, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7400 OPPS APC relative weights. The ~~department~~ medicaid agency uses the ambulatory payment classification (APC) relative weights established by the centers for medicare and medicaid services (CMS) at the time the budget target adjustor is established. See WAC ~~388-550-7050~~ 182-550-1050 for the definition of budget target adjustor.

[WSR 11-14-075, recodified as § 182-550-7400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7400, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7400, filed 10/1/04, effective 11/1/04.]

WAC 182-550-7450 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~~ agency 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~~ agency calculates the OPPS budget target adjustor using:

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

(b) The ~~department's~~ agency’s budget target;

(c) The ~~department's~~ agency’s outpatient fee schedule;

(d) Addendum B to 42 C.F.R. 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~~ agency 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~~ agency in the Biennial Appropriations Act.

[WSR 11-14-075, recodified as § 182-550-7450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7450, filed 5/28/09, effective 7/1/09.]

WAC 182-550-7500 OPPS rate. (1) The ~~department~~ medicaid agency calculates hospital-specific outpatient prospective payment system (OPPS) rates using:

(a) A payment method model established by the ~~department~~agency; 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~~ agency may adjust OPPS rates to pay for graduate medical education (GME) costs. The ~~department~~ agency 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~~ agency may adjust the hospital's OPPS rate.

(b) The ~~department~~ agency 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~~ agency 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~~ agency in the Biennial Appropriations Act.

[WSR 11-14-075, recodified as § 182-550-7500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7500, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

NEW SECTION

WAC 182-550-7550 OPPS Payment Enhancements.

(1) Pediatric adjustment.

(a) The medicaid agency establishes a policy adjustor to be applied for all enhanced ambulatory patient group (EAPG) services for clients under eighteen years of age.

(b) Effective July 1st, 2014, this adjustor equals one point thirty-five (1.35).

(2) Chemotherapy and combined chemotherapy/pharmacotherapy adjustment.

(a) The agency establishes a policy adjustor to be applied to services grouped as chemotherapy drugs or combined chemotherapy and pharmacotherapy drugs.

(b) Effective July 1st, 2014, this adjustor equals one point one (1.1).

(3) Sole Community Hospitals (SCH).

(a) To qualify as an SCH, a hospital must meet all of the following criteria. The hospital must:

(i) Be certified as an SCH by the centers for medicare and medicaid services (CMS) as of January 1, 2013;

(ii) Have a level III adult trauma service designation by the Department of Health as of January 1, 2014;

(iii) Have less than one hundred and fifty acute care licensed beds in state fiscal year 2011; and

(iv) Be owned and operated by the state or a political subdivision.

(b) Effective January 1, 2015, the agency will apply an adjustor of one point twenty-five (1.25) to the EAPG conversion factor for any hospital that meets the conditions in subsection (3)(a).

WAC 182-550-7600 OPPS payment calculation. (1) The ~~department~~ medicaid agency follows the discounting and modifier policies of the centers for medicare and medicaid services (CMS). The ~~department~~ agency calculates the ambulatory payment classification (APC) payment ~~as follows:~~ by multiplying:

(a) The national payment rate by the hospital OPPS rate;

(b) The result of (1)(a) by the budget target adjustor; and

(c) If applicable, the result of (1)(b) by any discount factor and units of service. Otherwise, the APC payment is the result of (1)(b).

~~APC payment =~~

~~National payment rate x Hospital OPPS 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~~ agency 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~~ agency 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~~ agency in the Biennial Appropriations Act.

[WSR 11-14-075, recodified as § 182-550-7600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7600, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7600,

filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7600, filed 10/1/04, effective 11/1/04.]

REPEAL. ~~**WAC 182-550-7100 OPPS—Exempt hospitals.** (1) The department exempted the following hospitals from the initial implementation of the department's outpatient prospective payment system (OPPS) in 2004:~~

~~(a) Cancer hospitals;~~

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

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

~~(d) Pediatric hospitals;~~

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

~~(f) Rehabilitation hospitals; and~~

~~(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).~~

~~[WSR 11-14-075, recodified as § 182-550-7100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7100, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7100, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7100, filed 10/1/04, effective 11/1/04.]~~