[NEW SECTION]

WAC 182-550-3840 Payment adjustment for potentially preventable readmissions. (1) The medicaid agency adjusts the payment rate to a hospital with an excessive number of potentially preventable readmissions (PPRs), using the criteria described in subsection (4) of this section. The agency calculates the number of excess PPRs using a risk-adjusted comparison, as described in subsection (5) of this section, between the actual and expected number of PPRs attributable to a hospital, and prospectively reduces the payment.

(2) Payment reductions under this section do not apply to critical access hospitals under WAC 182-550-2598; however, critical access hospital claims are included in the PPR analysis.

(3) The following definitions and those found in chapter 182-500 WAC apply to this section:

(a) "Actual PPR chains" means the number of PPR chains attributable to a hospital, based on the PPR analysis.

(b) "Excess PPR chains" means the difference between a hospital's actual PPR chains and the expected PPR chains, not to be less than 0.

(c) "Expected PPR chains" means the number of PPR chains expected for a hospital, based on the hospital's mix of services provided and clients served in the PPR analysis.

(d) "Excess readmission payments" means a hospital's number of excess readmissions multiplied by the average payments per PPR chain.

(e) "Initial admission" means an admission to a hospital that is not identified as a PPR that is followed by a PPR for the same recipient within thirty days, as determined by the PPR software under standard settings.

(f) "Non-qualifying admission" means an admission excluded from the determination of readmissions by the PPR software under standard settings. Non-qualifying admissions exclude initial admissions, only admissions, and PPRs.

(g) "Only admission" means an admission that is not a PPR, an initial admission, or other non-qualifying admission, as determined by the PPR software under standard settings.

(h) "Potentially preventable readmission (PPR)" means a readmission meeting the criteria in subsection (4) of this section that follows a prior discharge from a hospital within thirty days for the same recipient, as determined by the PPR software under standard settings. A PPR can occur at the same hospital as the initial readmission or at a different hospital.

(i) "Potentially preventable readmission chain" or "PPR chain" means the collection of one or more PPRs attributable to an initial admission.

(j) "PPR analysis" means the historical claims data processed by the PPR software under standard settings used to determine each hospital's excess PPR chains, as described in subsection (5) of this section.

(k) "PPR software" means the software created and maintained by the 3M™ Corporation and currently used by the agency to identify PPRs.

(l) "Readmission reduction factor" means a prospective reduction to inpatient payment rates based on the excess readmissions payments divided by the total hospital inpatient payments in the PPR analysis.

(4) Readmission Criteria.

(a) A PPR is an inpatient readmission within 30 days after discharge that is clinically related to the initial admission, as defined by the PPR software using standard settings. A PPR meets the following criteria:

(i) The readmission is potentially preventable through appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period;

(ii) The readmission is for a condition or procedure related to the care provided during the prior discharge or during the period immediately after the prior discharge;

(iii) The PPR chain has one or more readmissions that are clinically related to the initial admission. The first readmission is within thirty days after the initial admission, and the thirty-day timeframe begins again at the discharge of the most recent readmission; and

(iv) The readmission is to the same or to any other hospital.

(5) Methodology to determine excess readmissions

(a) The agency's analysis is based on the 3M™ Health Information Systems Potentially Preventable Readmissions Classification System under standard settings currently used by the agency.

(b) The following readmissions are excluded from the PPR analysis prior to processing the claims data through the PPR software:

(i) Enrollees in state-only programs;

(ii) Dually-eligible medicare/medicaid enrollees;

(iii) Mental health and chemical dependency claims covered by the division of behavioral health and recovery (DBHR); and

(iv) Claims occurring at out-of-state, non-critical border hospitals.

(c) Non-qualifying admissions identified by the PPR software under standard settings are excluded from the determination of excess PPR chains.

(d) The following claims are also excluded from the determination of excess PPR chains:

(i) Trauma claims qualifying for supplemental payments for approved trauma service centers under WAC 182-550-5450;

(ii) Newborn cases with the mother's patient information reported in the claim;

(iii) Newborn jaundice cases; and

(iv) Transplant diagnosis-related group (DRG) initial admissions or admissions within 180 days of a transplant DRG.

(e) The agency will prospectively apply a readmission reduction factor to inpatient rates for dates of service provided on January 1, 2016, through June 30, 2016, based on a PPR analysis consisting of the following claims data:

(i) PPR analysis will consist of fee-for-service (FFS) and managed care claims data, including claims denied under the legacy readmission

policy under WAC 182-550-3000, and excluding the claims described in subsection (5)(b) of this section.

(ii) PPR analysis claim services dates will consist of discharge dates within state fiscal year 2014 (July 1, 2013, through June 30, 2014), with the following exceptions:

(A) PPR analysis will include PPRs with a discharge date after state fiscal year 2014 that were in a PPR chain with an initial admission discharge date in state fiscal year 2014.

(B) PPR analysis will exclude PPRs with a discharge date in state fiscal year 2014 that were in a PPR chain with an initial admission discharge date before state fiscal year 2014.

(iii) A readmission reduction factor for each hospital is based on the hospital's excess readmission payments divided by the total hospital inpatient payments in the PPR analysis.

(f) The agency will annually update the readmission reduction factors on July 1st, starting on July 1, 2016, based on a PPR analysis consisting of the following claims data:

(i) PPR analysis will consist of FFS and managed care claims data, including claims denied under the legacy readmission policy under WAC 182-550-3000, and excluding the claims described in subsection (5)(b) of this section.

(ii) PPR analysis claim services dates will consist of discharge dates within the calendar year prior to the July 1st effective date (for readmission reduction factors effective July 1, 2016, the PPR analysis

will be based on claims with discharge dates in calendar year 2015), with the following exceptions:

(A) PPR analysis will include PPRs with a discharge date after the calendar year that were in a PPR chain where the initial admission discharge date was in the calendar year.

(B) PPR analysis will exclude PPRs with a discharge date in the calendar year that were in a PPR chain where the initial admission discharge date was before the calendar year.

(iii) A readmission reduction factor for each hospital is based on the hospital's excess readmission payments divided by the total hospital inpatient payments in the PPR analysis.

[AMENDATORY SECTION]

WAC 182-550-2900 Payment limits—Inpatient hospital services. (1) To be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the agency; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of such a hospital, and meet the definition in WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) The agency does not pay for any of the following:

(a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

(d) Additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the agency or mental health designee (see WAC 182-550-2600), as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received approval for an extended LOS from the agency or mental health designee as specified in WAC 182-550-4300(6). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. A mental health designee may also perform those utilization reviews to evaluate an extended LOS.

(e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

~~(f) Two separate inpatient hospitalizations if a client is readmitted to the same or an affiliated hospital or distinct unit within fourteen calendar days of discharge and the agency determines one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000.~~

(~~g~~f) A client's day(s) of absence from the hospital or distinct unit.

(~~h~~g) An inappropriate or nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.

(~~i~~h) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.

(3) This section defines when the agency considers payment for an interim billed inpatient hospital claim.

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged prior to the next sixty calendar day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the agency is not the primary payer:

(i) The agency pays an interim billed nonpsychiatric claim when the criteria in (a) of this subsection are met; and

(ii) Either of the following:

(A) Sixty calendar days have passed from the date the agency became the primary payer; or

(B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(c) For psychiatric claims, (a)(i) and (b)(i) of this subsection do not apply.

(4) The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less upon the client's formal release from the hospital or distinct unit.

(5) To be eligible for payment, a hospital or distinct unit must bill the agency using an inpatient hospital claim:

(a) In accordance with the current national uniform billing data element specifications:

(i) Developed by the National Uniform Billing Committee (NUBC);

(ii) Approved or modified, or both, by the Washington state payer group or the agency; and

(iii) In effect on the date of the client's admission.

(b) In accordance with the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) In accordance with the agency's published provider guides and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the agency considers and pays an initial interim billed hospital claim and any subsequent interim billed hospital claims;

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and

(g) With the appropriate National Uniform Billing Committee (NUBC) revenue code(s) specific to the service or treatment provided to the client.

(6) When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by C.F.R. §447.271.

(7) The agency allows hospitals an all-inclusive administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care. The agency allows this day rate only when an appropriate placement outside the hospital is not available.

(8) The agency pays for observation services according to WAC 182-550-6000, 182-550-7200, and other applicable rules.

(9) The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:

(a) Client responsibility (e.g., spenddown);

(b) Any third-party liability amount, including medicare part A and part B; and

(c) Any other adjustments as determined by the agency.

(10) The agency pays hospitals less for services provided to clients eligible under state-administered programs, as provided in WAC 182-550-4800.

(11) All hospital providers must present final charges to the agency according to WAC 182-502-0150.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-2900, filed 5/29/14, effective 7/1/14. WSR 11-14-075,

recodified as § 182-550-2900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-2900, filed 6/28/07, effective 8/1/07; WSR 04-20-058, § 388-550-2900, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-2900, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. WSR 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-2900, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

[AMENDATORY SECTION]

WAC 182-550-3000 Payment method. (1) The medicaid agency uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 182-550-4300 and 182-550-4400.

(2) The agency assigns a DRG code to each claim for an inpatient hospital stay using 3M™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

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

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(4) An inpatient claim payment includes all hospital covered services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) The inpatient hospital stay;

(b) Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient

hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim;

(c) Any hospital covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000
Per Diem	Hospital-specific daily rate for the service (psych, rehab, detox, or CUP) times covered allowable days	182-550-2600 and 182-550-3381
Single Case Rate	Hospital specific bariatric case rate per stay	182-550-3470
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300

Payment Method	General Description of Payment Formula	WAC Reference
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ancillary charges that are allowable and covered for administrative days	182-550-3381

(6) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) A claim qualifies as a high outlier (see WAC 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a Washington apple health program on one or more days of the hospital stay;

(d) A client has third-party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges; or

~~(f) A client is discharged from an inpatient hospital stay and, within fourteen calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or its designee performs a retrospective utilization review (see WAC 182-550-1700) on~~

~~the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for payment.~~

~~(g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition). The agency or its designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments;~~

(~~h~~f) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

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

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

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

(10) The agency pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 182-550-2900.

(11) The agency applies to the allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(12) The agency pays hospitals in designated bordering cities for allowed covered services as described in WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described in WAC 182-550-4000.

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

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

(16) Hospitals participating in the Washington apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by the agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

(19) Participating hospitals must permit the agency to conduct periodic audits of their financial records, statistical records, and any other records as determined by the agency.

(20) The agency limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(21) For a client's hospital stay that involves regional support network (RSN)-approved voluntary inpatient or involuntary inpatient hospitalizations, the hospital must bill the agency for payment. When the hospital contracts directly with the RSN, the hospital must bill the RSN for payment.

(22) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the agency may manually price the claim at the hospital's psychiatric per diem rate.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3000, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3000, filed 6/30/11, effective 7/1/11. Statu-

tory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-3000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]