

**WAC 182-550-5450 Supplemental distributions to approved trauma service centers.** (1) The trauma care fund (TCF) is an amount appropriated to the medicaid agency each state fiscal year (SFY), at the legislature's sole discretion, for the purpose of supplementing the agency's payments to eligible trauma service centers for providing qualified trauma services to medicaid clients.

(2) Encounter data, for trauma care provided to medicaid clients enrolled in an agency-contracted managed care organization, may be included when calculating supplemental distributions from the TCF, so long as the beginning dates of service for trauma care are on and after July 1, 2013.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable rules;

(c) Meet the billing requirements in this section and other applicable rules;

(d) Submit all information the agency requires to monitor the program; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) Allocated into five payment pools. Timing of payments is described in subsection (5) of this section. Distributions from the payment pools to the individual hospitals are determined by first summing the agency's qualifying payments to each eligible hospital since the beginning of the service year. This amount is then expressed as a percentage of the agency's total payments to all eligible hospitals for qualifying services provided during the service year-to-date. For TCF purposes, service year is defined as the SFY. Each hospital's qualifying payment percentage for the service year-to-date is multiplied by the available amount for the service year-to-date, and then the agency subtracts what has been allocated to each hospital for the service year-to-date to determine the portion of the current payment pool to be paid to each qualifying hospital. Eligible hospitals and qualifying payments are described in (a)(i) through (iii) of this subsection. Qualifying payments are the agency's payments to:

(i) Level I, Level II, and Level III trauma service centers for qualified medicaid trauma cases since the beginning of the service year. The agency determines the countable payment for trauma care provided to medicaid clients based on date of service, not date of payment;

(ii) The Level I, Level II, and Level III hospitals for trauma cases transferred to these facilities since the beginning of the service year. A Level I, Level II, or Level III hospital that receives a transferred trauma case from any lower level hospital is eligible for an enhanced payment, regardless of the client's injury severity score (ISS); and

(iii) Level II and Level III hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in (b) of this subsection) transferred by these hospitals since the beginning of the service year to a trauma service center with a higher designation level.

(b) Paid only for a medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

- (ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or
- (iii) The conditions of (c) of this subsection.
- (c) Made to hospitals, as follows, for a trauma case that is transferred:
  - (i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is designated or recognized by DOH as an approved Level I, Level II, or Level III adult or pediatric trauma service center;
  - (ii) A hospital that transfers the trauma case qualifies for payment only if:
    - (A) The hospital is designated or recognized by DOH as an approved Level II or Level III adult or pediatric trauma service center; and
    - (B) The ISS requirements in (b)(i) or (ii) of this subsection are met.
  - (iii) A hospital that DOH designates or recognizes as an approved Level IV or Level V trauma service center does not qualify for supplemental distributions for trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in (b) of this subsection.
- (d) Not funded by disproportionate share hospital (DSH) funds; and
- (e) Not distributed by the agency to:
  - (i) Trauma service centers designated or recognized as Level IV or Level V;
  - (ii) Critical access hospitals (CAHs), except when the CAH is also a Level III trauma service center; or
  - (iii) Any facility for follow-up services related to the qualifying trauma incident but provided to the client after the client has been discharged from the initial hospitalization for the qualifying injury.
- (5) Distributions for an SFY are paid as follows:
  - (a) The first supplemental distribution from the TCF is made three to six months after the SFY begins;
  - (b) Subsequent distributions are made approximately every two to four months after the first distribution is made, except as described in (c) of this subsection;
  - (c) The final distribution from the TCF for an SFY is:
    - (i) Made one year after the end of the SFY;
    - (ii) Limited to the remaining balance of the agency's TCF appropriation for that SFY; and
    - (iii) Distributed based on each eligible hospital's percentage share of the total payments made by the agency to all designated trauma service centers for qualified trauma services provided during the relevant SFY.
- (6) For purposes of the supplemental distributions from the TCF, all of the following apply:
  - (a) At its discretion, and with sufficient public notice, the agency may adjust the deadline for submission and/or adjustment of trauma claims in response to budgetary program needs;
  - (b) The agency considers a provider's request for a trauma claim adjustment only if the adjustment request is received by the agency within three hundred sixty-five calendar days from the date of the initial trauma service;
  - (c) Except as provided in (a) of this subsection, the deadline for making adjustments to a trauma claim is the same as the deadline

for submitting the initial claim to the agency as specified in WAC 182-502-0150(3). See WAC 182-502-0150 (11) and (12) for other time limits applicable to TCF claims;

(d) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(e) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the agency in any SFY cannot exceed the amount appropriated by the legislature for that SFY. The agency has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

[Statutory Authority: RCW 41.05.021 and Washington State Plan Amendment 13-15. WSR 14-10-002, § 182-550-5450, filed 4/23/14, effective 5/24/14. Statutory Authority: RCW 41.05.021. WSR 13-17-017, § 182-550-5450, filed 8/9/13, effective 9/9/13; WSR 12-14-041, § 182-550-5450, filed 6/27/12, effective 7/28/12. WSR 11-14-075, recodified as § 182-550-5450, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. WSR 10-12-013, § 388-550-5450, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.160, 74.09.500, and 70.168.040. WSR 08-08-065, § 388-550-5450, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-5450, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-5450, filed 3/30/06, effective 4/30/06; WSR 04-19-113, § 388-550-5450, filed 9/21/04, effective 10/22/04.]