WAC 182-550-3830 Adjustments to inpatient rates. (1) The medicaid agency updates all of the following components of a hospital's specific diagnosis-related group (DRG) factor and per diem rates at rebase:

(a) Wage index adjustment;

(b) Direct graduate medical education (DGME); and

(c) Indirect medical education (IME).

(2) Effective January 1, 2015, the agency updates the sole community hospital adjustment.

(3) The agency does not update the statewide average DRG factor between rebasing periods, except:

(a) To satisfy the budget neutrality conditions in WAC 182-550-3850; and

(b) When directed by the legislature.

(4) The agency updates the wage index to reflect current labor costs in the core-based statistical area (CBSA) where a hospital is located. The agency:

(a) Determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(b) Multiplies the amount in (a) of this subsection by the most recent wage index information published by the Centers for Medicare and Medicaid Services (CMS) when the rates are set; then

(c) Adds the nonlabor portion of the base rate to the amount in (b) of this subsection to produce a hospital-specific wage adjusted factor.

(5) DGME. The agency obtains DGME information from the hospital's most recently filed medicare cost report that is available in the CMS health care cost report information system (HCRIS) dataset.

(a) The hospital's medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(b) If a hospital's medicare cost report is not available on HCRIS, the agency may use the CMS Form 2552-10 to calculate DGME.

(c) If a hospital has not submitted a CMS medicare cost report in more than eighteen months from the end of the hospital's cost reporting period, the agency considers the current DGME costs to be zero.

(d) The agency calculates the hospital-specific DGME by dividing the DGME cost reported on worksheet B, part 1 of the CMS cost report by the adjusted total costs from the CMS cost report.

(6) IME. The agency sets the IME adjustment equal to the "IME adjustment factor for Operating PPS" available in the most recent CMS final rule impact file on CMS's website as of May 1st of the rate-setting year.

(7) The agency considers an in-state hospital to qualify for a rate enhancement if all of the following conditions apply. The hospital must:

(a) Be certified by CMS as a sole community hospital as of January 1, 2013;

(b) Have a level III adult trauma service designation from the department of health as of January 1, 2014;

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

(d) Be owned and operated by the state or a political subdivision; and

(e) Not participate in the certified public expenditures (CPE) payment program defined in WAC 182-550-4650.

(8) If an in-state hospital qualifies for the rate enhancement in subsection (7) of this section, effective:

(a) January 1, 2015, through June 30, 2018, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.25.

(b) July 1, 2018, through June 30, 2021, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.50.

(c) July 1, 2021, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.25.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2019 c 415 § 211(14). WSR 20-01-075, § 182-550-3830, filed 12/11/19, effective 1/11/20. Statutory Authority: RCW 41.05.021, 41.05.160. WSR 18-09-022, § 182-550-3830, filed 4/11/18, effective 5/12/18; WSR 15-10-014, § 182-550-3830, filed 4/23/15, effective 5/24/15; WSR 14-22-003, § 182-550-3830, filed 10/22/14, effective 11/22/14.]