WAC 182-550-3800 Rebasing. The medicaid agency redesigns (rebases) the medicaid inpatient payment system as needed. The base inpatient conversion factor and per diem rates are only updated during a detailed rebasing process, or as directed by the state legislature. Inpatient payment system factors such as the ratio of costs-to-charges (RCC), weighted costs-to-charges (WCC), and administrative day rate are rebased on an annual basis. As part of the rebasing, the agency does all of the following:

(1) Gathers data. The agency uses the following data resources considered to be the most complete and available at the time:

(a) One year of paid claim data from the agency's medicaid management information system (MMIS). The agency excludes:

(i) Claims related to state programs and paid at the Title XIX reduced rates from the claim data; and

(ii) Critical access hospital claims paid per WAC 182-550-2598; and

(b) The hospital's most current medicare cost report data from the health care cost report information system (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS). If the hospital's medicare cost report from HCRIS is not available, the agency uses the medicare cost report provided by the hospital.

(c) FFS and managed care encounter data.

(2) Estimates costs. The agency estimates costs by multiplying the ratio of costs-to-charges (RCC) by the total billed charges.

(3) Specifies resource use with relative weights. The agency uses national relative weights designed by Solventum Corporation as part of its all-patient refined-diagnostic related group (APR-DRG) payment system. The agency periodically reviews and determines the most appropriate APR-DRG grouper version to use.

(4) Calculates base payment factors. The agency calculates the average, or base, DRG conversion factor and per diem rates. The base is calculated as the maximum amount that can be used, along with all other payment factors and adjustments described in this chapter. The agency models the rebased system to be budget neutral on a prospective basis, including global adjustments to the budget target determined by the agency. The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients. The agency will publish base rate factors on its website.

(5) Determines provider specific adjustments. The following adjustments are applied to the base factor or rate established in subsection (4) of this section:

(a) Wage index adjustments reflect labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(i) The agency determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(ii) The amount in (a)(i) of this subsection is multiplied by the most recent wage index information published by CMS at the time the rates are set; then

(iii) The agency adds the nonlabor portion of the base rate to the amount in (a)(ii) of this subsection to produce a hospital-specific wage adjusted factor.

(b) Indirect medical education factors are applied to the hospital-specific base factor or rate. The agency uses the indirect medical education factor established by medicare on the most currently available medicare cost report that exists at the time the rates are set; and

(c) Direct medical education amounts are applied to the hospital-specific base factor or rate. The agency determines a percentage of direct medical education costs to overall costs using the most currently available medicare cost report that exists at the time the rates are set.

(6) To maintain budget neutrality, the agency makes global adjustments as needed.

(7) The final, hospital-specific rate is calculated using the base rate established in subsection (4) of this section along with any applicable adjustments in subsections (5) and (6) of this section.

(8) When rebasing psychiatric per diem rates, the agency uses medicaid claims data and medicare cost report data from the calendar year base period ending two years prior to the effective date of rebasing, using the methodology described for psychiatric per diem rates effective January 1, 2024.

(a) When rebasing, the agency will determine new budget target adjusters, not to exceed a factor of 100 percent.

(b) Hospital psychiatric units with at least 200 Washington medicaid bed days in the base period will receive a cost-based rate with a psychiatric unit-specific budget target adjuster applied.

(c) Hospital psychiatric units with less than 200 Washington medicaid psychiatric bed days in the base period will receive a psychiatric per diem rate equal to the statewide average per diem.

(d) The agency conducts annual reviews for updated cost information to determine whether new or existing providers continue to meet the 200 or more bed days criteria.

(9) The agency sets psychiatric per diem rates specific to long-term civil commitments separately from other psychiatric per diem rates.

(a) In order to qualify for a provider-specific long-term civil commitment psychiatric per diem, the provider must be contracted with the agency to provide long-term civil commitment beds.

(b) The agency sets the provider-specific rate at the beginning of the state fiscal year. If a provider contracts with the agency during the state fiscal year, their initial rate will be set at the greater of:

(i) The in-state, state-wide average long-term psychiatric per diem for their category of hospital; or

(ii) Their current provider-specific short-term psychiatric per diem.

(c) The agency sets the rate for acute care hospitals under chapter 70.41 RCW with distinct psychiatric units as follows:

(i) Hospitals that have a 12-month medicare cost report with at least 200 psychiatric bed days on file with the agency receive a long-term psychiatric per diem rate equivalent to the costs documented on the medicare cost report.

(ii) Hospitals that do not have a 12-month cost report with at least 200 bed days on file with the agency receive a long-term psychiatric per diem rate equivalent to the greater of:

(A) The average long-term psychiatric per diem of all acute care hospitals providing long-term psychiatric services in-state; or

(B) Their current provider-specific short-term psychiatric per diem.

(iii) The long-term psychiatric rate is applied to agency-contracted hospitals for long-term psychiatric services. The acute care hospital long-term psychiatric per diem will be rebased annually at

the beginning of the state fiscal year using most recently available medicare cost report data.

(iv) The agency sets the rate so as not to exceed the amount provided by the legislature.

(d) The agency sets the rates for free-standing psychiatric hospitals under chapter 71.12 RCW as follows:

(i) Hospitals will receive a long-term psychiatric per diem rate as approved by the legislature.

(ii) In addition to a long-term psychiatric per diem rate, the hospital may annually submit supplemental cost data to the agency for consideration by May 1st for the upcoming state fiscal year. If approved, the agency will make appropriate adjustments to the medicaid inpatient long-term psychiatric per diem payment rate of the hospital. Adjustment of costs may include any of the following:

(A) Costs associated with professional services and fees not accounted for in the hospital's medicare cost report or reimbursed separately;

(B) Costs associated with the hospital providing the long-term psychiatric patient access to involuntary treatment court services that are not reimbursed separately;

(C) Other costs associated with caring for long-term psychiatric patients that are not reimbursed separately.

(iii) The agency sets the rate so as to not exceed the amount provided by the legislature.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 24-23-012, s 182-550-3800, filed 11/8/24, effective 12/9/24; WSR 23-20-048, § 182-550-3800, filed 9/28/23, effective 10/29/23. Statutory Authority: RCW 41.05.021, 41.05.160 and 2021 c 334 §§ 211(46) and 215(66). WSR 22-03-008, § 182-550-3800, filed 1/6/22, effective 2/6/22. Statutory Authority: RCW 41.05.021, 41.05.160 and 2020 c 357 § 215 (24)(b). WSR 21-02-087, § 182-550-3800, filed 1/6/21, effective 2/6/21. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-12-043, § 182-550-3800, filed 5/30/18, effective 7/1/18. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3800, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-3800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 05-06-044, § 388-550-3800, filed 2/25/05, effective 7/1/05. 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, § 388-550-3800, filed 7/31/01, effective 8/31/01. 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, § 388-550-3800, filed 12/18/97, effective 1/18/98.]