

## WSR 24-20-072

## PROPOSED RULES

## HEALTH CARE AUTHORITY

[Filed September 27, 2024, 9:51 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 24-11-115.

Title of Rule and Other Identifying Information: WAC 182-550-3800 Rebasing.

Hearing Location(s): On November 5, 2024, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. To attend the virtual public hearing, you must register in advance [https://us02web.zoom.us/webinar/register/WN\\_yD-r9EuYSnSoSXrF38FcTQ](https://us02web.zoom.us/webinar/register/WN_yD-r9EuYSnSoSXrF38FcTQ). If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: November 6, 2024.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email [arc@hca.wa.gov](mailto:arc@hca.wa.gov), fax 360-586-9727, beginning September 30, 2024, 8:00 a.m., by November 5, 2024, by 11:59 p.m.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-9727, telecommunication relay service 711, email [Johanna.Larson@hca.wa.gov](mailto:Johanna.Larson@hca.wa.gov), by October 18, 2024.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending these rules to provide more general language due to frequent changes of percentages and dollar amounts. Added psychiatric per diem rate information and psychiatric unit-specific budget target adjuster. HCA will only do cost-based rates once per year; an average is applied if contracting period is between fiscal years.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Freudenstein, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Abby Cole, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1835.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Scope of exemption for rule proposal from Regulatory Fairness Act requirements:

Is fully exempt.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rule changes affect hospitals. The

proposed rule does not impose more-than-minor costs on small businesses.

September 27, 2024  
Wendy Barcus  
Rules Coordinator

### OTS-5846.3

AMENDATORY SECTION (Amending WSR 23-20-048, filed 9/28/23, effective 10/29/23)

**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 (~~uses one of two methods to estimate costs. The agency may perform an aggregate cost determination~~) estimates costs by multiplying the ratio of costs-to-charges (RCC) by the total billed charges (~~, or the agency may use the following detailed costing method:~~

~~(a) The agency identifies routine and ancillary cost for operating capital, and direct medical education cost components using different worksheets from the hospital's medicare cost report;~~

~~(b) The agency estimates costs for each claim in the dataset as follows:~~

~~(i) Accommodation services. The agency multiplies the average hospital cost per day reported in the medicare cost report data for each type of accommodation service (e.g., adult and pediatric, intensive care unit, psychiatric, nursery) by the number of days reported at the claim line level by type of service; and~~

~~(ii) Ancillary services. The agency multiplies the RCC reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, or clinic) by the allowed charges reported at the claim line level by type of service; and~~

~~(c) The agency uses the following standard cost components for accommodation and ancillary services for estimating costs of claims:~~

- ~~(i) Routine cost components:~~
  - ~~(A) Routine care;~~
  - ~~(B) Intensive care;~~
  - ~~(C) Intensive care-psychiatric;~~
  - ~~(D) Coronary care;~~
  - ~~(E) Nursery;~~
  - ~~(F) Neonatal ICU;~~
  - ~~(G) Alcohol/substance abuse;~~
  - ~~(H) Psychiatric;~~
  - ~~(I) Oncology; and~~
  - ~~(J) Rehabilitation.~~
- ~~(ii) Ancillary cost components:~~
  - ~~(A) Operating room;~~
  - ~~(B) Recovery room;~~
  - ~~(C) Delivery/labor room;~~
  - ~~(D) Anesthesiology;~~
  - ~~(E) Radio, diagnostic;~~
  - ~~(F) Radio, therapeutic;~~
  - ~~(G) Radioisotope;~~
  - ~~(H) Laboratory;~~
  - ~~(I) Blood administration;~~
  - ~~(J) Intravenous therapy;~~
  - ~~(K) Respiratory therapy;~~
  - ~~(L) Physical therapy;~~
  - ~~(M) Occupational therapy;~~
  - ~~(N) Speech pathology;~~
  - ~~(O) Electrocardiography;~~
  - ~~(P) Electroencephalography;~~
  - ~~(Q) Medical supplies;~~
  - ~~(R) Drugs;~~
  - ~~(S) Renal dialysis/home dialysis;~~
  - ~~(T) Ancillary oncology;~~
  - ~~(U) Cardiology;~~
  - ~~(V) Ambulatory surgery;~~
  - ~~(W) CT scan/MRI;~~
  - ~~(X) Clinic;~~
  - ~~(Y) Emergency;~~
  - ~~(Z) Ultrasound;~~
  - ~~(AA) NICU transportation;~~
  - ~~(BB) GI laboratory;~~
  - ~~(CC) Miscellaneous; and~~
  - ~~(DD) Observation beds).~~

(3) Specifies resource use with relative weights. The agency uses national relative weights designed by ((3M<sup>TM</sup>)) 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) ((To maintain budget neutrality, the agency makes global adjustments as needed.~~

~~(a) Claims paid under the DRG, rehab per diem, and withdrawal management per diem payment methods were reduced to support an estimated \$3,500,000 increase in psychiatric payments to acute hospitals.~~

~~(b) Claims for acute hospitals paid under the psychiatric per diem method were increased by a factor to inflate estimated system payments by \$3,500,000.~~

~~(c) Effective for dates of admission on and after October 1, 2017, the agency increased psychiatric per diem rates as directed by the legislature. The increase applies to any hospital with 200 or more psychiatric bed days.~~

~~(i) The agency prioritized the increase for hospitals not currently paid based on provider-specific costs using a similar methodology to set rates for existing inpatient facilities utilizing cost report information for hospital fiscal years ending in 2016.~~

~~(ii) The distribution of funds for each fiscal year is as follows:~~

~~(A) Free-standing psychiatric hospitals receive 68.15 percent of the statewide average cost per day.~~

~~(B) All other hospitals receive the greater of 78.41 percent of their provider-specific cost, or their current medicaid psychiatric per diem rate.~~

~~(iii) The agency set the increased rates to assure that the distribution of funds does not exceed the amounts provided by the legislature.~~

~~(iv)) 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 ((and)) or existing providers continue to meet the 200 or more bed days criteria.

~~((v) The agency will apply the same cost percentage criteria for future rebasing of the psychiatric per diem rates.~~

~~(6) Effective July 1, 2020,))~~ (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 ~~((time of contracting))~~ 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 ~~((, provider-specific long-term psychiatric per diem rates, or the)); or~~

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

(iii) The long-term psychiatric rate is applied to ~~((any hospital that accepts patients committed to a psychiatric facility for a period of 90 days or greater.))~~ 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 ((without an existing long-term rate receive a per diem rate equivalent to either the greater of the short-term rate or the state-wide average long-term psychiatric rate for free-standing psychiatric hospitals.~~

~~(ii) Hospitals that have an existing long-term per diem will continue to receive the \$940 established for July 1, 2021)) will receive a long-term psychiatric per diem rate as approved by the legislature.~~

~~(ii) In addition to ((the \$940)) a long-term psychiatric per diem rate, the hospital may annually submit supplemental cost data ((with the cost report)) 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.~~

~~((7) 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.~~

~~(8) 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 (6) and (7) of this section.)~~