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 fee-for-service (FFS) 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 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™ 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 three million five hundred thousand dollar 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 three million five hundred thousand dollars.

(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 two hundred 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) The agency conducts annual reviews for updated cost information to determine whether new and existing providers meet the two hundred or more bed 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, 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.

(c) The agency sets the rate for acute care hospitals 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 the average of all acute care hospitals providing long-term psychiatric services in-state, provider-specific long-term psychiatric per diem rates, or the current short-term psychiatric per diem. 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. 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 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. In addition to the $940 per diem rate, the hospital may submit supplemental cost data with the cost report to the agency for consideration. If approved, the agency will make appropriate adjustments to the medicaid inpatient 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.

[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.]