

## WSR 21-24-086

## PROPOSED RULES

## HEALTH CARE AUTHORITY

[Filed November 30, 2021, 4:52 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 21-15-041.

Title of Rule and Other Identifying Information: WAC 182-550-3800 Rebasing, 182-550-3830 Adjustments to inpatient rates, and 182-550-7500 OPPS rate.

Hearing Location(s): On January 4, 2022, at 10:00 a.m. The health care authority (HCA) remains closed in response to the coronavirus disease 2019 (COVID-19) public health emergency. Until further notice, HCA continues to hold public hearings virtually without a physical meeting place. This promotes social distancing and the safety of the residents of Washington state. To attend the virtual public hearing, you must register in advance at [https://zoom.us/webinar/register/WN\\_EO-r4q2sQmeswJiqMwS3Rw](https://zoom.us/webinar/register/WN_EO-r4q2sQmeswJiqMwS3Rw). After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: Not sooner than January 5, 2022.

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, by January 4, 2022.

Assistance for Persons with Disabilities: Contact HCA rules coordinator, phone 360-725-1306, fax 360-586-9727, telecommunication[s] relay service 711, email [arc@hca.wa.gov](mailto:arc@hca.wa.gov), by December 17, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending these sections to add qualifying criteria for and reflect an extension of the current rate increase for Sole Community hospitals. ESSB 5092, section 211(46) extends the rate increase through June of 2023. HCA also plans to implement ESSB 5092, section 215(66) to adjust rates paid for long-term civil commitments. Hospitals may now submit costs not included in their medicare cost report to be evaluated by the agency for a potential rate increase.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; ESSB 5092, sections 211(46) and 215(66).

Statute Being Implemented: RCW 41.05.021, 41.05.160; ESSB 5092, sections 211(46) and 215(66).

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

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

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: Sarah Cook, P.O. Box 55688, Olympia, WA 98504-5688, 360-725-1577.

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.

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 does not impose a disproportionate cost impact on businesses.

November 30, 2021  
Wendy Barcus  
Rules Coordinator

## OTS-3313.2

AMENDATORY SECTION (Amending WSR 21-02-087, filed 1/6/21, effective 2/6/21)

**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 ~~((detox))~~ 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, ~~((through June 30, 2021,))~~ 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 ~~((as follows:~~

~~(i) For a hospital that has a medicare cost report on file with the agency for the most recent filing year, the rate is set using hospital specific costs or nine hundred forty dollars, whichever is greater.~~

~~(ii) For a hospital that does not have a medicare cost report on file with the agency, the rate is set using the average of all in-state long-term psychiatric per diem rates based on provider type or the hospital's current short-term psychiatric per diem rates, whichever is greater.~~

~~(d))~~ 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(~~s~~) so as to not exceed the amount(~~s~~ appropriated) 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 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.]

AMENDATORY SECTION (Amending WSR 20-01-075, filed 12/11/19, effective 1/11/20)

**WAC 182-550-3830 Adjustments to inpatient rates.** (1) The medic-aid 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; and

(f) Accept single bed certification patients as of July 1, 2021, according to RCW 71.05.745.

(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))~~ 2023, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.50.

(c) July 1, ~~((2021))~~ 2023, 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.]

AMENDATORY SECTION (Amending WSR 20-01-075, filed 12/11/19, effective 1/11/20)

**WAC 182-550-7500 OPPS rate.** (1) The medicaid agency calculates hospital-specific outpatient prospective payment system (OPPS) rates using all of the following:

(a) A base conversion factor established by the agency;

(b) An adjustment for direct graduate medical education (DGME);

and

(c) The latest wage index information established and published by the centers for medicare and medicaid services (CMS) when the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(2) Base conversion factors. The agency calculates the base enhanced ambulatory patient group (EAPG) conversion factor during a hospital payment system rebasing. The base is calculated as the maximum amount that can be used, along with all other payment factors and adjustments described in this chapter, to maintain aggregate payments across the system. The agency will publish base conversion factors on its website.

(3) Wage index adjustments reflect labor costs in the CBSA where a hospital is located.

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

(b) Multiplying the amount in (a) of this subsection is multiplied by the most recent wage index information published by CMS when the rates are set; then

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

(4) DGME. The agency obtains the DGME information from the hospital's most recently filed medicare cost report as 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) In the case where 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 may remove the hospital's DGME adjustment.

(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.

(5) The formula for calculating the hospital's final specific conversion factor is:

$$\text{EAPG base rate} \times (.6(\text{wage index}) + .4) / (1 - \text{DGME})$$

(6) The agency considers an in-state hospital a sole community hospital if all 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.

(e) Accept single bed certification patients as of July 1, 2021, according to RCW 71.05.745.

(7) If the hospital meets the agency's sole community hospital (SCH) criteria listed in subsection (6) of this section, effective:

(a) January 1, 2015, through June 30, 2018, the agency multiplies the hospital's specific conversion factor by 1.25;



(b) July 1, 2018, through June 30, ((2021)) 2023, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.50;

(c) July 1, ((2021)) 2023, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.25.

(8) The formula for calculating a sole community hospital's final conversion factor is:

[EAPG base rate × (.6(wage index) + .4)/(1-DGME)] × SCH Factor

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2019 c 415 § 211(14). WSR 20-01-075, § 182-550-7500, filed 12/11/19, effective 1/11/20. Statutory Authority: RCW 41.05.021, 41.05.160, and 2018 c 299 § 213 (1)(fff). WSR 18-16-059, § 182-550-7500, filed 7/26/18, effective 8/26/18. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 14-22-003, § 182-550-7500, filed 10/22/14, effective 11/22/14. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-7500, filed 6/25/14, effective 7/26/14. WSR 11-14-075, recodified as § 182-550-7500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-062, § 388-550-7500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-13-100, § 388-550-7500, filed 6/20/07, effective 8/1/07; WSR 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

**Reviser's note:** The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

**Reviser's note:** The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.