PROPOSED RULE MAKING

CR-102 (December 2017)  
(Implements RCW 34.05.320)  
Do NOT use for expedited rule making

<table>
<thead>
<tr>
<th>Agency: Health Care Authority</th>
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<tbody>
<tr>
<td>☑ Original Notice</td>
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<td>☐ Supplemental Notice to WSR</td>
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<td>☐ Continuance of WSR ______</td>
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| Preproposal Statement of Inquiry was filed as WSR 21-15-041; or |
| ☐ Expedited Rule Making--Proposed notice was filed as WSR ______; or |
| ☐ Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or |
| ☐ Proposal is exempt under RCW ______. |

**Title of rule and other identifying information:** (describe subject) 182-550-3800 Rebasing; 182-550-3830 Adjustments to inpatient rates; 182-550-7500 OPPS rate

**Hearing location(s):**

| Date: January 4, 2022 | Time: 10:00 AM | Location: (be specific) 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. | Comment: To attend the virtual public hearing, you must register in advance for this public hearing: [https://zoom.us/webinar/register/WN_EOR4q2sQmeswJiqMwS3Rw](https://zoom.us/webinar/register/WN_EOR4q2sQmeswJiqMwS3Rw) 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 *(Note: This is NOT the effective date)*

**Submit written comments to:**

Name: HCA Rules Coordinator  
Address: PO Box 42716, Olympia WA 98504-2716  
Email: arc@hca.wa.gov  
Fax: (360) 586-9727  
Other: By (date) January 4, 2022

**Assistance for persons with disabilities:**

Contact HCA Rules Coordinator  
Phone: (360) 725-1306  
Fax: (360) 586-9727  
TTY: Telecommunication Relay Services (TRS): 711  
Email: arc@hca.wa.gov  
Other: By (date) December 17, 2021
Purpose of the proposal and its anticipated effects, including any changes in existing rules: The Health Care Authority (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, Sec. 211, (46) extends the rate increase through June of 2023. HCA also plans to implement ESSB 5092, Sec. 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, Engrossed Substitute Senate Bill 5092, Sec. 211, (46), and ESSB 5092, Sec. 215, (66)

Statute being implemented: RCW 41.05.021, 41.05.160, Engrossed Substitute Senate Bill 5092, Sec. 211, (46), and ESSB 5092, Sec. 215, (66)

Is rule necessary because of a:
  Federal Law? ☐ Yes ☒ No
  Federal Court Decision? ☐ Yes ☒ No
  State Court Decision? ☐ Yes ☒ No
If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: (person or organization) Health Care Authority ☒ Governmental

Name of agency personnel responsible for:

<table>
<thead>
<tr>
<th>Name</th>
<th>Office Location</th>
<th>Phone</th>
</tr>
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<tbody>
<tr>
<td>Drafting: Valerie Freudenstein</td>
<td>PO Box 42716, Olympia WA 98504-2716</td>
<td>360-725-1344</td>
</tr>
<tr>
<td>Implementation: Sarah Cook</td>
<td>PO Box 55688, Olympia, WA 98504-5688</td>
<td>360-725-1577</td>
</tr>
<tr>
<td>Enforcement: Sarah Cook</td>
<td>PO Box 55688, Olympia, WA 98504-5688</td>
<td>360-725-1577</td>
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Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No
If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
  Name: [Name]
  Address: [Address]
  Phone: [Phone]
  Fax: [Fax]
  TTY: [TTY]
  Email: [Email]
  Other: [Other]

Is a cost-benefit analysis required under RCW 34.05.328?
  ☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
    Name: [Name]
    Address: [Address]
    Phone: [Phone]
    Fax: [Fax]
TTY: 
Email: 
Other: ☒ No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:
This rule proposal, or portions of the proposal, may be exempt from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

☐ RCW 34.05.310 (4)(b) (Internal government operations)

☐ RCW 34.05.310 (4)(c) (Incorporation by reference)

☐ RCW 34.05.310 (4)(d) (Correct or clarify language)

☐ RCW 34.05.310 (4)(e) (Dictated by statute)

☐ RCW 34.05.310 (4)(f) (Set or adjust fees)

☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is not exempt, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The proposed rule does not impose a disproportionate cost impact on businesses.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name: 
Address: 
Phone: 
Fax: 
TTY: 
Email: 
Other:

Date: November 30, 2021

Name: Wendy Barcus
Title: HCA Rules Coordinator

Signature:
WAC 182-550-3800 Rebasings. 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 service (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
Rehabilitation.

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

(c) July 1, 2023, the agency multiplies the hospital's specific conversion factor and per diem rates by 1.25.

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.
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.

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.

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

\[
\text{EAPG base rate} \times \frac{.6(\text{wage index}) + .4}{1-\text{DGME}}
\]

The agency considers an in-state hospital a sole community hospital if all the following conditions apply. The hospital must:

- Be certified by CMS as a sole community hospital as of January 1, 2013.
- Have a level III adult trauma service designation from the department of health as of January 1, 2014.
- Have less than one hundred fifty acute care licensed beds in fiscal year 2011.
- Be owned and operated by the state or a political subdivision.
- Accept single bed certification patients as of July 1, 2021, according to RCW 71.05.745.

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

- January 1, 2015, through June 30, 2018, the agency multiplies the hospital's specific conversion factor by 1.25;
- July 1, 2018, through June 30, 2023, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.50;
- July 1, 2023, the agency multiplies an in-state hospital's specific EAPG conversion factor by 1.25.

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

\[
\left[ \text{EAPG base rate} \times \frac{.6(\text{wage index}) + .4}{1-\text{DGME}} \right] \times \text{SCH Factor}
\]