PROPOSED RULE MAKING

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

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 01, 2020
TIME: 1:52 PM

WSR 20-24-116

Agency: Health Care Authority

☒ **Original Notice**
☐ **Supplemental Notice to WSR _____**
☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 20-18-097 **; 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) WAC 182-550-3800 Rebasing.

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
January 5, 2021	10:00 AM	In response to the coronavirus disease 2019 (COVID-19) public health emergency, the agency will not provide a physical location for this hearing. This promotes social distancing and the safety of the citizens of Washington State. A virtual public hearing, without a physical meeting space, will be held instead.	To attend the virtual public hearing, you must register at the following link: https://attendee.gotowebinar.com/register/4755918165672449039. **Webinar ID:** 186-501-491 After registering, you will receive a confirmation email containing the information about joining the webinar.

Date of intended adoption: Not sooner than January 6, 2021 (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 5, 2021

Assistance for persons with disabilities:
Contact Amber Lougheed
Phone: (360) 725-1349
Fax: (360) 586-9727
TTY: Telecommunication Relay Services (TRS): 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) December 18, 2021

Purpose of the proposal and its anticipated effects, including any changes in existing rules: This rule is being amended to increase psychiatric per diem rates for community hospitals that serve patients in long-term inpatient psychiatric care.

Reasons supporting proposal: See purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160, ESSB 6168, Chapter 357, Laws of 2020, Sec. 215(24)(b).

Statute being implemented: RCW 41.05.021, 41.05.160, ESSB 6168, Chapter 357, Laws of 2020, Sec. 215(24)(b).

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

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Valerie Freudenstein	PO Box 42716, Olympia WA 98504-2716	360-725-1344
Implementation:	Abigail Cole	PO Box 45510, Olympia, WA 98504-5510	360-725-1835
Enforcement:	Abigail Cole	PO Box 45510, Olympia, WA 98504-5510	360-725-1835

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

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:
Phone:
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.

☐ 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: December 1, 2020	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 18-12-043, filed 5/30/18, effective 7/1/18)

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 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) The agency sets the rates so as to not exceed the amounts appropriated 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.

((~~(7)~~)) (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 ((~~(5)~~)) (6) and ((~~(6)~~)) (7) of this section.