

WAC 182-550-4500 Payment method—Ratio of costs-to-charges (RCC). (1) The medicaid agency pays hospitals using the ratio of costs-to-charges (RCC) payment method for services exempt from the following payment methods:

- (a) Ambulatory payment classification (APC);
- (b) Diagnosis-related group (DRG);
- (c) Enhanced ambulatory patient group (EAPG);
- (d) Per case;
- (e) Per diem; and
- (f) Maximum allowable fee schedule.

(2) The agency:

(a) Determines the payment for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC by the allowed covered charges for medically necessary services; and

(ii) Outpatient claims by multiplying the hospital's outpatient RCC by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection:

- (i) All applicable adjustments for client responsibility;
- (ii) Any third-party liability;
- (iii) Medicare payments; and
- (iv) Any other adjustments as determined by the agency.

(c) Limits the RCC payment to the hospital's usual and customary charges for services allowed by the agency.

(3) The agency uses the RCC payment method to calculate the following:

(a) Payment for the following services:

(i) Organ transplant services (see WAC 182-550-4400 (4) (h));

(ii) Hospital services provided at a long-term acute care (LTAC) facility not covered under the LTAC per diem rate (see WAC 182-550-2596); and

(iii) Any other hospital service identified by the agency as being paid by the RCC payment method; and

(b) Costs for the following:

(i) High outlier qualifying claims (see WAC 182-550-3700); and

(ii) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments under WAC 182-550-4650(5).

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 182-550-3000(8), the agency may apply an inpatient adjustment factor to the inpatient RCC payments made for the services in subsection (3) of this section.

(5) This section explains how the agency calculates each in-state and critical border hospital's RCC. For noncritical border city hospitals, see WAC 182-550-3900. The agency:

(a) Divides adjusted costs by adjusted patient charges. The agency determines the allowable costs and associated charges.

(b) Excludes agency nonallowed costs and nonallowed charges, such as costs and charges attributable to a change in ownership.

(c) Bases the RCC calculation on data from the hospital's annual medicare cost report (Form 2552) and applicable patient revenue reconciliation data provided by the hospital. The medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) Updates a hospital's inpatient RCC annually after the hospital sends its hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and the agency. If medicare grants a delay in submission of the CMS medicare cost report to the

medicare fiscal intermediary, the agency may determine an alternate method to adjust the RCC.

(e) Limits a noncritical access hospital's RCC to one point zero (1.0).

(6) For a hospital formed as a result of a merger (see WAC 182-550-4200), the agency combines the previous hospital's medicare cost reports and follows the process in subsection (5) of this section. The agency does not use partial year cost reports for this purpose.

(7) For newly constructed hospitals and hospitals not otherwise addressed in this chapter, the agency annually calculates a weighted average in-state RCC by dividing the sum of agency-determined costs for all in-state hospitals with RCCs by the sum of agency-determined charges for all hospitals with RCCs.

(8) The agency calculates each hospital's outpatient RCC annually. The agency calculates:

(a) A hospital's outpatient RCC by multiplying the hospital's inpatient RCC by the outpatient adjustment factor (OAF); and

(b) The weighted average in-state hospital outpatient RCC by multiplying the in-state weighted average inpatient RCC by the OAF.

(9) The OAF:

(a) Is the ratio between the outpatient and inpatient RCC payments;

(b) Is updated annually to adjust for cost and charge inflation; and

(c) Must not exceed one point zero (1.0).

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4500, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4500, 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, § 388-550-4500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4500, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-4500, filed 6/12/03, effective 7/13/03. 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, § 388-550-4500, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-4500, filed 2/26/99, effective 3/29/99. 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, § 388-550-4500, filed 12/18/97, effective 1/18/98.]