WAC 182-550-2598 Critical access hospitals (CAHs). (1) The following definitions and abbreviations and those found in chapter 182-500 WAC and WAC 182-182-1050 apply to this section:

(a) "CAH" see "critical access hospital."

(b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with the use of the CAH's final settled medicare cost report (Form 2552-96) after the end of the CAH's HFY.

(c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.

(d) "HFY" see "hospital fiscal year."

(e) "Hospital fiscal year" means each individual hospital's medicare cost report fiscal year.

(f) "Interim CAH payment" means the actual payment the medicaid agency makes for claims submitted by a CAH for service provided during its current HFY, using the appropriate weighted costs-to-charges (WCC) rate, as determined by the agency.

(g) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in each hospital's medicare cost report.

(h) "Weighted costs-to-charges (WCC) rate" means a rate the agency uses to determine a CAH payment. See subsection (5) of this section for how the agency calculates a WCC rate.

(i) "WCC rate" see "weighted costs-to-charges rate."

(2) To be paid as a CAH by the agency, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the agency upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter 182-502 WAC. For information on audits and the audit appeal process, see chapter 182-502A WAC.

(3) The agency pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service Washington apple health clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using weighted costs-to-charges WCC rates and a retrospective cost settlement process. The agency pays CAH fee-for-service claims subject to retrospective cost settlement, adjustments such as a third party payment amount, any client responsibility amount, etc.

(4) For inpatient and outpatient hospital services provided to clients enrolled in a managed care organization (MCO) plan, WCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The agency considers managed care health options and MHD designee WCC payment rates to be cost. Cost settlements are not performed by the agency for managed care claims.

(5) The agency prospectively calculates fee-for-service and managed care inpatient and outpatient WCC rates separately for each CAH.

(a) Before the agency's calculation of the prospective interim inpatient WCC and outpatient WCC rates for each hospital participating in the CAH program, the CAH must timely submit the following to the agency:

(i) Within twenty working days of receiving the request from the agency, the CAH's estimated aggregate charge master change for its next HFY;

(ii) At the time that the "as filed" version of the medicare cost report the CAH initially submits to the medicare fiscal intermediary for the cost settlement of its most recently completed HFY, a copy of that same medicare cost report;

(iii) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, the CAH's corresponding revenue codes and procedure codes to cost centers crosswalk that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in the hospital's medicare cost report;

(iv) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, a document indicating any differences between the CAH's revenue codes and procedure codes to cost centers crosswalk and the standard revenue codes and procedure codes to cost centers crosswalk that the agency provides to the CAH from the agency's CAH WCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the agency that a difference exists in the CAH's placement of statistics for the anesthesia revenue code normally identified to the anesthesia cost center in the agency's CAH WCC rate calculation model, but identified to the surgery cost center in the CAH's submitted medicare cost report.)

(b) The agency:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH WCC rate calculation model will be allowed when the CAH timely submits the document identified in (a)(iii) and (a)(iv) of this subsection. If the CAH does not timely submit the document, the agency may use the CAH WCC rate calculation model without considering the differences.

(ii) Does not allow unbundling or merging of the standard cost centers identified in the CAH WCC rate calculation model when the agency calculates the WCC rates. This is a standard the agency follows during the rate calculation process even though the CAH hospital may have in contrast to the CAH WCC rate calculation model indicated multiple cost centers, or merged into fewer costs centers, when reporting in the medicare cost report. (For example, a CAH reports to the agency that in the agency's standard radiology cost center grouping in the CAH WCC rate calculation model, the hospital has established three costs centers in the medicare cost report, which are radioisotopes, radiology therapeutic, and radiology diagnostic. During the rate calculation process, the agency combines these three cost centers under the standard radiology cost center grouping. No unbundling of the standard cost center grouping is allowed.)

(c) The agency:

(i) Obtains from its medicaid management information system (MMIS), the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (a)(ii) of this subsection:

(A) Washington apple health program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DRG) codes (for inpatient claims only);

(D) Claim allowed charges, third party liability, client paid amounts, and agency paid amounts; and

(E) Units of service.

(ii) Obtains Level III trauma payment data from the department of health (DOH).

(iii) Obtains the costs-to-charges ration (CCR) of each respective cost center from the "as filed" version of the medicare cost report identified in (a)(ii) of this subsection, supplemented by any crosswalk information as described in (a)(iii) and (a)(iv) of this subsection.

(iv) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified:

(A) Washington apple health program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DGR) codes (for inpatient claims only); and

(D) Claim allowed charges.

(v) Separates the inpatient claims data and outpatient hospital claims data;

(vi) Obtains the cost center claim allowed charges by classifying inpatient and outpatient hospital claim allowed charges from (c)(i) and (c)(iv) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" medicare cost report the CAH initially submits to the agency.

(vii) Uses the claims classifications and cost center combinations as defined in the agency's CAH WCC rate calculation model;

(viii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;

(ix) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been timely submitted (see (a)(iii), (a)(iv), and (b)(i) of this subsection) and a cost center average is being used;

(x) Does not allow an unbundling of cost centers (see (b)(ii) of this subsection);

(xi) Determines the agency-weighted costs for each cost center by multiplying the cost center's claim allowed charges from (c)(i) and (c)(iv) of this subsection for the appropriate inpatient or outpatient claim type by the related service costs center ratio;

(xii) Sums all:

(A) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for inpatient hospital claims.

(B) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for outpatient hospital claims.

(xiii) Sums all:

(A) Agency-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.

(B) Agency-weighted costs from (c)(xi) of this subsection separately for outpatient hospital claims.

(xiv) Multiplies each hospital's total agency-weighted costs from (c)(xiii) of this subsection by the centers for medicare and medicaid services (CMS) medicare market basket inflation rate to update costs from the HFY to the rate setting period. The medicare market basket inflation rate is published and updated by CMS periodically;

(xv) Multiplies each hospital's total claim allowed charges from (c)(xii) of this subsection by the CAH estimated charge master change from (a)(i) of this subsection. If the charge master change factor is

not submitted timely by the hospital (see (a)(i) of this subsection), the agency will apply a reasonable alternative factor; and

(xvi) Determines:

(A) The inpatient WCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(B) The outpatient WCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(6) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective WCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate MMIS summary claims data for that HFY.

(b) MCO clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(7) For a newly licensed hospital that is also a CAH, the agency uses the current statewide average WCC rates for the initial prospective WCC rates.

(8) For a CAH that comes under new ownership, the agency uses the prior owner's WCC rates until:

(a) The new owner submits its first "as filed" medicare cost report to the medicare fiscal intermediary, and at the same time to the agency, the documents identified in (5)(a)(i) through (a)(iv) of this section; and

(b) The agency has calculated new WCC rates based on the new owner's "as filed" medicare cost report and other timely submitted documents.

(9) In addition to the prospective managed care inpatient and outpatient WCC rates, the agency:

(a) Incorporates the WCC rates into the calculations for the agency's MCO capitated premium that will be paid to the MCO plan; and

(b) Requires all MCO plans having contract relationships with CAHs to pay inpatient and outpatient WCC rates applicable to managed care claims. For purposes of this section, the agency considers the WCC rates used to pay CAHs for care given to clients enrolled in an MCO plan to be cost. Cost settlements are not performed for claims that are submitted to the MCO plans.

(10) For fee-for-service claims only, the agency uses the same methodology as outlined in subsection (5) of this section to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" medicare cost report data from that HFY that is being cost settled, the other documents identified in subsection (5)(a)(i), (a)(iii) and (a)(iv) of this section, when data from the MMIS related to fee-for-service claims. Specifically, the agency:

(a) Compares actual agency total interim CAH payments to the agency-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, agency claim payments, and Level III trauma payments); and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The agency recoups from the hos-

pital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(11) The agency performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the agency uses the hospital's "final settled" medicare cost report instead of the initial "as filed" medicare cost report for the HFY being cost settled. The "final settled" medicare cost report received from the medicare fiscal intermediary must be submitted by the CAH to the agency by the sixtieth day of the hospital's receipt of that medicare cost report.

(12) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(13) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the hospital's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for agency programs.

(14) The agency pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than WCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the agency uses the RCW payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units. The exception is for state-administered programs' psychiatric claims, which are paid using:

(i) The DRG payment method for claims grouped to stable DRG relative weights (unless the claim has an HIV-related diagnosis), and in conjunction with the base community psychiatric hospitalization payment method; or

(ii) The RCW payment method for other psychiatric claims (except for DRGs 469 and 470), in conjunction with the base community psychiatric hospitalization payment method.

(b) For dates of admission after July 31, 2007, the agency uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The agency may conduct a post pay or on-site review of any CAH.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-2598, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-2598, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-054, § 388-550-2598, filed 6/28/07, effective 8/1/07; WSR 07-03-077, § 388-550-2598, filed 1/17/07, effective 2/17/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.5225. WSR 06-04-089, § 388-550-2598, filed 1/31/06, effective 3/3/06; WSR 05-01-026, § 388-550-2598, filed 12/3/04, effective 1/3/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.5225, and HB 1162, 2001 2nd sp.s. c 2. WSR 02-13-099, § 388-550-2598, filed 6/18/02, effective 7/19/02.]