WSR 23-17-014
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed August 4, 2023, 4:02 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 23-13-104.

Title of Rule and Other Identifying Information: WAC 182-550-2900 Payment limits—Inpatient hospital services, 182-550-3800 Rebasing, 182-550-3830 Adjustments to inpatient rates, 182-550-4500 Payment method—Ratio of costs-to-charges (RCC), 182-550-7200 OPPS—Billing requirements and payment method, 182-550-7550 OPPS payment enhancements, 182-550-8000 Hospital safety net program (HSNP)—Purpose, and 182-550-8100 Assessment notices—Process and timelines.

Hearing Location(s): On September 26, 2023, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. To attend the virtual public hearing, you must register in advance https://us02web.zoom.us/webinar/register/WN_E7tAxNWnSVCG-SIhvxxsWg. If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: September 27, 2023.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by September 26, 2023, by 11:59 p.m.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email Johanna.larson@hca.wa.gov, by September 15, 2023.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending these rules to update terminology, revise rates approved by the legislature, remove outdated information, and make other general policy changes.

Reasons Supporting Proposal: See purpose above.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1408; Implementation and Enforcement: Abby Cole, P.O. Box 45510, Olympia, WA 98504-5510, 360-725-1835.

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.

Scope of exemption for rule proposal:

Is not exempt.

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 rules do not impose any costs on small businesses.

August 4, 2023
Wendy Barcus

OTS-4728.2

AMENDATORY SECTION (Amending WSR 21-18-059, filed 8/26/21, effective 9/26/21)

WAC 182-550-2900 Payment limits—Inpatient hospital services.
(1) **Eligibility for payment.** To be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the medicaid agency; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of that hospital, as defined in WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC 182-550-6700.

(2) **Exclusions.** The agency does not pay for any of the following:

(a) Inpatient care or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

(d) Additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the agency or the agency's designee under WAC 182-550-2600, as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not received prior authorization for an extended LOS from the agency or the agency's designee as specified in WAC 182-550-4300(4). The agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC 182-550-1700, to evaluate an extended LOS. An agency designee may also perform those utilization reviews to evaluate an extended LOS.

(e) Inpatient hospital services when the agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The agency may perform a retrospective utilization review as described in WAC 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(f) Two separate inpatient hospitalizations if a client is readmitted to the same or affiliated hospital or distinct unit within ((~~fourteen~~)) 14 calendar days of discharge and the agency determines that one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000 (7)(f) for the agency's review of ((~~fourteen~~)) 14-day readmissions.

(g) Inpatient claims for ((~~fourteen~~)) 14-day readmissions considered to be provider preventable as described in WAC 182-550-2950.

(h) A client's day(s) of absence from the hospital or distinct unit.

(i) A nonemergency transfer of a client. See WAC 182-550-3600 for hospital transfers.

(j) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.

(k) An early elective delivery as defined in WAC 182-500-0030. The agency may pay for a delivery before ((~~thirty-nine~~)) 39 weeks gestation, including induction and cesarean section, if medically necessary under WAC 182-533-0400(20).

(3) **Interim billed inpatient hospital claims.** This section defines when the agency considers payment for an interim billed inpatient hospital claim.

(a) When the agency is the primary payer, each interim billed nonpsychiatric claim must:

(i) Be submitted in ((~~sixty~~)) 60-calendar-day intervals, unless the client is discharged before the next ((~~sixty~~)) 60-calendar-day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the agency is not the primary payer:

(i) The agency pays an interim billed nonpsychiatric claim when the criteria in (a) of this subsection are met; and

(ii) Either of the following:

(A) Sixty calendar days have passed from the date the agency became the primary payer; or

(B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(c) For psychiatric claims, (a)(i) and (b)(i) of this subsection do not apply.

(i) When the agency is the primary payer, each billed psychiatric claim may be submitted in 60-calendar-day intervals unless the client is discharged before the next 60-calendar-day interval.

(ii) If a claim is submitted under (c)(i) of this subsection, the claim must document the current dates of services billed and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(d) When the agency is not the primary payer, the agency pays a billed psychiatric claim when:

(i) The criteria in (c)(i) of this subsection are met; and

(ii) Either of the following occur:

(A) Sixty calendar days have passed from the date the agency became the primary payer; or

(B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(4) **Admission period for claims.** The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of ((~~sixty~~)) 60 calendar days or less upon the client's formal release from the hospital or distinct unit.

(5) **Billing for hospital claims.** To be eligible for payment, a hospital or distinct unit must bill the agency using an inpatient hospital claim:

(a) Under the current national uniform billing data element specifications:

(i) Developed by the National Uniform Billing Committee (NUBC);

(ii) Approved or modified, or both, by the Washington state payer group or the agency; and

(iii) In effect on the date of the client's admission.

(b) Under the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) Under the agency's published billing instructions and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the agency considers and pays an initial interim billed hospital claim and any subsequent interim billed hospital claims;

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and

(g) With the appropriate NUBC revenue code specific to the service or treatment provided to the client.

(6) **Multiple hospital rates.** When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by 42 C.F.R. Sec. 447.271.

(7) **Administrative day rate.** The agency allows hospitals an administrative day rate for those days of a hospital stay in which a client no longer meets criteria for the acute inpatient level of care, as provided in WAC 182-550-4550.

(8) **Payment for observation services.** The agency pays for observation services according to WAC 182-550-6000, 182-550-7200, and other applicable rules.

(9) **Required adjustments.** The agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include:

(a) Client participation (e.g., spenddown);

(b) Any third-party liability amount, including medicare part A and part B; and

(c) Any other adjustments as determined by the agency.

(10) **Clients under state-administered programs.** The agency pays hospitals less for services provided to clients eligible under state-administered programs, as provided in WAC 182-550-4800.

(11) **Final charges.** All hospital providers must present final charges to the agency according to WAC 182-502-0150.

AMENDATORY SECTION (Amending WSR 22-03-008, filed 1/6/22, effective 2/6/22)

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 withdrawal management per diem payment methods were reduced to support an estimated ((~~three million five hundred thousand dollar~~)) $3,500,000 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~~)) $3,500,000.

(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~~)) 200 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~~)) 200 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, 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 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 23-01-013, filed 12/8/22, effective 1/8/23)

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 12 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 18 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) Sole community hospitals.

(a) For sole community hospitals' rate enhancements, the agency multiplies an in-state hospital's specific conversion factor and per diem rates by a multiplier if the hospital meets all the following criteria per RCW 74.09.5225:

(i) Be certified by CMS as a sole community hospital as of January 1, 2013;

(ii) Have a level III adult trauma service designation from the Washington state department of health (DOH) as of January 1, 2014;

(iii) Have less than 150 acute care licensed beds in fiscal year 2011;

(iv) Be owned and operated by the state or a political subdivision; and

(v) Not participate in the certified public expenditures (CPE) payment program defined in WAC 182-550-4650.

(b) As of July 1, 2021<u>, through June 30, 2023</u>, an additional increase is applied for hospitals that accept single bed certifications per RCW 71.05.745.

Enhancement Multiplier by Year						
	Effective For the Dates					
Provider Category	07/01/2015 - 06/30/2020	07/01/2020 - 06/30/2021	07/01/2021 - 06/30/2022	07/01/2022 - 06/30/2023	<u>07/01/2023 - 12/31/2023</u>	<u>01/01/2024 - 06/30/2024</u>
Sole community hospital	1.25	1.5	N/A	1.25	<u>1.25</u>	<u>1.5</u>

Enhancement Multiplier by Year						
	Effective For the Dates					
Provider Category	07/01/2015 - 06/30/2020	07/01/2020 - 06/30/2021	07/01/2021 - 06/30/2022	07/01/2022 - 06/30/2023	07/01/2023 - 12/31/2023	01/01/2024 - 06/30/2024
Sole community hospital accepting single bed certifications	N/A	N/A	1.5	1.5	N/A	N/A

AMENDATORY SECTION (Amending WSR 14-12-047, filed 5/29/14, effective 7/1/14)

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~~)) 12 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).~~))

AMENDATORY SECTION (Amending WSR 14-14-049, filed 6/25/14, effective 7/26/14)

WAC 182-550-7200 OPPS—Billing requirements and payment method. This section describes hospital provider billing requirements and the payment methods the medicaid agency uses to pay for covered outpatient hospital services provided by hospitals included in the outpatient prospective payment system (OPPS).

(1) Providers must bill according to national correct coding initiative (NCCI) standards maintained by the Centers for Medicare and Medicaid Services (CMS).

ENHANCED AMBULATORY PATIENT GROUP (EAPG) METHOD

(2) The agency uses the enhanced ambulatory patient group (EAPG) method as the primary payment method for OPPS. Examples of services paid by the EAPG method include:

(a) Surgeries;
(b) Significant procedures;
(c) Observation services;
(d) Medical visits;
(e) Dental procedures; and
(f) Ancillary services.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(3) The agency pays using the outpatient fee schedule for:

(a) Covered services exempted from the EAPG payment method due to agency policy;

(b) Covered services for which there are no established relative weights, such as:

(i) Durable medical equipment procedures grouped to EAPG type 7; and

(ii) Physical therapy procedures grouped to EAPG type 21;

(c) Corneal tissue acquisition; and

(d) Other services as identified by the agency and posted on the agency's website.

((~~**HOSPITAL OUTPATIENT RATIO OF COSTS-TO-CHARGES (RCC)**~~

~~(4) The agency uses the hospital outpatient ratio of costs-to-charges (RCC) in WAC 182-550-3900 and 182-550-4500 to pay for the services listed in subsection (3) of this section for which the agency has not established a maximum allowable fee.~~))

AMENDATORY SECTION (Amending WSR 23-01-014, filed 12/8/22, effective 1/8/23)

WAC 182-550-7550 OPPS payment enhancements. (1) Pediatric adjustment.

(a) The medicaid agency establishes a policy adjustor to be applied to all enhanced ambulatory patient group (EAPG) services for clients under age 18 years.

(b) Effective July 1, 2014, this adjustor equals one point thirty-five (1.35).

(2) Chemotherapy and combined chemotherapy/pharmacotherapy adjustment.

(a) The agency establishes a policy adjustor to be applied to services grouped as chemotherapy drugs or combined chemotherapy and pharmacotherapy drugs.

(b) Effective July 1, 2014, this adjustor equals one point one (1.1).

(3) Sole community hospitals.

(a) For sole community hospital's rate enhancements, the agency multiplies the in-state hospital's specific EAPG conversion factor by a multiplier if the hospital meets all of the following criteria per RCW 74.09.5225:

(i) Be certified by CMS as a sole community hospital as of January 1, 2013;

(ii) Have a level III adult trauma service designation from the Washington state department of health (DOH) as of January 1, 2014;

(iii) Have less than 150 acute care licensed beds in fiscal year 2011; and

(iv) Be owned and operated by the state or a political subdivisions.

(b) As of July 1, 2021, through June 30, 2023, an additional increase may be applied for hospitals that accept single bed certifications per RCW 71.05.745.

Enhancement Multiplier by Year						
	Effective For the Dates					
Provider Category	07/01/2015 - 06/30/2020	07/01/2020 - 06/30/2021	07/01/2021 - 06/30/2022	07/01/2022 - 06/30/2023	07/01/2023 - 12/31/2023	01/01/2024 - 06/30/2024
Sole community hospital	1.25	1.5	N/A	1.25	1.25	1.50
Sole community hospital accepting single bed certifications	N/A	N/A	1.5	1.5	N/A	N/A

AMENDATORY SECTION (Amending WSR 20-14-054, filed 6/26/20, effective 7/27/20)

WAC 182-550-8000 Hospital safety net ((~~assessment (HSNA)~~)) program (HSNP)—Purpose. Chapter 74.60 RCW establishes the hospital safety net ((~~assessment (HSNA)~~)) program (HSNP). The ((~~HSNA program imposes an assessment on certain Washington state hospitals~~)) HSNP provides funding that is used solely to increase funding from all other sources and support additional payments to hospitals ((~~for~~)) as authorized ((~~medicaid services~~)) by chapter 74.60 RCW. The medicaid agency has authority to issue rules associated with the ((~~HSNA program~~)) HSNP under RCW 41.05.021 (1)(m)(iv) and 74.60.050(1).

AMENDATORY SECTION (Amending WSR 20-14-054, filed 6/26/20, effective 7/27/20)

WAC 182-550-8100 Assessment notices—Process and timelines. (1) **Notification.** The medicaid agency sends hospital safety net ((~~assessment (HSNA)~~)) program (HSNP) assessment notices on or about ((~~thirty~~)) 30 calendar days prior to the end of each quarter as required by RCW 74.60.030 (1)(a).

(2) **Payment due date.** Each hospital must pay its assessment in full by the due date listed in the ((~~HSNA~~)) HSNP notice.

(3) **First past-due notification.** If a hospital does not pay its ((~~HSNA~~)) HSNP assessment in full by the due date, the agency sends the hospital a past-due notice. The past-due notice informs the hospital of the actions the agency may take if the hospital's assessment becomes ((~~ninety~~)) 60 calendar days past due.

(4) **Final past-due notification.** If a hospital does not pay its assessment in full within ((~~ninety~~)) 60 calendar days of its due date stated in the ((~~HSNA~~)) HSNP notice, the agency sends the hospital a final past-due notice.

(a) The final past-due notice informs the hospital of the actions the agency takes, as required by RCW 74.60.050(2), to offset funds from the agency's scheduled payments to the hospital.

(b) The agency does not offset funds from managed care capitation payments, as described in RCW 74.60.130.

(5) **Appeal.** A hospital may appeal the actions the agency takes to offset funds by following the process outlined in WAC 182-502-0050.