WSR 26-14-064
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed June 26, 2026, 9:37 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 26-08-050.

Title of Rule and Other Identifying Information: WAC 182-550-8100 Assessment notices—Process and timelines, and new WAC 182-550-8200 Hospital safety net supplemental directed payments to hospitals.

Hearing Location(s): On August 4, 2026, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. Virtual public hearings are held via Microsoft Teams webinar. To attend, you must register in advance at https://events.gcc.teams.microsoft.com/event/32d4231e-6e47-41ee-8ced-3a1f93bd02ee@11d0e217-264e-400a-8ba0-57dcc127d72d.

After registering, you will receive a confirmation email containing information about joining the public hearing. You will be able to join the public hearing through most standard internet browsers; you do not need to install Microsoft Teams.

Date of Intended Adoption: Not sooner than August 5, 2026.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, beginning June 26, 2026, 8:00 a.m., by August 4, 2026, 11:59 p.m.

Assistance for Persons with Disabilities: Contact Jessica Nguyen, phone 360-725-1174, fax 360-586-9727, telecommunication relay service 711, email arc@hca.wa.gov, by July 17, 2026.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA amended these rules to update when hospital safety net program assessment notices are sent from "on or about 30 calendar days prior" to "on or before 45 days" to align with RCW 74.60.030(1). The reference to RCW 74.60.030 (1)(a) was updated to RCW 74.60.030(1) in WAC 182-550-8100(1). HCA also added language for settlement guidelines to include timelines, appeals, and exclusions and added a new section for assessment calculations, WAC 182-550-8200.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 74.60.030, 41.05.021, and 41.05.160.

Statute Being Implemented: RCW 74.60.030, 41.05.021, and 41.05.160.

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

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Blake O'Connor, 626 7th Avenue S.E., Olympia, WA 98501, 360-725-1344; Implementation and Enforcement: Abby Cole, 626 7th Avenue S.E., Olympia, WA 98501, 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.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: The proposed rules apply only to hospitals; therefore, they do not affect small businesses.

Scope of exemption for rule proposal:

Is fully exempt.

June 26, 2026
Wendy Barcus
Rules Coordinator

RDS-7250.2

AMENDATORY SECTION (Amending WSR 23-20-048, filed 9/28/23, effective 10/29/23)

WAC 182-550-8100 Assessment notices—Process and timelines. (1) **Calculation of nonmedicare revenue for nonexempt hospitals.** The medicaid agency determines each nonexempt hospital's annual assessment using the process outlined in RCW 74.60.030. HCA uses the hospital's medicare cost report data as filed for the applicable year for these calculations. The agency uses the following time frames for determining what data set is used for the calculation of the hospital's assessment.

(a) For the purposes of this section, annualized means the total amount divided by actual months, multiplied by 12.

(b) The agency uses the second quarterly release of health care cost report information system (HCRIS) data from the Centers for Medicare and Medicaid Services (CMS). This release is typically available by July 31st of each year.

(c) If a second quarterly release is not available at the time of calculation, the agency will use the most recently available HCRIS data release from CMS.

(d) The agency uses the medicare cost report data for the hospital from three years prior. For example, for calculating calendar year 2027 assessments, the agency will use available medicare cost report data as filed for the hospitals' fiscal year ending in 2024. For subsequent years, the agency uses the cost report for the next succeeding fiscal year data.

(e) For any hospital without a medicare cost report for the relevant year, including any recently opened hospital, the agency uses the most recently available cost report at the time of calculation or an annualized partial report available by June 1st reflecting at least six months of information.

(2) **Notification.** ((~~The medicaid agency sends hospital safety net program (HSNP) assessment notices on or about 30 calendar days prior to the end of each quarter as required by RCW 74.60.030 (1)(a).~~

~~(2)~~)) (a) Before January 1st of each calendar year, the agency sends notices of annual assessment to each hospital informing the hospital of its calculated inpatient and outpatient nonmedicare net patient revenue and the assessed amount. The agency calculates quarterly assessment payments by dividing the hospital annual assessment by four.

(b) The agency sends quarterly hospital safety net (HSNP) assessment notices on or before 45 calendar days prior to the end of each quarter as required by RCW 74.60.030.

(c) A hospital may dispute the agency's assessment calculation by following the process outlined in WAC 182-502-0050.

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

((~~(3)~~)) (4) **First past-due notification.**

(a) If a hospital does not pay its HSNP assessment in full by the due date, the agency sends the hospital ((~~a~~)) past-due notice.

(b) The past-due notice informs the hospital of the actions the agency may take if the hospital's assessment becomes 60 calendar days past due.

((~~(4)~~)) (5) **Final past-due notification.**

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

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

(d) The agency may charge interest on delinquent assessments at the rate specified in RCW 82.32.050.

((~~(5) **Appeal.**~~)) (6) **Dispute.** A hospital may ((~~appeal~~)) dispute the actions the agency takes to offset funds by following the process outlined in WAC 182-502-0050.

NEW SECTION

WAC 182-550-8200 Hospital safety net supplemental directed payments to hospitals. (1)(a) The medicaid agency performs an annual reconciliation of amounts paid to each hospital based on its annual claims data.

(b) The agency directs its agency-contracted managed care organizations (MCOs) to make adjusted payments, if necessary, in the subsequent quarter or quarters based on such reconciliation.

(c) Before the annual reconciliation, the agency sends the inpatient discharges and outpatient encounter data used for reconciliation to each hospital for review. The agency sends aggregated reconciliation data to the Washington state hospital association (WSHA) for review.

(2) **Annual reconciliation timelines.** The agency completes an annual reconciliation within one calendar year of the end of the payment year being reconciled, using accepted encounters available in the medicaid management information system (MMIS). For example, annual encounter data available from the MMIS in November 2025 would be used for the annual reconciliation of calendar year 2024.

(3) **Annual encounter data exclusions.** The following encounters are not included in supplemental payment calculations.

(a) Inpatient claims with the patient status "still patient;"

(b) Encounters reported as being paid under a subcapitated arrangement;

(c) Encounters reported as denied by an MCO;

(d) All state-only funded eligibility programs;

(e) Claims for clients with no medicaid eligibility on the date of service;

(f) Claims paid by agency noncontracted MCOs; and

(g) Encounters for patients classified as "normal newborn." Normal newborn is a patient assigned to the Solventum all patient refined diagnosis related group (APR-DRG). Normal newborns are excluded from the prospective payment system and critical access hospital supplemental payments to MCOs, as outlined in RCW 74.60.130.

(4) **Provider disputes of reconciliation calculations.**

(a) If a hospital wishes to dispute a determination by the agency during the reconciliation process that the hospital was overpaid, then the hospital must follow the process outlined in WAC 182-502-0230.

(b) If a hospital wishes to dispute a determination by the agency during the reconciliation process that the hospital was underpaid, then the hospital must follow the process outlined in WAC 182-502-0050.