WSR 26-17-005
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 5, 2026, 4:07 p.m., effective September 5, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (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.

Citation of Rules Affected by this Order: New WAC 182-550-8200; and amending WAC 182-550-8100.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-14-064 on June 26, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 1, Repealed 0.

Date Adopted: August 5, 2026.

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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 Medi-

care 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.