RULE-MAKING ORDER
EMERGENCY RULE ONLY

CR-103E (December 2017)
(Implements RCW 34.05.350 and 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 21, 2025
TIME: 9:19 AM

WSR 25-15-120

Agency: Health Care Authority

Effective date of rule:

Emergency Rules

☐ Immediately upon filing.

☒ Later (specify) August 1, 2025

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is amending these rules to remove references to "other medically necessary ancillary services as determined by the agency" to align with Substitute House Bill 2051, Sec. 1, (13)(b) & (c) which is effective July 27, 2025.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-2590, 182-550-2600, 182-550-3000, 182-550-3381, 182-550-4550
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: SHB 2051, Chapter 367, Laws of 2025

EMERGENCY RULE

Under RCW 34.05.350 the agency for good cause finds:

☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

☒ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding: Emergency rules are necessary while the permanent rulemaking process is conducted. The agency filed a preproposal statement of inquiry on June 13, 2025, under WSR 25-13-064 and is currently conducting an external review to interested partners of the permanent rules.

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	5	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

New ____ Amended ____ Repealed ____

The number of sections adopted on the agency's own initiative:

New ____ Amended ____ Repealed ____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New ____ Amended 5 Repealed ____

The number of sections adopted using:

Negotiated rule making: New ____ Amended ____ Repealed ____

Pilot rule making: New ____ Amended ____ Repealed ____

Other alternative rule making: New ____ Amended 5 Repealed ____

Date Adopted: July 21, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 25-10-099, filed 5/7/25, effective 6/7/25)

WAC 182-550-2590 Agency prior authorization requirements for Level 1 and Level 2 LTAC services. (1) The medicaid agency requires prior authorization for Level 1 and Level 2 long term acute care (LTAC) inpatient stays. The prior authorization process includes all the following:

(a) For an initial 30-day stay:

(i) The client must:

(A) Be eligible under one of the programs listed in WAC 182-550-2575; and

(B) Require Level 1 or Level 2 LTAC services as defined in WAC 182-550-1050.

(ii) The LTAC provider of services must:

(A) Before admitting the client to the LTAC hospital, submit a request for prior authorization to the agency as published in the agency's LTAC billing instructions;

(B) Include sufficient medical information to justify the requested initial stay;

(C) Obtain prior authorization from the agency's medical director or designee, when accepting the client from the transferring hospital; and

(D) Meet all the requirements in WAC 182-550-2580.

(b) For any extension of stay, the criteria in (a) of this subsection must be met, and the LTAC provider of services must submit a request for the extension of stay to the agency with sufficient medical justification.

(2) The agency authorizes Level 1 or Level 2 LTAC services for initial stays or extensions of stay based on the client's circumstances and the medical justification received.

(3) A client who does not agree with a decision regarding a length of stay has a right to an administrative hearing under chapter 182-526 WAC. After receiving a request for an administrative hearing, the agency may request additional information from the client and the facility, or both. After the agency reviews the available information, the result may be:

(a) A reversal of the initial agency decision;

(b) Resolution of the client's issue(s); or

(c) An administrative hearing conducted according to chapter 182-526 WAC.

(4) The agency may authorize an administrative day rate payment, ((~~as well as payment for medically necessary ancillary services as determined by the agency,~~)) pharmacy services, and pharmaceuticals, for a client who meets one or more of the following. The client:

(a) Does not meet the requirements for Level 1 or Level 2 LTAC services;

(b) Is waiting for placement in another hospital or other facility; or

(c) If appropriate, is waiting to be discharged to the client's residence.

AMENDATORY SECTION (Amending WSR 24-09-027, filed 4/10/24, effective 5/11/24)

WAC 182-550-2600 Inpatient psychiatric services. (1) The medicaid agency or the agency's designee pays for covered inpatient psychiatric services for eligible Washington apple health clients.

(2) The definitions found in chapter 182-500 WAC and WAC 182-550-1050 apply to this section.

(3) To be paid for an inpatient psychiatric admission, the hospital provider or hospital unit provider must meet the requirements for payment including the applicable general conditions of payment criteria in WAC 182-502-0100.

(4) When billing the agency directly for Washington apple health clients not enrolled in an agency-contracted managed care organization (MCO) plan, hospitals may use the expedited prior authorization (EPA) process for inpatient psychiatric services that require authorization when the EPA criteria is met.

(a) To meet the EPA criteria, the inpatient admission must:

(i) Be medically necessary;

(ii) Have psychiatric needs as the focus of treatment and not have an acute medical condition;

(iii) Not have a less-restrictive placement available; and

(iv) Be approved or ordered by the professional in charge of the facility.

(b) If the EPA criteria is not met, a hospital may request prior authorization from the agency or the agency's designee.

(5) Authorization of elective, nonemergency, or emergency-related poststabilization services by an agency-contracted MCO plan are subject to federal rules, including 42 C.F.R. 438.114 and 438.210.

(6) When clients enrolled in an agency-contracted MCO plan are involuntarily detained or committed under chapter 71.05 or 71.34 RCW, the stay must be treated as either an emergency or poststabilization service, and authorization must follow the rules found in 42 C.F.R. 438.114.

(7) When a hospital or hospital unit bills the agency directly, the agency pays the administrative day rate and pays for pharmacy services((~~,~~)) and pharmaceuticals((~~, and medically necessary ancillary services, as determined by the agency,~~)) for any authorized days that meet the administrative day definition in WAC 182-550-1050 when less restrictive alternative treatments are not available, posing a barrier to the client's safe discharge.

(8) The agency may review paid claims and recoup any improperly paid claims, including determining whether the client did not meet EPA criteria or other conditions of payment. See WAC 182-502-0230 and chapter 182-502A WAC.

AMENDATORY SECTION (Amending WSR 23-04-049, filed 1/26/23, effective 2/26/23)

WAC 182-550-3000 Payment method. (1) The medicaid agency uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 182-550-4300 and 182-550-4400.

(2) The agency assigns a DRG code to each claim for an inpatient hospital stay using ((~~3M~~)) Solventum™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

(i) Ratio of costs-to-charges (RCC); and

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(4) An inpatient claim payment includes all hospital covered services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) The inpatient hospital stay;

(b) Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim;

(c) Any hospital covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000
Per Diem	Hospital-specific daily rate for the service (psych, rehab, withdrawal management, or SUPP) times covered allowable days	182-550-2600 and 182-550-3381
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598

Payment Method	General Description of Payment Formula	WAC Reference
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ((~~ancillary~~)) pharmaceutical charges that are allowable and covered for administrative days	182-550-3381

(6) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) A claim qualifies as a high outlier (see WAC 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a Washington apple health program on one or more days of the hospital stay;

(d) A client has third-party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges;

(f) A client is discharged from an inpatient hospital stay and, within 14 calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or the agency's designee performs a retrospective utilization review (see WAC 182-550-1700) on the initial admission and all readmissions to determine which inpatient hospital stays qualify for payment. The review may determine:

(i) If both admissions qualify for separate reimbursement;

(ii) If both admissions must be combined to be reimbursed as one payment; or

(iii) Which inpatient hospital stay qualifies for individual payment.

(g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition described in WAC 182-502-0022). The agency or the agency's designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments; or

(h) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

(b) The agency will apply the inpatient adjustment factor when the agency determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

(9) The agency does not pay for a client's day of absence from the hospital.

(10) The agency pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 182-550-2900.

(11) The agency applies to the allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(12) The agency pays hospitals in designated bordering cities for allowed covered services as described under WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described under WAC 182-550-4000.

(14) The agency's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the agency would have paid using medicare payment principles.

(15) When hospital ownership changes, the agency's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(16) Hospitals participating in the apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by the agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

(19) Participating hospitals must permit the agency to conduct periodic audits of their financial records, statistical records, and any other records as determined by the agency.

(20) The agency limits payment for private room accommodations to the semiprivate room rate. 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.

(21) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the agency may manually price the claim at the hospital's psychiatric per diem rate.

AMENDATORY SECTION (Amending WSR 23-21-063, filed 10/12/23, effective 1/1/24)

WAC 182-550-3381 Payment method for acute PM&R services and administrative day services. This section describes the agency's payment method for acute physical medicine and rehabilitation (PM&R) services provided by acute PM&R hospitals.

(1) The agency pays an acute PM&R hospital for acute PM&R services based on a rehabilitation per diem rate. See chapter 182-550 WAC and WAC 182-550-3000.

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Social services (e.g., discharge planning);

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When the agency authorizes administrative day(s) for a client as described in WAC 182-550-2561(8), the agency pays the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed for the client's use during the administrative portion of the client's stay((~~; and~~

~~(c) Medically necessary ancillary services as determined by the agency~~)).

(4) The agency pays for transportation services provided to a client receiving acute PM&R services in an acute PM&R hospital according to chapter 182-546 WAC.

AMENDATORY SECTION (Amending WSR 23-21-063, filed 10/12/23, effective 1/1/24)

WAC 182-550-4550 Administrative day rate and swing bed day rate. (1) **Administrative day rate.**

(a) The medicaid agency allows hospitals an administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because:

(i) An appropriate placement outside the hospital is not available (no placement administrative day); or

(ii) The postpartum parent's newborn remains on an inpatient claim for monitoring post-in utero exposure to substances that may lead to physiologic dependence and continuous care by the postpartum parent is the appropriate first-line treatment (newborn administrative day). "Postpartum parent" means the client who delivered the baby(ies).

(b) The agency uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1st of each year.

(c) The agency pays for pharmacy services((~~,~~)) and pharmaceuticals ((~~and medically necessary ancillary services, as determined by the agency,~~)) when these services are provided during administrative days.

(d) The agency identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(e) The agency pays for up to five newborn administrative days. The agency pays for additional days with expedited prior authorization (EPA). For EPA, a hospital must establish that the clinically appropriate EPA criteria outlined in the agency's published billing guides have been met. The hospital must use the appropriate EPA number when billing the agency.

(f) The agency pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a no placement administrative day stay.

(g) The agency pays the hospital the newborn administrative day rate only if:

(i) The postpartum parent rooms in with their newborn and provides parental support/care; and

(ii) The hospital provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder.

(2) **Swing bed day rate.** The agency allows hospitals a swing bed day rate for those days when a client is receiving agency-approved nursing service level of care in a swing bed. The agency's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The agency does not pay a hospital the rate applicable to the acute inpatient level of care for those days of a hospital stay when a client is receiving agency-approved nursing service level of care in a swing bed.

(b) The agency's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 182-550-6000 and 182-550-7200. These ancillary services may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The agency allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving agency-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The agency does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.