RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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WSR 19-04-004

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) March 1, 2019 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

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 modified these sections to remove the bariatric fixed case rate.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-3000, 182-550-3470, 182-550-4400, 182-550-4800
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-01-080 on December 17, 2018 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

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Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended	4	Repealed	____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Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	4	Repealed	____

Date Adopted: January 23, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 18-11-074, filed 5/16/18, effective 7/1/18)

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™ 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, detox, or CUP) times covered allowable days	182-550-2600 and 182-550-3381
((~~Single Case Rate~~	~~Hospital specific bariatric case rate per stay~~	~~182-550-3470~~))
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

Payment Method	General Description of Payment Formula	WAC Reference
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
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 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 fourteen 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(s)~~)) 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 lan-

guage 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(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 ((~~in~~)) under WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described ((~~in~~)) 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 ((~~Washington~~)) 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 a client's hospital stay that involves regional support network (RSN)-approved voluntary inpatient or involuntary inpatient

hospitalizations, the hospital must bill the agency for payment. When the hospital contracts directly with the RSN, the hospital must bill the RSN for payment.

(22) 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 15-18-065, filed 8/27/15, effective 9/27/15)

WAC 182-550-3470 Payment method—Bariatric surgery—Per case rate. (1) Effective through June 30, 2019, the medicaid agency:

(a) Pays for bariatric surgery provided in designated agency-approved hospitals when all criteria established in WAC 182-550-2301 are met;

(b) Requires qualification and prior authorization of the provider before bariatric surgery related services are provided (see WAC 182-550-2301); and

(c) Uses a per case rate to pay for bariatric surgery.

(2) For dates of admission before August 1, 2007, the agency determines the per case rate by using a hospital-specific medicare fee schedule rate the agency used to pay for bariatric surgery.

(3) For dates of admission after July 31, 2007, the agency determines the per case rate by using the bariatric per case rate calculation method described in this subsection and established by the agency's new inpatient payment system implemented on August 1, 2007.

(a) To adjust hospital-specific operating, capital, and direct medical education costs, the agency:

(i) Inflates the hospital-specific operating, capital, and direct medical education routine costs from the hospital's medicare cost report fiscal year to the mid-point of the state fiscal year.

(ii) Divides the labor portion of the hospital-specific operating costs by the hospital-specific medicare wage index in effect for the medicare inpatient prospective payment system federal fiscal year that most closely matches the time period covered by the medicare cost report used for these calculations.

(b) To determine the statewide standardized weighted average cost per case by using the adjusted hospital-specific operating and capital costs derived in (a) of this subsection, the agency:

(i) Adjusts the hospital-specific operating and capital costs to remove the indirect costs associated with approved medical education programs; then

(ii) Calculates the operating standardized amount by dividing statewide aggregate adjusted operating costs by the statewide aggregate number cases in the base year claims data; then

(iii) Calculates the capital standardized amount by dividing statewide aggregate adjusted capital costs by the statewide aggregate number of cases in the base year claims data.

(c) To make hospital-specific adjustments to the statewide operating and capital standardized amounts, the agency:

(i) Defines the adjusted operating standardized amount for bariatric services as the average of all instate hospitals operating

standardized amount after making adjustments for the wage index and the indirect medical education. The agency:

(A) To determine the labor portion, uses the factor established by medicare multiplied by the statewide operating standardized amount, then multiplies the labor portion of the operating standardized amount by (1.0 plus the most currently available hospital-specific medicare wage index); then

(B) Adds the nonlabor portion of the operating standardized amount to the labor portion derived in (c)(i)(A) of this subsection; then

(C) Multiplies the amount derived in (c)(i)(B) of this subsection by 1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor to derive the operating standardized amount for bariatric services; then

(D) Adjusts the hospital-specific operating standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(E) Calculates the statewide bariatric operating payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(i)(D) of this subsection for each hospital approved by the agency to provide bariatric services; and

(II) Dividing the results in (E)(I) of this subsection by the number of instate hospitals approved by the agency to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all instate hospitals capital standardized amount after adjusting for the indirect medical education. The agency:

(A) Multiplies the amount derived in (b)(iii) of this subsection by (1.0 plus the most currently available hospital-specific medicare capital indirect medical education factor) to derive the adjusted indirect medical education capital standardized amount for bariatric services.

(B) Adjusts the hospital-specific capital standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(C) Calculates the statewide bariatric capital payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(ii)(B) of this subsection for each hospital approved by the agency to provide bariatric services; and

(II) Dividing the results derived in (C)(I) of this subsection by the number of instate hospitals approved by the agency to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the instate hospitals hospital-specific direct medical education weighted cost per case multiplied by the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year. The agency calculates the statewide bariatric direct medical education standardized payment per case by:

(A) Multiplying the hospital-specific direct medical education weighted cost per case for each hospital approved by the agency to provide bariatric services by the CMS PPS input price index; then

(B) Totaling the hospital-specific amounts derived in (iii)(A) of this subsection for each hospital approved by the agency to provide bariatric services.

(d) To determine hospital-specific bariatric payment per case amount, the agency sums for each hospital the instate statewide bariatric operating payment per case, the instate statewide bariatric capital payment per case, and the hospital-specific direct medical education payment per case. (For critical border hospitals, the direct medical education payment per case is limited at the highest direct medical education payment per case amount for the instate hospitals approved by the agency to provide bariatric services.)

(e) The agency adjusts the hospital-specific bariatric payment per case amount by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services.

(f) The agency may make other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes as directed by the legislature).

AMENDATORY SECTION (Amending WSR 16-04-051, filed 1/28/16, effective 3/1/16)

WAC 182-550-4400 Services—Exempt from DRG payment. (1) Inpatient services are exempt from the diagnosis-related group (DRG) payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) Subject to the restrictions and limitations in this section, the agency exempts the following services for medicaid and CHIP clients from the DRG payment method. This policy also applies to covered services paid through medical care services (MCS) and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the agency to perform these services.

(b) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemical-using pregnant (CUP) women by a certified hospital. These are medicaid program services and are not covered or funded by the agency through MCS or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. A mental health designee that arranges to pay a hospital directly for psychiatric services may use the agency's payment methods or contract with the hospital to pay using different methods. Claims not paid directly through a mental health designee are paid through the agency's payment system.

(e) Chronic pain management treatment provided in a hospital approved by the agency to provide that service.

(f) Administrative day services. The agency pays administrative days for one or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate. The administrative day rate is based on the statewide average daily medicaid nursing facility rate, which is adjusted annually. The agency may designate part of a client's stay to be paid an administrative day rate upon review of the claim or the client's medical record, or both.

(g) Inpatient services recorded on a claim grouped by the agency to a DRG for which the agency has not published an all-patient DRG (AP-DRG) or all-patient refined DRG (APR-DRG) relative weight. The agency will deny payment for claims grouped to DRG 469, DRG 470, APR DRG 955, or APR DRG 956.

(h) Organ transplants that involve heart, intestine, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The agency pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method. The agency maintains a list of DRGs which qualify as transplants on the agency's web site.

((~~(i) Bariatric surgery performed in hospitals that meet the criteria in WAC 182-550-2301. The agency pays hospitals for bariatric surgery on a per case rate basis for clients in medicaid and state-administered programs when the services are prior authorized and take place at an approved hospital. See WAC 182-550-3000 and 182-550-3470.~~))

AMENDATORY SECTION (Amending WSR 18-12-043, filed 5/30/18, effective 7/1/18)

WAC 182-550-4800 Hospital payment methods—State-administered programs. This section does not apply to out-of-state hospitals unless they are border hospitals (critical or noncritical).

(1) The medicaid agency:

(a) Pays for services provided to a client eligible for a state-administered program (SAP) based on SAP rates;

(b) Establishes SAP rates independently from the process used in setting the medicaid payment rates;

(c) Calculates a ratable each year to adjust each hospital's SAP rates for their percentage of community-based dollars to the total revenues for all hospitals;

(d) Calculates an equivalency factor (EF) to keep the SAP payment rates at the same level before and after the medicaid rates were rebased.

(2) The agency has established the following:

(a) SAP diagnosis-related group (DRG) conversion factor (CF) for claims grouped under DRG classifications services;

(b) SAP per diem rates for claims grouped under the following specialty service categories:

(i) Chemical-using pregnant (CUP) women;

(ii) Detoxification;

(iii) Physical medicine and rehabilitation (PM&R); and

(iv) Psychiatric((~~;~~)).

(c) ((~~SAP per case rate for claims grouped under bariatric services; and~~

~~(d)~~)) SAP ratio of costs-to-charges (RCC) for claims grouped under transplant services.

(3) This subsection describes the SAP DRG CF and payment calculation processes used by the agency to pay claims using the DRG payment method. The agency pays for services grouped to a DRG classification provided to clients eligible for a SAP based on the use of a DRG CF, a DRG relative weight, and a maximum service adjustor. This process is similar to the payment method used to pay for medicaid and CHIP services grouped to a DRG classification.

(a) The agency's SAP DRG CF calculation process is as follows:

(i) The hospital's specific DRG CF used to calculate payment for a SAP claim is the medicaid DRG CF multiplied by the applicable EF multiplied by the ratable;

(ii) For hospitals that do not have a ratable or an EF, the SAP CF is the hospital's specific medicaid CF multiplied by the average EF and the average ratable; and

(iii) For noncritical border hospitals, the SAP DRG CF is the lowest in-state medicaid DRG CF multiplied by the average ratable and the average EF.

(b) The agency calculates the SAP DRG EF as follows:

(i) The hospital-specific current SAP DRG CF is divided by the rebased medicaid DRG CF and then divided by the ratable factor to compute the preliminary EF.

(ii) The current SAP DRG payment is determined by multiplying the hospital specific SAP DRG CF by the AP-DRG version 23 relative weight.

(iii) The current aggregate DRG payment is determined by summing the current SAP DRG payments for all hospitals.

(iv) The hospital projected SAP DRG payment is determined by multiplying the hospital specific current SAP DRG CF by the APR-DRG relative weights and the maximum service adjustor.

(v) The projected aggregate DRG payment is determined by summing the projected SAP program DRG payments for all hospitals.

(vi) The aggregate amounts derived in (b)(iii) and (v) of this subsection are compared to identify a neutrality factor that keeps the projected aggregate SAP DRG payment (based on DRG-APR relative weights) at the same level as the previous aggregate SAP DRG payment (based on AP-DRG relative weights version 23.0).

(vii) The neutrality factor is multiplied by the hospital specific preliminary EF to determine the hospital specific final EF that is used to determine the SAP DRG conversion factors for the rebased system implementation.

(c) The agency calculates the DRG payment for services paid under the DRG payment method as follows:

(i) The agency calculates the allowed amount for the inlier portion of the SAP DRG payment by multiplying the SAP DRG CF by the DRG relative weight and the maximum service adjustor.

(ii) SAP claims are also subject to outlier pricing. See WAC 182-550-3700 for details on outlier pricing.

(4) This subsection describes how the agency calculates the SAP per diem rate and payment for CUP, detoxification, PM&R, and psychiatric services.

(a) The agency calculates the SAP per diem rate for in-state and critical border hospitals by multiplying the hospital's specific medicaid per diem by the ratable and the per diem EF.

(b) The agency calculates the SAP per diem rate for noncritical border hospitals by multiplying the lowest in-state medicaid per diem rate by the average ratable and the average per diem EF.

(c) For hospitals with more than twenty nonpsychiatric SAP per diem paid services during SFY 2011, the agency calculates a per diem EF for each hospital using the individual hospital's claims as follows:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments by the total number of days associated with the payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payments (same claims used in (c)(i) of this subsection).

(iii) The agency divides the hospital estimated SAP average payment per day in (a) of this subsection by the hospital medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (c)(iii) of this subsection by the hospital specific ratable factor to determine the EF.

(d) For hospitals with twenty or less nonpsychiatric SAP per diem paid services during SFY 2011, the EF is an average for all hospitals. The agency uses the following process to determine the average EF:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments for all hospitals by the total number of days associated with the aggregate payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payment (same claims used in (d)(i) of this subsection).

(iii) The agency divides the SAP average per day in (a) of this subsection by the medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (d)(iii) of this subsection by the hospital specific ratable factor to determine the EF. The EF is an average based on claims for all the hospitals in the group.

(e) The agency uses a psychiatric EF ((~~is used~~)) to keep SAP psychiatric rates at the level required by the Washington state legislature. The agency's SAP psychiatric rates are eighty-five and four one hundredths of a percent (85.04%) of the agency's medicaid psychiatric rates. The factor is applied to all hospitals.

(f) The agency calculates the SAP per diem allowed amount for CUP, detoxification, PM&R, and psychiatric services by multiplying the hospital's SAP per diem rate by the agency's allowed patient days.

(g) The agency does not apply the high outlier or transfer policy to the payment calculations for CUP, detoxification, PM&R, and psychiatric services.

(5) ((~~This subsection describes the SAP per case rate and payment processes for bariatric surgery services.~~

~~(a) The agency calculates the SAP per case rate for bariatric surgery services by multiplying the hospital's medicaid per case rate for bariatric surgery services by the hospital's ratable.~~

~~(b) The per case payment rate for bariatric surgery services is an all-inclusive rate.~~

~~(c) The agency does not apply the high outlier or transfer policy to the payment calculations for bariatric surgery services.~~

~~(6)~~)) The agency calculates the SAP RCC by multiplying the medicaid RCC by the hospital's ratable.

((~~(7)~~)) (6) The agency annually establishes ((~~annually~~)) the hospital-specific ratable factor used in the calculation of SAP payment rate based on the most current hospital revenue data available from the department of health (DOH). The agency uses the following process to determine the hospital ratable factor:

(a) The agency adds the hospital's medicaid revenue, medicare revenue, charity care, and bad debts as reported in DOH data.

(b) The agency determines the hospital's community care dollars by subtracting the hospital's low-income disproportionate share hospital (LIDSH) payments from the amount derived in (a) of this subsection.

(c) The agency calculates the hospital net revenue by subtracting the hospital-based physician revenue (based on information available from the hospital's medicare cost report or provided by the hospitals) from the DOH total hospital revenue report.

(d) The agency calculates the preliminary hospital-specific ratable by dividing the amount derived in (b) of this subsection by the amount derived in (c) of this subsection.

(e) The agency determines a neutrality factor by comparing the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the preliminary ratable to the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the prior year ratable. The neutrality factor is used to keep the projected SAP payments at the same current payment level.

(f) The agency determines the final hospital-specific ratable by multiplying the hospital-specific preliminary ratable by the neutrality factor.

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

((~~(8)~~)) (7) The agency does not pay an SAP claim paid by the DRG method at greater than the billed charges.

((~~(9)~~)) (8) SAP rates do not apply to the critical access hospital (CAH) program's weighted cost-to-charges, to the long-term acute care (LTAC) program's per diem rate, or to the certified public expenditure (CPE) program's RCC (except as the RCC applies to the CPE hold harmless described ((~~in~~)) under WAC 182-550-4670).