RULE-MAKING ORDER
PERMANENT RULE ONLY

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

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: April 10, 2024
TIME: 10:15 AM

WSR 24-09-028

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(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: HCA removed references to the hospital outpatient ratio of costs-to-charges (RCC) payment method due to the discontinuation of this payment method.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-4000, 182-550-4500
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: N/A

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 24-06-034 on February 29, 2024 (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Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended	2	Repealed	____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Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	2	Repealed	____

Date Adopted: April 10, 2024	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

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

WAC 182-550-4000 Payment method—Out-of-state hospitals. This section describes the payment methods the agency uses to pay hospitals located out-of-state for providing services to eligible Washington apple health clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC 182-501-0175. Payment methods that apply to bordering city hospitals, including critical border hospitals, are described in WAC 182-550-3900. See also WAC 182-501-0180, health care services provided outside the state of Washington - General provisions, and WAC 182-502-0120, payment for health care services provided outside the state of Washington.

(1) Emergency hospital services.

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals, the agency:

(i) Pays using the same methods used to pay in-state hospitals as specified in this chapter; and

(ii) Calculates the payment using the lowest in-state inpatient hospital rate corresponding to the payment method.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals, the agency pays an out-of-state hospital using the following methods:

(i) The agency's outpatient prospective payment system (OPPS) described in WAC 182-550-7000; and

(ii) The maximum allowable fee schedule method described in WAC 182-550-6000. When the maximum allowable fee schedule method is used, the agency limits payment to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount((~~; and~~

~~(iii) The hospital outpatient RCC payment method described in WAC 182-550-4500. When using the RCC payment method, the agency pays the lowest in-state hospital outpatient RCC, excluding weighted costs-to-charges (WCC) rates that are paid to in-state critical access hospitals~~)).

(2) Nonemergency hospital services.

(a) The agency pays for:

(i) Contracted and prior authorized nonemergency hospital services according to the contract terms whether or not the hospital has signed a core provider agreement; and

(ii) Nonemergency hospital services authorized by the agency after the fact (subsequent to the date of admission, if the client is still at the out-of-state hospital, or after the services have been provided) according to subsections (1) and (3) of this section.

(b) The agency does not pay for:

(i) Nonemergency hospital services provided to a Washington apple health client in a hospital located out-of-state unless the hospital is contracted and prior authorized by the agency or the agency's designee for the specific service provided to a specific client; and

(ii) Unauthorized nonemergency hospital services are not paid by the agency. See WAC 182-501-0182.

(3) The agency makes claim payment adjustments including, but not limited to, client responsibility, third-party liability, and medicare. All applicable adjustments are factored into the final hospital payment amount.

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

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 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.