Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 26-0003

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion letter
3) Summary Form (with 179-like data)
4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 13, 2026

Ryan Moran, Director
Trinity Wilson, State Medicaid Director
Washington State Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) – 26-0003

Dear Directors Moran and Wilson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 26-0003. This amendment updates the Rural Emergency Hospital protocol in the Washington state plan.

We conducted our review of your submittal according to statutory requirements in Section 1905(a)(9) of the Social Security Act and implementing regulations at 42 CFR § 440.90. This letter informs you that Washington's Medicaid SPA TN 26-0003 was approved on November 12, 2026, with an effective date of March 6, 2026.

Enclosed are copies of Form CMS-179, approved SPA pages and the companion letter to be incorporated into the Washington State Plan.

If you have any questions, please contact Edwin Walaszek at (212) 616-2512 or via email at edwin.walaszek1@cms.hhs.gov.

Sincerely,

Mandy L. Strom
Acting Deputy Director, Division of Program Operations

Enclosures

cc: Jason McGill, Assistant Director, Medicaid Programs Division (MPD)
Ann Myers, State Plan Coordinator, Medicaid Programs Division (MPD)
Abigail Cole, Section Manager, Hospital Finance & Drug Rebate

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
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Medicaid and CHIP Operations Group

November 13, 2026

Ryan Moran, Director
Trinity Wilson, State Medicaid Director
Washington State Health Care Authority
Post Office Box 45502
Olympia, WA 98504-5010

Re: Washington State Plan Amendment (SPA) – 26-0003

We are issuing this letter as a companion to the Centers for Medicare & Medicaid Services'(CMS) approval of Washington's State Plan Amendment (SPA) 26-0003. This amendment proposes to update the Rural Emergency Hospital protocol in the state plan. During our review, we identified certain issues with Washington's current state plan, which are the subject of this letter.

Reference to Inpatient Methodology in Section 4.19-B

1. CMS conducted a same-page review of Attachment 4.19-B, Page 18b, item VIII Institutional Services for the Critical Access Hospital (CAH) Program. Based on a review of the state's currently approved state plan, CMS recognizes that there is previously approved payment methodology language in Attachment 4.19-B pages that references a payment methodology authorized under Attachment 4.19-A pages for certain Medicare crossover claims. CMS generally does not authorize inpatient payment methodologies to be used for non-institutional services authorized in Attachment 4.19-B of the state plan.

   Section 1905(a) of the Social Security Act (the Act) authorizes Inpatient Hospital Services as their own Medicaid benefit category at 42 CFR 440.10, separate from Outpatient Hospital Services at 42 CFR 440.20(a) where Critical Access Hospitals are authorized in Washington's state plan. As required by 42 CFR 430.10, the state plan must be a comprehensive written statement containing "all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the state program." To ensure compliance with 42 CFR 430.10, the state must revise the state plan to ensure the state has payment authority under the appropriate Medicaid benefit for Inpatient Hospital Services. CMS is requesting the state submit a state plan amendment to remove the reference to the payment methodology for Inpatient Hospital Services that is currently authorized under Institutional Services on Attachment 4.19-B, Page 18b to a separate Attachment 4.19-A page. CMS is available to provide technical assistance to Washington as needed.

We are requesting your response on or before February 12, 2027, which is within 90 days from the date of this companion letter.

If you have any questions, please contact Edwin Walaszek at (212) 616-2512 or via email at edwin.walaszek1@cms.hhs.gov.

Sincerely,

Mandy L. Strom
Acting Deputy Director, Division of Program Operations

Enclosures

cc: Jason McGill, Assistant Director, Medicaid Programs Division (MPD)
Ann Myers, State Plan Coordinator, Medicaid Programs Division (MPD)
Abigail Cole, Section Manager, Hospital Finance & Drug Rebate

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0003

2. STATE: WA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~January 1, 2026~~ March 6, 2026

5. FEDERAL STATUTE/REGULATION CITATION
~~Section 1905(a) of the Social Security Act~~ 1905(a)(9) of the Act and 42 CFR 440.90

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
2026 $ 0
2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A page 26a
Attachment 3.1-B page 27a
~~Attachment 4.19-A Part 1 page 11~~
~~Attachment 4.19-B pages 18, 18-1~~
~~Attachment 4.19-B Page 5(a) (new)~~
Attachment 4.19-A Part 1 Page 26c, 26d, 26e (NEW)
Attachment 4.19-B Page 5a, 5b, 5c (NEW)
Attachment 4.19-B page 18
Attachment 4.19-B pages 18a, 18b (NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 3.1-A page 26a (TN 25-0015)
Attachment 3.1-B page 27a (TN 25-0015)
~~Attachment 4.19-A Part 1 page 11 (TN 16-0025)~~ ~~0025~~
Attachment 4.19-B pages 18 (TN 04-013), ~~18-1 (TN 15-0028)~~

9. SUBJECT OF AMENDMENT
Rural Emergency Hospitals

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
(●) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED: EXEMPT

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Trinity Wilson

13. TITLE
Interim Medicaid Director

14. DATE SUBMITTED
March 4, 2026

15. RETURN TO
State Plan Coordinator
POB 42716
Olympia, WA 98504-2716

FOR CMS USE ONLY

16. DATE RECEIVED
March 4, 2026

17. DATE APPROVED
November 12, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
March 6, 2026

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Mandy L. Strom

21. TITLE OF APPROVING OFFICIAL
Acting Deputy Director, Division of Program Operations

22. REMARKS

11/03/26: State provides the following pen and ink authorization:
- Box 13: Remove 'interim'
- Box 7: Add Attachment 4.19-A Part 1 Page 26c (NEW); Attachment 4.19-A Part I Page 26d (NEW); Attachment 4.19-A Part 1 Page 26e (NEW); Attachment 4.19-B Page 5a, 5b, 5c (NEW); Attachment 4.19-B Page 18a, 18b (NEW)

FORM CMS-179

4/30/26: State provides the following pen and ink authorization:
- Box 7: For Attachment 4.19-B, remove page "18-1" and add page "5a (new)"
- Box 8: For Attachment 4.19-B, remove page "18-1 (TN 15-0028)"

4/07/26: State provides the following pen and ink authorization:
- Box 4: Change to 'March 6, 2026'

3/06/26: State provides the following pen and ink authorization:
- Box 5: Change to 1905(a)(9) of the Act and 42 CFR 440.90 Box 8: Change superseded SPA to Attachment 4.19-A Part 1 page 11 to (TN 16-0025)

State Plan under Title XIX of the Social Security Act
State/Territory: Washington

Section 1905(a)(9) Clinic Services

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**
Click or tap here to enter text.

☒ IHS and Tribal Clinics **[Select below if applicable.]**:

☐ Limitations apply only to this clinic type within the benefit category. **[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].**
Click or tap here to enter text.

☒ Renal Dialysis Clinics **[Select below if applicable.]**:

☒ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

Freestanding kidney centers
(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)
(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.
(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. Includes physician services, medical supplies, equipment, drugs, and laboratory tests.

☒ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]**:

Freestanding ambulatory surgery centers
(1) Allowed procedures are covered when they are medically necessary
(2) Some procedures are covered only when they meet certain limitation requirements and have been prior authorized by the agency.

Rural Emergency Hospitals
(1) Rural emergency hospitals (REH) services are provided by clinics certified by Medicare as REHs.
(2) Allowed procedures are covered when they are medically necessary

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Washington

Section 1905(a)(9) Clinic Services

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**
Click or tap here to enter text.

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☐ Limitations apply only to this clinic type within the benefit category. **[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].**
Click or tap here to enter text.

☒ Renal Dialysis Clinics **[Select below if applicable.]**:

☒ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

Freestanding kidney centers
(1) Description of facility: A center devoted specially to treating End Stage Renal Disease (ESRD)
(2) Description of service: Peritoneal dialysis or hemodialysis for ESRD.
(3) Program coverage: Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. Includes physician services, medical supplies, equipment, drugs, and laboratory tests.

☒ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]**:

Freestanding ambulatory surgery centers
(1) Allowed procedures are covered when they are medically necessary
(2) Some procedures are covered only when they meet certain limitation requirements and have been prior authorized by the agency

Rural Emergency Hospitals
(1) A licensed critical access hospital that applies for and receives licensure as a rural emergency hospital (REH). REH facilities must meet regulatory requirements set by Medicare.
(2) Allowed procedures are covered when they are medically necessary.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES (cont.)

C. GENERAL REIMBURSEMENT POLICIES (cont)

23. Critical Access Hospital (CAH) Payment

1. Critical Access Hospitals (CAH) that meet the Medicare qualifications for CAH designation as of July 1, 2025, are reimbursed by the agency for services through a cost reimbursement method, not to exceed 100% of reasonable and allowable costs, utilizing Medicare cost principles. The agency follows cost principles described in 2 CFR 200 for identifying Medicaid fee-for-service only costs and data. Room and board costs are not allowable and are excluded for reimbursement,

2. Distinct units are excluded from cost-based reimbursement and payment methodology as those units follow the same methodology as other hospitals.

3. CAHs are required to submit their as-filed Medicare 2552 cost report to the agency no later than 5 months after the end of the hospital-specific fiscal year. CAHs will receive prospective payments based on a hospital-specific inpatient cost-to-charge (IWCC) ratio calculated each January 1st, using a base year Medicare cost report with a hospital-specific year ending 2-years prior to the calendar year. For example, prospective rates for calendar year 2027 will be calculated using the hospital cost report with a hospital-specific fiscal year ending in 2025.

4. Allowable costs are calculated in accordance with the Medicare Provider Reimbursement Manual, CMS publication 15-1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

C. GENERAL REIMBURSEMENT POLICIES (cont)

23. Critical Access Hospital (CAH) Payment (cont)

5. Allowable cost center costs are identified by cost center in the Medicare 2552 cost report and are as follows:

03000	ADULTS & PEDIATRICS	06100	PBP CLINICAL LAB
03100	INTENSIVE CARE UNIT	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS
03200	CORONARY CARE UNIT	06300	BLOOD STORING PROCESSING & TRANSFUSING
03300	BURN INTENSIVE CARE UNIT	06400	INTRAVENOUS THERAPY
03400	SURGICAL INTENSIVE CARE UNIT	06500	RESPIRATORY THERAPY
03500	OTHER ICU	06600	PHYSICAL THERAPY
04300	NURSERY	06700	OCCUPATIONAL THERAPY
05000	OPERATING ROOM	06800	SPEECH PATHOLOGY
05100	RECOVERY ROOM	06900	ELECTROCARDIOLOGY
05200	DELIVERY ROOM & LABOR ROOM	07000	ELECTROENCEPHALOGRAPHY
05300	ANESTHESIOLOGY	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS
05400	RADIOLOGY – DIAGNOSTIC	07200	IMPLANT DEVICES CHARGED TO PATIENTS
05500	RADIOLOGY – THERAPEUTIC	07300	DRUGS CHARGED TO PATIENTS
05600	RADIOISOTOPE	07400	RENAL DIALYSIS
05700	CT SCAN	07500	ASC (NON-DISTINCT PART)
05800	MRI	07600	OTHER ANCILLARY COST CENTERS
05900	CARDIAC CATHETERIZATION	09100	EMERGENCY
06000	LABORATORY	09200	OBSERVATION BEDS
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6. To calculate the prospective rate for inpatient, the agency:
   a. Using a cost center to revenue code crosswalk, assigns billed charges to the allowable cost centers and multiplies cost center-specific cost-to-charges ratios from the Medicare 2552 cost report by the sum of all inpatient fee-for-service and managed care allowed charges by cost center from the base hospital-specific fiscal year, defined as the hospital-specific fiscal year end, ending 2 years prior to the calendar year being calculated. If a cost-center ratio is missing, a hospital average cost-to-charge ratio is used for that cost-center.
   b. Multiplies the weighted costs calculated in (a) by the most recently published CMS Medicare inpatient market basket inflation factor to inflate costs from the base year to the calendar year.
   c. Multiplies the total allowed charges by the CAH-submitted chargemaster increase. If the CAH does not submit the chargemaster increase within 20 working days of the agency request, a default increase of 8% is used.
   d. The prospective IWCC used to pay claims is the result of the inflated costs (b) divided by the charges, including the chargemaster increase (c).

Prospective claim payments are calculated by multiplying covered charges by the prospective IWCC and paid at the time of the claim.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

C. GENERAL REIMBURSEMENT POLICIES (cont)

23. Critical Access Hospital (CAH) Payment (cont)

7. An interim settlement is performed retrospectively using the CAH submitted as-filed Medicare 2552 cost report. This settlement occurs when the provider submits their as-filed cost report to the agency. The same process as above is used for the interim settlement, without inflationary or chargemaster increases.

8. The IWCC is multiplied by actual year covered charges, on a claims level, to replicate actual cost. Claims payments made during the year, including any third-party liability or client responsibility, are subtracted from calculated costs and if the prospective payments exceed costs, the CAH reimburses the agency and the federal share is returned according to 42 CFR 433 subpart F. If prospective payments are less than costs, the agency provides an additional payment to the CAH.

9. A final settlement is processed retrospectively using the CAH-submitted settled Medicare 2552 cost report. This final settlement occurs within six months of when the hospital settled Medicare cost report is available from either the CMS Healthcare Provider Cost Reporting Information System (**HCRIS**) or is submitted by the hospital to the agency, no later than 60 days from the date the hospital receives it from the intermediary. The same process as the interim settlement is used for the final settlement, without inflationary or chargemaster increases. The IWCC is multiplied by actual year covered charges on a claims level, to replicate actual cost. Claims payments made during the year, including any third-party liability or client responsibility, and any payments made or recouped during the interim settlement are subtracted and if the prospective payments exceed costs, the CAH reimburses the agency and the federal share is returned according to 42 CFR 433 subpart F. If prospective payments are less than costs, the agency provides an additional payment to the CAH.

10. A hospital that converts to a CAH will use their current hospital specific inpatient ratio of cost to charges for claims until the next rate setting period to occur prior to January 1st.

11. For a newly licensed CAH, the agency uses the current statewide average IWCC rates for the initial prospective IWCC rates.

12. For a CAH that changes ownership, the agency uses the prior owner's IWCC rates until a new full year as-filed cost report is available from HCRIS or submitted by the hospital to the agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

II. Clinic Services (cont.)

E. Rural Emergency Hospital (REH) Program

1. Rural emergency hospitals (REH) that meet the Medicare qualifications for REH designation, are reimbursed by the agency for services through a cost reimbursement method, not to exceed 100% of reasonable and allowable costs, utilizing Medicare cost principles. The agency follows cost principles described in 2 CFR 200 for identifying Medicaid fee-for-service only costs and data. Room and board costs are not allowable and are excluded for reimbursement,

2. Distinct units are excluded from cost-based reimbursement and payment methodology as those units follow the same methodology as other hospitals.

3. REHs are required to submit their as-filed Medicare 2552 cost report to the agency no later than 5 months after the end of the REH-specific fiscal year. REHs will receive prospective payments on a claims level based on a hospital-specific outpatient weighted cost-to-charge (OWCC) ratio calculated prior to January 1st, using a base year Medicare cost report with a hospital-specific fiscal year ending 2-years prior to the calendar year. For example, prospective rates for calendar year 2027 will be calculated using the REH-specific cost report with an REH-specific fiscal year ending in 2025.
   - Prospective claim payments are calculated by multiplying covered charges by the prospective OWCC and paid at the time of the claim.

4. Allowable costs are calculated in accordance with the Medicare Provider Reimbursement Manual, CMS publication 15-1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

II. Clinic Services (cont.)

E. Rural Emergency Hospital Program (cont)

5. Allowable costs are identified by cost center in the Medicare 2552 cost report and are as follows:

03000	ADULTS & PEDIATRICS	06100	PBP CLINICAL LAB
03100	INTENSIVE CARE UNIT	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS
03200	CORONARY CARE UNIT	06300	BLOOD STORING PROCESSING & TRANSFUSING
03300	BURN INTENSIVE CARE UNIT	06400	INTRAVENOUS THERAPY
03400	SURGICAL INTENSIVE CARE UNIT	06500	RESPIRATORY THERAPY
03500	OTHER ICU	06600	PHYSICAL THERAPY
04300	NURSERY	06700	OCCUPATIONAL THERAPY
05000	OPERATING ROOM	06800	SPEECH PATHOLOGY
05100	RECOVERY ROOM	06900	ELECTROCARDIOLOGY
05200	DELIVERY ROOM & LABOR ROOM	07000	ELECTROENCEPHALOGRAPHY
05300	ANESTHESIOLOGY	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS
05400	RADIOLOGY – DIAGNOSTIC	07200	IMPLANT DEVICES CHARGED TO PATIENTS
05500	RADIOLOGY – THERAPEUTIC	07300	DRUGS CHARGED TO PATIENTS
05600	RADIOISOTOPE	07400	RENAL DIALYSIS
05700	CT SCAN	07500	ASC (NON-DISTINCT PART)
05800	MRI	07600	OTHER ANCILLARY COST CENTERS
05900	CARDIAC CATHETERIZATION	09100	EMERGENCY
06000	LABORATORY	09200	OBSERVATION BEDS
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6. To calculate the prospective OWCC rate, the agency:
   a. Using a cost center to revenue code crosswalk, assigns billed charges to the allowable cost centers and multiplies cost center-specific cost-to-charges ratios from the Medicare 2552 cost report by the sum of fee-for-service and managed care allowed charges by cost center from the base REH-specific fiscal year, defined as the REH-specific year end, ending 2 years prior to the calendar year being calculated. For example, prospective rates for calendar year 2027 will be calculated using the hospital cost report with a hospital-specific fiscal year ending in 2025. If a cost-center ratio is missing, a hospital average cost-to-charge ratio is used for that cost-center.
   b. Multiplies the weighted costs calculated in (a) by the most recently published CMS Medicare outpatient market basket inflation factor to inflate costs from the base year to the calendar year.
   c. Multiplies the total allowed charges by the REH-submitted chargemaster increase. If the REH does not submit the chargemaster increase within 20 working days of the agency request, a default increase of 8% is used.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

II. Clinic Services (cont.)

E. Rural Emergency Hospital Program (cont)

d. The prospective OWCC is the result of the inflated costs (b) divided by the charges, including the chargemaster increase (c).

Prospective claim payments are calculated by multiplying covered charges by the prospective OWCC and paid at the time of the claim.

7. An interim settlement is performed retrospectively using the REH submitted as-filed Medicare 2552 cost report. This settlement occurs when the provider submits their as-filed cost report to the agency. The same process as above is used for the interim settlement, without inflationary or chargemaster increases.

8. The OWCC is multiplied by actual year covered charges, on a claims level, to replicate actual cost. Claims payments made during the year, including any third-party liability or client responsibility, are subtracted from calculated costs and if the prospective payments exceed costs, the REH reimburses the agency and the federal share is returned according to 42 CFR 433 subpart F. If prospective payments are less than costs, the agency provides an additional payment to the REH.

9. A final settlement is processed retrospectively using the REH-submitted settled Medicare 2552 cost report. This final settlement occurs within six months of when the hospital settled Medicare cost report is available from either the CMS Healthcare Provider Cost Reporting Information System (**HCRIS**) or is submitted by the hospital to the agency, no later than 60 days from the date the hospital receives it from the intermediary. The same process as the interim settlement is used for the final settlement, without inflationary or chargemaster increases. The OWCC is multiplied by actual year covered charges on a claims level, to replicate actual cost. Claims payments made during the year, including any third-party liability or client responsibility, and any payments made or recouped during the interim settlement are subtracted and if the prospective payments exceed costs, the REH reimburses the agency and the federal share is returned according to 42 CFR 433 subpart F. If prospective payments are less than costs, the agency provides an additional payment to the REH.

10. A hospital that converts from a Critical Access Hospital (CAH) to an REH will use their current CAH-specific outpatient WCC for claims until the next rate setting period to occur prior to January 1st.

11. For a newly licensed REH that was not previously a CAH, the agency uses the current statewide average OWCC rates for the initial prospective OWCC rates.

12. For an REH that changes ownership, the agency uses the prior owner's outpatient WCC rates until a new full year as-filed cost report is available from HCRIS or submitted by the hospital to the agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont.)

D. Critical Access Hospital (CAH) Program

1. Critical Access Hospitals (CAHs) that meet the Medicare qualifications for CAH designation as of July 1, 2005, are reimbursed through a cost settlement method not to exceed 100% of reasonable and allowable costs, using Medicare cost principles. The agency follows the cost principles described in 42 CFR 200 for identifying Medicaid fee-for-service only costs and data. Room and board costs are not allowable and are excluded for reimbursement,

2. Distinct units are excluded from cost-based reimbursement and payment methodology as those units follow the same methodology as other hospitals.

3. CAHs are required to submit their as-filed Medicare 2552 cost report to the agency no later than 5 months after the end of the hospital-specific fiscal year. CAHs will receive prospective payments based on a hospital-specific weighted cost-to-charge (WCC) ratio calculated each January 1st, using a base year Medicare cost report with a hospital-specific fiscal year ending 2-years prior to the calendar year. For example, prospective rates for calendar year 2027 will be calculated using the hospital cost report with a hospital specific fiscal year ending in 2025.

4. Allowable costs are calculated in accordance with the Medicare Provider Reimbursement Manual, CMS publication 15-1.

5. Allowable costs are identified by cost center in the Medicare 2552 cost report and are as follows:

03000	ADULTS & PEDIATRICS	06100	PBP CLINICAL LAB
03100	INTENSIVE CARE UNIT	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS
03200	CORONARY CARE UNIT	06300	BLOOD STORING PROCESSING & TRANSFUSING
03300	BURN INTENSIVE CARE UNIT	06400	INTRAVENOUS THERAPY
03400	SURGICAL INTENSIVE CARE UNIT	06500	RESPIRATORY THERAPY
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04300	NURSERY	06700	OCCUPATIONAL THERAPY
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05500	RADIOLOGY – THERAPEUTIC	07300	DRUGS CHARGED TO PATIENTS
05600	RADIOISOTOPE	07400	RENAL DIALYSIS
05700	CT SCAN	07500	ASC (NON-DISTINCT PART)
05800	MRI	07600	OTHER ANCILLARY COST CENTERS
05900	CARDIAC CATHETERIZATION	09100	EMERGENCY
06000	LABORATORY	09200	OBSERVATION BEDS
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont.)

D. Critical Access Hospital (CAH) Program (cont)

6. To calculate the prospective rate, separately for outpatient, the agency:
   a. Uses a cost center revenue code cross-walk, assigns billed charges to the allowable cost centers and multiplies specific cost-to-charge ratios from the Medicare 2552 cost report by the sum of all outpatient fee-for-service and managed care allowed charges by cost center from the base hospital-specific fiscal year, defined as the hospital-specific fiscal year end, ending 2 years prior to the calendar year being calculated. For example, prospective rates for calendar year 2027 will be calculated using the hospital cost report with a hospital specific fiscal year ending in 2025. If a cost-center ratio is missing, a hospital average cost to charge ratio is used for that cost-center.
   b. Multiplies the weighted costs calculated in (a) by the most recently published CMS Medicare outpatient market basket inflation factor for the base year to the calendar year.
   c. Multiplies the total allowed charges by the CAH submitted chargemaster increase. If the CAH does not submit the chargemaster increase within 20 working days of the agency request, a default increase of 8% is used.
   d. The prospective OWCC used to pay claims is the result of the inflated costs (b) divided by the charges, including the chargemaster increase (c).

   Prospective claim payments are calculated by multiplying covered charges by the prospective OWCC and paid at the time of the claim.

7. An interim settlement is performed retrospectively using the CAH-submitted as-filed Medicare 2552 cost report. This settlement occurs when the provider submits their as-filed report to the agency. The same process as above is used for the interim settlement, without inflationary or chargemaster increases.

8. The OWCC is multiplied by actual year covered charges, on a claims level, to replicate actual cost. Claims payments, including any third-party liability or client responsibility, made during the year are subtracted from calculated costs and if the prospective payments exceed costs, the CAH reimburses the agency and the federal share is returned according to 42 CFR 433 subpart F. If prospective payments are less than costs, the agency provides an additional payment to the CAH.

9. A final settlement is processed retrospectively using the CAH-submitted, settled Medicare 2552 cost report. This final settlement occurs within six months of when the hospital settled Medicare cost report is available from either the CMS Healthcare Provider Cost Reporting Information System (**HCRIS**) or is submitted by the hospital to the agency, no later than 60 days from the date the hospital receives it from the intermediary. The same process as the interim settlement is used for the final settlement, without inflationary or chargemaster increases. The OWCC is multiplied by actual year covered charges on a claims level, to replicate actual cost. Claims payments made during the year, including any third-party liability or client responsibility, and any payments made or recouped during the interim settlement are subtracted from calculated costs and if the prospective payments exceed costs , the CAH reimburses the agency and the federal share is returned. according to 42 CFR 433 subpart F. If payments are less than costs, the agency provides an additional payment to the CAH.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VIII. Institutional Services (cont.)

D. Critical Access Hospital (CAH) Program (cont)

10. A hospital that converts to a CAH will use the current statewide average outpatient WCC rate for the initial prospective outpatient WCC rates.

11. For a CAH that changes ownership, the agency uses the prior owner's outpatient WCC rates until a new full year as-filed cost report is available from HCRIS or submitted by the hospital to the agency.

E. Medicare-Related Policies for Outpatient Hospital Payments

For payment methods related to the Medicare Part A, Part B, and Part C deductibles, coinsurance, and/or co-pays, please refer to Supplement 1 to Attachment 4.19-B, as updated. Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medicaid. For these clients, the state considers the Medicare Part B Outpatient Hospital payments to be payment in full. The state will pay the Medicare deductible and co-insurance related to a Medicaid clients' Medicare Part B outpatient hospital claim only up to the maximum payment level calculated using the Medicaid "hospital outpatient rate" described in subsection VIII. A. above, and Supplement 1 to Attachment 4.19-B. However, the maximum payment level will exclude any trauma enhanced payment amount.

If the Medicare Part B covered charges and payments are combined with the Medicare Part A inpatient covered charges and payments on a Medicare claim, obscuring the Part B charges and payment amounts, the total Medicaid payment to a Medicaid provider will be calculated as described in Attachment 4.19-A for Medicare crossovers, and Supplement 1 to Attachment 4.19-B, for Medicare Part A services. The total Medicaid payment to a Medicaid provider for Medicare Part C outpatient hospital-related care provided to a Medicaid client will be calculated as described in Supplement 1 to Attachment 4.19-B.