RULE-MAKING ORDER
PERMANENT RULE ONLY

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

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DATE: May 04, 2023
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WSR 23-11-007

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Purpose: The agency is correcting cross-references to a repealed rule and an outdated reference to an agency program. The agency is replacing references to WAC 182-532-0720 with references to chapter 182-532 WAC because that rule was repealed under WSR 19-18-024. The agency is replacing instances of the term TAKE CHARGE with current program terminology, specifically the Family Planning Only programs under chapter 182-532 WAC.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-503-0005, 182-503-0510, 182-505-0300, 182-513-1605, 182-513-1615, 182-530-7250, 182-550-4900
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 23-06-051 on February 27, 2023 (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Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	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	New		Amended		Repealed	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	New		Amended		Repealed	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	New		Amended	7	Repealed	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	7	Repealed	

Date Adopted: May 4, 2023	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 22-20-052, filed 9/28/22, effective 10/29/22)

WAC 182-503-0005 Washington apple health—How to apply. (1) You may apply for Washington apple health at any time.

(2) For apple health programs for children, pregnant people, parents and caretaker relatives, and adults age 64 and under without medicare (including people who have a disability or are blind), you may apply:

(a) Online via the Washington Healthplanfinder at www.wahealthplanfinder.org;

(b) By calling the Washington Healthplanfinder customer support center and completing an application by telephone;

(c) By completing the application for health care coverage (HCA 18-001P), and mailing or faxing to Washington Healthplanfinder; or

(d) At a department of social and health services (DSHS) community services office (CSO).

(3) If you seek apple health coverage and are age 65 or older, have a disability, are blind, need assistance with medicare costs, or seek coverage of long-term services and supports, you may apply:

(a) Online via Washington Connection at www.WashingtonConnection.org;

(b) By completing the application for aged, blind, disabled/long-term care coverage (HCA 18-005) and mailing or faxing it to DSHS;

(c) By calling the DSHS customer service contact center and completing an application by telephone;

(d) In person at a local DSHS CSO or home and community services (HCS) office; or

(e) As specified in subsection (2) of this section, if you are a child, pregnant, a parent or caretaker relative, or an adult age 64 and under without medicare.

(4) You may receive help filing an application.

(a) For households containing people described in subsection (2) of this section:

(i) Call the Washington Healthplanfinder customer support center number listed on the application for health care coverage form (HCA 18-001P); or

(ii) Contact a navigator, health care authority volunteer assistor, or broker.

(b) For people described in subsection (3) of this section who are not applying with a household containing people described in subsection (2) of this section:

(i) Call or visit a local DSHS CSO or HCS office; or

(ii) Call the DSHS community services customer service contact center number listed on the medicaid application form.

(5) To apply for tailored supports for older adults (TSOA), see WAC 182-513-1625.

(6) You must apply directly with the service provider for the following programs:

(a) The breast and cervical cancer treatment program under WAC 182-505-0120;

(b) The ((~~TAKE CHARGE~~)) family planning only programs under chapter 182-532 WAC; and

(c) The kidney disease program under chapter 182-540 WAC.

(7) For the confidential pregnant minor program under WAC 182-505-0117 and for minors living independently, you must complete a separate application directly with us (the medicaid agency).

More information on how to give us an application may be found at the agency's website: www.hca.wa.gov/free-or-low-cost-health-care (search for "teen").

(8) As the primary applicant or head of household, you may start an application for apple health by providing your:

(a) Full name;

(b) Date of birth;

(c) Physical address, and mailing addresses (if different); and

(d) Signature.

(9) To complete an application for apple health, you must also give us all of the other information requested on the application.

(10) You may have an authorized representative apply on your behalf as described in WAC 182-503-0130.

(11) We help you with your application or renewal for apple health in a manner that is accessible to you. We provide equal access (EA) services as described in WAC 182-503-0120 if you:

(a) Ask for EA services, you apply for or receive long-term services and supports, or we determine that you would benefit from EA services; or

(b) Have limited-English proficiency as described in WAC 182-503-0110.

AMENDATORY SECTION (Amending WSR 17-12-019, filed 5/30/17, effective 7/1/17)

WAC 182-503-0510 Washington apple health—Program summary. (1) The agency categorizes Washington apple health programs into three groups based on the income methodology used to determine eligibility:

(a) Those that use a modified adjusted gross income (MAGI)-based methodology described in WAC 182-509-0300, called MAGI-based apple health programs;

(b) Those that use an income methodology other than MAGI, called non-MAGI-based apple health programs, which include:

(i) Supplemental security income (SSI)-related apple health programs;

(ii) Temporary assistance for needy families (TANF)-related apple health programs; and

(iii) Other apple health programs not based on MAGI, SSI, or TANF methodologies.

(c) Those that provide coverage based on a specific status or entitlement in federal rule and not on countable income, called deemed eligible apple health programs.

(2) MAGI-based apple health programs include the following:

(a) Apple health parent and caretaker relative program described in WAC 182-505-0240;

(b) MAGI-based apple health adult medical program described in WAC 182-505-0250, for which the scope of coverage is called the alternative benefits plan (ABP) described in WAC 182-500-0010;

(c) Apple health for pregnant women program described in WAC 182-505-0115;

(d) Apple health for kids program described in WAC 182-505-0210 (3)(a);

(e) Premium-based apple health for kids described in WAC 182-505-0215;

(f) Apple health long-term care for children and adults described in chapter 182-514 WAC; and

(g) Apple health alien emergency medical program described in WAC 182-507-0110 through 182-507-0125 when the person is eligible based on criteria for a MAGI-based apple health program.

(3) Non-MAGI-based apple health programs include the following:

(a) SSI-related programs which use the income methodologies of the SSI program (except where the agency has adopted more liberal rules than SSI) described in chapter 182-512 WAC to determine eligibility:

(i) Apple health for workers with disabilities (HWD) described in chapter 182-511 WAC;

(ii) Apple health SSI-related programs described in chapters 182-512 and 182-519 WAC;

(iii) Apple health long-term care and hospice programs described in chapters 182-513 and 182-515 WAC;

(iv) Apple health medicare savings programs described in chapter 182-517 WAC; and

(v) Apple health alien emergency medical (AEM) programs described in WAC 182-507-0110 and 182-507-0125 when the person meets the age, blindness or disability criteria specified in WAC 182-512-0050.

(b) TANF-related programs which use the income methodologies based on the TANF cash program described in WAC 388-450-0170 to determine eligibility, with variations as specified in WAC 182-509-0001(5) and program specific rules:

(i) Refugee medical assistance (RMA) program described in WAC 182-507-0130; and

(ii) Apple health medically needy (MN) coverage for pregnant women and children who do not meet SSI-related criteria.

(c) Other programs:

(i) Breast and cervical cancer program described in WAC 182-505-0120;

(ii) ((~~TAKE CHARGE~~)) Family planning only programs described in chapter 182-532 WAC ((~~182-532-0720~~));

(iii) Medical care services described in WAC 182-508-0005;

(iv) Apple health for pregnant minors described in WAC 182-505-0117;

(v) Kidney disease program described in chapter 182-540 WAC; and

(vi) Tailored supports for older adults described in WAC 182-513-1610.

(4) Deemed eligible apple health programs include:

(a) Apple health SSI medical program described in chapter 182-510 WAC, or a person who meets the medicaid eligibility criteria in 1619b of the Social Security Act;

(b) Newborn medical program described in WAC 182-505-0210(2);

(c) Foster care program described in WAC 182-505-0211;

(d) Medical extension program described in WAC 182-523-0100; and

(e) Family planning extension described in WAC 182-505-0115(5).

(5) A person is eligible for categorically needy (CN) health care coverage when the household's countable income is at or below the categorically needy income level (CNIL) for the specific program.

(6) If income is above the CNIL, a person is eligible for the MN program if the person is:

(a) A child;

(b) A pregnant woman; or

(c) SSI-related (aged 65, blind or disabled).

(7) MN health care coverage is not available to parents, caretaker relatives, or adults unless they are eligible under subsection (6) of this section.

(8) A person who is eligible for the apple health MAGI-based adult program listed in subsection (2)(b) of this section is eligible for ABP health care coverage as defined in WAC 182-500-0010. Such a person may apply for more comprehensive coverage through another apple health program at any time.

(9) For the other specific program requirements a person must meet to qualify for apple health, see chapters 182-503 through 182-527 WAC.

AMENDATORY SECTION (Amending WSR 17-12-018, filed 5/30/17, effective 6/30/17)

WAC 182-505-0300 Hospital presumptive eligibility. (1) **Purpose.** The hospital presumptive eligibility (HPE) program provides temporary Washington apple health coverage to HPE-eligible persons who enroll through an HPE-qualified hospital.

(2) **HPE-eligible persons.** To be HPE-eligible:

(a) A person must:

(i) Be younger than age ((~~sixty-five~~)) 65; and

(ii) Meet the eligibility requirements for one or more of the following programs:

(A) Washington apple health for pregnant women (chapter 182-505 WAC);

(B) Washington apple health for kids (chapter 182-505 WAC);

(C) Washington apple health for foster care (chapter 182-505 WAC);

(D) Washington apple health for parents and caretaker relatives (chapter 182-505 WAC);

(E) Washington apple health for adults (chapter 182-505 WAC); or

(F) ((~~TAKE CHARGE for~~)) Family planning only services (chapter 182-532 WAC).

(b) A person must not:

(i) Be an apple health beneficiary;

(ii) Be a supplemental security income beneficiary; or

(iii) Have received HPE coverage within the preceding ((~~twenty-four~~)) 24 months.

(3) **HPE-qualified hospitals.** To be HPE-qualified, a hospital must:

(a) Operate in Washington state;

(b) Submit a signed core provider agreement (CPA) to the agency;

(c) Submit a signed HPE agreement to the agency;

(d) Comply with the terms of the CPA and HPE agreements;

(e) Determine HPE eligibility using only those employees who have successfully completed the agency's HPE training;

(f) Agree to provide HPE-application assistance to anyone who requests it; and

(g) Agree to be listed on the agency's website as an HPE-application assistance provider.

(4) **Limitations.**

(a) An HPE-qualified hospital must attempt to help the person complete a regular apple health application before filing an HPE application. If the person cannot indicate whether they expect to file a federal tax return or be claimed as a tax dependent, the HPE-qualified hospital may treat the person as a nonfiler under WAC 182-506-0010 (5)(c) for HPE purposes.

(b) HPE coverage begins on the earlier of:

(i) The day the HPE-qualified hospital determines the person is eligible; or

(ii) The day the HPE-qualified hospital provides a covered medical service to the person, but only if the hospital determines the person is eligible and submits the decision to the agency no later than five calendar days after the date of service.

(c) HPE coverage ends on the earlier of:

(i) The last day of the month following the month in which HPE coverage began; or

(ii) The day the agency determines the person is eligible for other apple health coverage.

(d) HPE coverage does not qualify a person for continuous eligibility under WAC 182-504-0015.

(e) If HPE coverage is based on pregnancy, the pregnant person is eligible for HPE coverage only once for that pregnancy.

(f) The HPE program covers only those services included in the programs listed in subsection (2)(e) of this section, except that pregnancy-related services are limited to ambulatory prenatal care.

(g) A child born to a person with HPE coverage is ineligible for apple health under WAC 182-505-0210(2). An HPE-qualified hospital must complete a separate HPE determination for the newborn child.

AMENDATORY SECTION (Amending WSR 17-12-019, filed 5/30/17, effective 7/1/17)

WAC 182-513-1605 Medicaid alternative care (MAC)—Eligibility. (1) The person receiving care must meet the financial eligibility criteria for medicaid alternative care (MAC).

(2) To be eligible for MAC services, the person receiving care must:

(a) Be age ((~~fifty-five~~)) 55 or older;

(b) Be assessed as meeting nursing facility level of care under WAC 388-106-0355, and choose to receive services under the MAC program instead of other long-term services and supports;

(c) Meet residency requirements under WAC 182-503-0520;

(d) Live at home and not in a residential or institutional setting;

(e) Have an eligible unpaid caregiver under WAC 388-106-1905;

(f) Meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b); and

(g) Be eligible for either:

(i) A noninstitutional medicaid program, which provides categorically needy (CN) or alternative benefit plan (ABP) scope of care under WAC 182-501-0060; or

(ii) An SSI-related CN program by using spousal impoverishment protections institutionalized (SIPI) spouse rules under WAC 182-513-1660.

(3) An applicant whose eligibility is limited to one or more of the following programs is not eligible for MAC:

(a) The medically needy program under WAC 182-519-0100;

(b) The medicare savings programs under WAC 182-517-0300;

(c) The family planning program under WAC 182-505-0115;

(d) The ((~~TAKE CHARGE~~)) family planning only programs under chapter 182-532 WAC ((~~182-532-720~~));

(e) The medical care services (MCS) program under WAC 182-508-0005;

(f) The alien emergency medical (AEM) program under WAC 182-507-0110 through 182-507-0120;

(g) The state funded long-term care for noncitizens program under WAC 182-507-0125;

(h) The kidney disease program under chapter 182-540 WAC; or

(i) The tailored supports for older adults (TSOA) program under WAC 182-513-1610.

(4) The following rules do not apply to services provided under the MAC benefit:

(a) Transfer of asset penalties under WAC 182-513-1363;

(b) Excess home equity under WAC 182-513-1350; and

(c) Estate recovery under chapter 182-527 WAC.

AMENDATORY SECTION (Amending WSR 17-12-019, filed 5/30/17, effective 7/1/17)

WAC 182-513-1615 Tailored supports for older adults (TSOA)—General eligibility. (1) The person receiving care must meet the finan-

cial eligibility criteria for tailored supports for older adults (TSOA).

(2) To be eligible for the TSOA program, the person receiving care must:

(a) Be age ((~~fifty-five~~)) 55 or older;

(b) Be assessed as meeting nursing facility level of care under WAC 388-106-0355;

(c) Meet residency requirements under WAC 182-503-0520;

(d) Live at home and not in a residential or institutional setting;

(e) Have an eligible unpaid caregiver under WAC 388-106-1905, or meet the criteria under WAC 388-106-1910 if the person does not have an eligible unpaid caregiver;

(f) Meet citizenship or immigration status requirements under WAC 182-503-0535. To be eligible for TSOA, a person must be a:

(i) U.S. citizen under WAC 182-503-0535 (1)(c);

(ii) U.S. national under WAC 182-503-0535 (1)(d);

(iii) Qualifying American Indian born abroad under WAC 182-503-0535 (1)(f); or

(iv) Qualified alien under WAC 182-503-0535 (1)(b) and have either met or is exempt from the five-year bar requirement for medicaid.

(g) Provide a valid Social Security number under WAC 182-503-0515;

(h) Have countable resources within specific program limits under WAC 182-513-1640; and

(i) Meet income requirements under WAC 182-513-1635.

(3) TSOA applicants who receive coverage under Washington apple health programs are not eligible for TSOA, unless their enrollment is limited to the:

(a) Medically needy program under WAC 182-519-0100;

(b) Medicare savings programs under WAC 182-517-0300;

(c) Family planning program under WAC 182-505-0115;

(d) ((~~TAKE CHARGE~~)) Family planning only programs under chapter 182-532 WAC ((~~182-532-720~~)); or

(e) Kidney disease program under chapter 182-540 WAC.

(4) A person who receives apple health coverage under a categorically needy (CN) or alternative benefit plan (ABP) program is not eligible for TSOA but may qualify for:

(a) Caregiver supports under medicaid alternative care (MAC) under WAC 182-513-1605; or

(b) Other long-term services and supports under chapter 182-513 or 182-515 WAC.

(5) The following rules do not apply to services provided under the TSOA benefit:

(a) Transfer of asset penalties under WAC 182-513-1363;

(b) Excess home equity under WAC 182-513-1350;

(c) Client financial responsibility under WAC 182-515-1509;

(d) Estate recovery under chapter 182-527 WAC;

(e) Disability requirements under WAC 182-512-0050;

(f) Requirement to do anything necessary to obtain income under WAC 182-512-0700(1); and

(g) Assignment of rights and cooperation under WAC 182-503-0540.

AMENDATORY SECTION (Amending WSR 17-07-001, filed 3/1/17, effective 4/1/17)

WAC 182-530-7250 Reimbursement—Miscellaneous. (1) The medicaid agency reimburses for covered drugs, devices, and drug-related supplies provided or administered by nonpharmacy providers under specified conditions, as follows:

(a) The agency reimburses for drugs administered or prepared and delivered for individual use by an authorized prescriber during an office visit according to specific program rules found in:

(i) Chapter 182-531 WAC, Physician-related services;

(ii) Chapter 182-532 WAC, Reproductive health/family planning only((~~/TAKE CHARGE~~)); and

(iii) Chapter 182-540 WAC, Kidney disease program and kidney center services.

(b) Providers who are purchasers of Public Health Services (PHS) discounted drugs must comply with PHS 340B program requirements and Washington medicaid requirements for 340B providers participating with medicaid. (See WAC 182-530-7900.)

(2) The agency may request providers to submit a current invoice for the actual cost of the drug, device, or drug-related supply billed. If an invoice is requested, the invoice must show the:

(a) Name of the drug, device, or drug-related supply;

(b) Drug or product manufacturer;

(c) NDC of the product or products;

(d) Drug strength;

(e) Product description;

(f) Quantity; and

(g) Cost, including any discounts or free goods associated with the invoice.

(3) The agency does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH). The agency does pay physicians, advanced registered nurse practitioners (ARNP), and pharmacists a fee for administering the vaccine.

AMENDATORY SECTION (Amending WSR 15-01-037, filed 12/8/14, effective 1/8/15)

WAC 182-550-4900 Disproportionate share hospital (DSH) payments ——General provisions. (1) As required by Section 1902 (a)(13)(A) of the Social Security Act (42 U.S.C. 1396 (a)(13)(A)) and RCW 74.09.730, the medicaid agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 U.S.C. 1396r-4;

(b) It satisfies all the requirements of agency rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the ((~~twelve~~)) 12-month medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year (SFY) for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the SFY two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the agency which the agency uses to verify medicaid client eligibility and applicable inpatient days.

(e) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the agency during a SFY. If a hospital does not qualify for DSH, the agency will not calculate the hospital-specific DSH cap and the hospital will not receive DSH payments.

(f) "Inpatient medicaid days" means inpatient days attributed to clients eligible for Title XIX medicaid programs. Excluded from this count are inpatient days attributed to clients eligible for state administered programs, medicare Part A, Title XXI, the refugee program and the ((~~TAKE CHARGE~~)) family planning only programs.

(g) "Low income utilization rate (LIUR)" means the sum of the following two percentages used to determine whether a hospital is DSH-eligible:

(i) The ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care), plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus

(ii) The ratio of inpatient charity care charges less inpatient cash subsidies received by the hospital from state and local govern-

ments, less contractual allowances and discounts, divided by total charges for inpatient services.

(h) "Medicaid inpatient utilization rate (MIPUR)" means the calculation (expressed as a percentage) used to determine whether a hospital is DSH-eligible. The numerator of which is the hospital's number of inpatient days attributable to clients who (for such days) were eligible for medical assistance during the base year (regardless of whether such clients received medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. "Inpatient days" include each day in which a person (including a newborn) is an inpatient in the hospital, whether or not the person is in a specialized ward and whether or not the person remains in the hospital for lack of suitable placement elsewhere.

(i) "Medicare cost report year" means the ((~~twelve~~)) 12-month period included in the annual cost report a medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) "Nonrural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(iii) Is not a small rural hospital as defined in (n) of this subsection; and

(iv) Is located in the state of Washington or in a designated bordering city. For DSH purposes, the agency considers as nonrural any hospital located in a designated bordering city.

(k) "Obstetric services" means routine, nonemergency obstetric services and the delivery of babies.

(l) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or medicare cost report year, or to a state fiscal year.

(m) "Statewide disproportionate share hospital (DSH) cap" means the maximum amount per SFY that the state can distribute in DSH payments to all qualifying hospitals during a SFY.

(n) "Small rural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(iii) Has fewer than ((~~seventy-five~~)) 75 acute beds;

(iv) Is located in the state of Washington; and

(v) Is located in a city or town with a nonstudent population of no more than ((~~seventeen thousand eight hundred six~~)) 17,806 in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(o) "Uninsured patient" means a person without creditable coverage as defined in 45 C.F.R. 146.113. (An "insured patient," for DSH program purposes, is a person with creditable coverage, even if the

insurer did not pay the full charges for the service.) To determine whether a service provided to an uninsured patient may be included for DSH application and calculation purposes, the agency considers only services that would have been covered and paid through the agency's fee-for-service process.

(4) To be considered for a DSH payment for each SFY, a hospital must meet the criteria in this section:

(a) DSH application requirements.

(i) Only a hospital located in the state of Washington or in a designated bordering city is eligible to apply for and receive DSH payments. An institution for mental disease (IMD) owned and operated by the state of Washington is exempt from the DSH application requirement.

(ii) A hospital that meets DSH program criteria is eligible for DSH payments in any SFY only if the agency receives the hospital's DSH application by the deadline posted on the agency's website.

(b) The DSH application review and correction period.

(i) This subsection applies only to DSH applications that meet the requirements under (a) of this subsection.

(ii) The agency reviews and may verify any information provided by the hospital on a DSH application. However, each hospital has the responsibility for ensuring its DSH application is complete and accurate.

(iii) If the agency finds that a hospital's application is incomplete or contains incorrect information, the agency will notify the hospital. The hospital must submit a new, corrected application. The agency must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the agency's website.

(iv) If a hospital finds that its application is incomplete or contains incorrect information, it may choose to submit changes and/or corrections to the DSH application. The agency must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the agency's website.

(c) Official DSH application.

(i) The agency considers as official the last signed DSH application submitted by the hospital as of the deadline for corrected DSH applications. A hospital cannot change its official DSH application. Only those hospitals with an official DSH application are eligible for DSH payments.

(ii) If the agency finds that a hospital's official DSH application is incomplete or contains inaccurate information that affects the hospital's LIDSH payment(s), the hospital does not qualify for, will not receive, and cannot retain, LIDSH payment(s). Refer to WAC 182-550-5000.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital satisfies the medicaid inpatient utilization rate (MIPUR) requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a MIPUR of one percent or more; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age ((~~eighteen~~)) 18; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's MIPUR, the agency uses inpatient days as follows:

(a) The total inpatient days on the official DSH application if this number is greater than the total inpatient hospital days on the medicare cost report; and

(b) The MMIS medicaid days as determined by the DSH reporting data file (DRDF) process if the Washington state medicaid days on the official DSH application do not match the eligible days on the final DRDF. If the hospital did not submit a DRDF, the agency uses paid medicaid days from MMIS.

(7) The agency administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Medical care services disproportionate share hospital (MCSDSH);

(c) Small rural disproportionate share hospital (SRDSH);

(d) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(e) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(f) Public hospital disproportionate share hospital (PHDSH);

(g) Children's health program disproportionate share hospital (CHPDSH); and

(h) Sole community disproportionate share hospital (SCDSH).

(8) The agency allows a hospital to receive any one or all of the DSH payment it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section) and provided that total DSH payments do not exceed the statewide DSH cap. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the agency calculates DSH payments for each DSH program for eligible hospitals using data from each hospital's base year. The agency does not use base year data for MCSDSH and CHPDSH payments, which are calculated based on specific claims data.

(10) The agency's total DSH payments to a hospital for any given SFY cannot exceed the hospital-specific DSH cap for that SFY. Except for critical access hospitals (CAHs), the agency determines a hospital's DSH cap as follows. The agency:

(a) Uses the overall ratio of costs-to-charges (RCC) to determine costs for:

(i) Medicaid services, including medicaid services provided under managed care organization (MCO) plans; and

(ii) Uninsured charges; then

(b) Subtracts all payments related to the costs derived in (a) of this subsection; then

(c) Makes any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to medicaid clients served under MCO plans, and uninsured patients. To determine a CAH's DSH cap amount, the agency:

(a) Uses the overall RCC to determine costs for:

(i) Medicaid services provided under MCO plans; and

(ii) Uninsured charges; then

(b) Subtracts the total payments made by, or on behalf of, the medicaid clients serviced under MCO plans, and uninsured patients.

(12) In any given federal fiscal year, the total of the agency's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the agency's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the agency will adjust DSH payments to each hospital to account for the amount overpaid. The agency makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;

(c) SRDSH;

(d) SCDSH;

(e) NRIADSH;

(f) MCSDSH;

(g) CHPDSH; and

(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the agency will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program regulations in the Washington Administrative Code for description of how amounts to be recouped are determined.

(15) The total amount the agency may distribute annually under a particular DSH program is capped by legislative appropriation. Any changes in payment amount to a hospital in a particular DSH program means a redistribution of payments within that DSH program. When necessary, the agency will recoup from hospitals to make additional payments to other DSH-eligible hospitals within that DSH program.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the agency will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

(b) If an individual hospital has been underpaid by a specified amount, the agency will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH program. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH program.

(c) This subsection does not apply to the DSH independent audit findings and recoupment process described in WAC 182-550-4940.

(17) All information related to a hospital's DSH application is subject to audit by the agency or its designee. The agency determines the extent and timing of the audits. For example, the agency or its designee may choose to do an audit of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the agency will recoup the overpayment amount as allowed in RCW 74.09.220 and chapter 41.05A RCW.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific SFY. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full SFY in which the rules are adopted.