RULE-MAKING ORDER
PERMANENT RULE ONLY

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

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DATE: March 13, 2025
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WSR 25-07-061

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 amended these rules as an overall housekeeping project. Additionally, the agency removed definitions for "base-year" and "uninsured patient," removed "with special needs" language from low-income clients, updated the abbreviation of the medicaid inpatient utilization rate from MIPUR to MIUR to align with CMS, updated WAC cross referencing, standardized language, removed language that the DSH application is posted to the agency's website, updated that the agency will use the medicare cost report rather than the DRDF to determine a hospital's MUIR, removed DSH programs no longer funded and not part of the program, and audit requests for additional information must be received 10 days from the initial notification. Also updated the name of the "provider data summary schedule (PDSS)" to "schedule of annual reporting requirements (SARR)."

Citation of rules affected by this order:

New:
Repealed:
Amended: 150-550-4900, 182-550-4935, 182-550-4940, 182-550-5000, 182-550-5150, 182-550-5200, 182-550-5300, 182-550-5400
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority: None

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 25-04-108 on February 4, 2025 (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Federal statute:	New	____	Amended	____	Repealed	____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	8	Repealed	____

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

	New	____	Amended	8	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	8	Repealed	____

Date Adopted: March 13, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 23-11-007, filed 5/4/23, effective 6/4/23)

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 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)~~)) (b) "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)~~)) (c) "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)~~)) (d) "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)~~)) (e) "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 family planning only programs.

((~~(g)~~)) (f) "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)~~)) (g) "Medicaid inpatient utilization rate (((~~MIPUR~~)) MIUR)" 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~~)) organization), 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)~~)) (h) "Medicare cost report year" means the 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)~~)) (i) "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)~~)) 182-500-0050;

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

((~~(l)~~)) (k) "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)~~)) (l) "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)~~)) (m) "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)~~)) 182-500-0050;

(iii) Has fewer than 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 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 published 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 published 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 published 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~~)) MIUR) 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~~)) an MIUR 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 obstetri-

cians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible ((~~individuals~~)) clients.

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

(A) Provides inpatient services predominantly to ((~~individuals~~)) clients younger than age 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~~)) MIUR, 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.~~)) the applicable year medicare cost report, as filed by the hospital.

(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); and

((~~(g)~~)) (e) 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)~~)) (c) MCSDSH;

((~~(g)~~)) (d) CHPDSH; and

((~~(h)~~)) (e) 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.

AMENDATORY SECTION (Amending WSR 15-18-065, filed 8/27/15, effective 9/27/15)

WAC 182-550-4935 DSH eligibility—Change in hospital ownership. (1) For purposes of eligibility for disproportionate share hospital (DSH) payments, a change in hospital ownership has occurred if any of the criteria in WAC 182-550-4200(1) is met.

(2) To be considered eligible for DSH, a hospital whose ownership has changed must notify the medicaid agency in writing no later than ((~~thirty~~)) 30 days after the change in ownership becomes final. The notice must include the new entity's fiscal year end.

(3) A hospital that 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, and changes ownership after that date is not eligible for DSH unless it continues to be classified as an acute care hospital serving pediatric and/or adult patients. See WAC 182-550-4900(5) for the obstetric services and utilization rate requirements for DSH eligibility.

(4) If the fiscal year reported on a hospital's medicare cost report does not exactly match the fiscal year reported on the hospital's DSH application to the agency, and if therefore the utilization data reported to the agency do not agree, the agency will use as the data source the document that gives the higher number of total inpatient hospital days for purposes of calculating the hospital's medicaid inpatient utilization rate (((~~MIPUR~~)) MIUR). See WAC 182-550-4900(6) ((~~(b)~~)).

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

WAC 182-550-4940 Disproportionate share hospital independent audit findings and recoupment process. (1) In order to comply with federal law and regulation (42 U.S.C. 1396r-4 (j)(2); 42 C.F.R. Part 455, Subpart D), the medicaid agency contracts with an independent auditor to conduct an annual, independent, certified audit of the agency's disproportionate share hospital (DSH) payments. Chapter 182-502A WAC is not applicable to the independent, certified audits described in this section.

(2) Under this section, a hospital may only dispute an overpayment, not an underpayment. Appeal rights and process follow WAC 182-502-0230.

(3) Hospitals must comply with the agency's or the auditor's requests for documentation. A hospital's failure to provide requested documentation ((~~may~~)) will result in a finding that any or all of the DSH payments for the audited year are overpayments.

((~~(3)~~)) (4) Beginning in state fiscal year 2011, an audit finding that demonstrates DSH payments made to a hospital in that year exceeded the documented hospital-specific DSH cap (as defined in WAC 182-550-4900((~~(3)~~))), is considered a discovery of an overpayment under 42 C.F.R. Part 433, Subpart F.

((~~(4)~~)) (5) Hospitals must return overpayments to the agency for redistribution to qualifying hospitals. A qualifying hospital is defined as a disproportionate share hospital that has a positive hospital-specific DSH cap.

((~~(5)~~)) (6) The additional DSH payment to be given to each of the other qualifying hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program. Only the recouped payments are redistributed among those eligible DSH hospitals that have a remaining positive hospital-specific DSH cap.

((~~(6)~~)) (7) The independent auditor will provide preliminary audit results to each hospital that received DSH payments, including a statement as to whether the hospital's payments did or did not exceed the hospital's DSH cap. Hospitals identified as receiving DSH payments exceeding their hospital-specific DSH cap may request additional information on the preliminary audit results. The agency must receive the hospital's request for the additional information on the preliminary audit results no later than ((~~the last working day in November of the year in which the audit is conducted~~)) 10 days from the initial notification which is sent electronically to the hospital.

((~~(7)~~)) (8) In response to a hospital's timely request under subsection ((~~(6)~~)) (7) of this section, the independent auditor will provide the hospital with at least the following information specific to the requesting hospital:

(a) Calculation of the medicaid inpatient utilization rate (MIUR);

(b) Regular inpatient and outpatient medicaid fee for service basic rate payments;

(c) Supplemental/enhanced inpatient and outpatient medicaid payments;

(d) Total medicaid payments;

(e) Total cost of care;

(f) Total cost of care of the uninsured; and

(g) A ((~~provider data summary schedule (PDSS) to compare to the agency's report~~)) schedule of annual reporting requirements (SARR), required by 42 C.F.R. Sec. 447.299, Subpart E, upon request from the hospital.

((~~(8) Under this section, a hospital may only dispute an overpayment. An overpayment hearing is held under WAC 182-502-0230.~~))

AMENDATORY SECTION (Amending WSR 15-18-065, filed 8/27/15, effective 9/27/15)

WAC 182-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) The medicaid agency makes low income disproportionate share hospital (LIDSH) payments to qualifying hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an LIDSH payment, a hospital must:

(a) Not be a hospital eligible for public disproportionate share (PHDSH) payments (see WAC 182-550-5400);

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(c) Meet the criteria in WAC 182-550-4900 (4) and (5);

(d) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive LIDSH payments; and

(e) Meet at least one of the following requirements. The hospital must:

(i) Have a medicaid inpatient utilization rate (((~~MIPUR~~)) MIUR) as defined in WAC 182-550-4900 (3)((~~(h)~~)) (g) at least one standard deviation above the mean medicaid inpatient utilization rate of in-state hospitals that receive medicaid payments; or

(ii) Have a low income utilization rate (LIUR) as defined in WAC 182-550-4900 (3)((~~(g)~~)) (h) that exceeds ((~~twenty-five~~)) 25 percent.

(3) The agency pays hospitals qualifying for LIDSH payments from a legislatively appropriated pool. The maximum amount of LIDSH payments in any state fiscal year (SFY) is the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(4) The agency determines LIDSH payments to each LIDSH eligible hospital using the following factors from the specific hospital's base year ((~~as defined in WAC 182-550-4900 (3)(a)~~)):

(a) The hospital's medicaid inpatient utilization rate (((~~MIPUR~~)) MIUR) (see WAC 182-550-4900 for how the agency calculates the ((~~MIPUR~~)) MIUR).

(b) The hospital's medicaid case mix index (CMI). The agency calculates the CMI by:

(i) Using the DRG weight for each of the hospital's paid inpatient claims assigned in the year the claim was paid;

(ii) Summing the DRG weights; and

(iii) Dividing this total by the number of claims.

The CMI the agency uses for LIDSH calculations is not the same as the CMI the agency uses in other hospital rate calculations.

(c) The number of the hospital's Title XIX medicaid discharges. The agency includes in this number only the discharges pertaining to Washington state medicaid clients.

(5) The agency calculates the LIDSH payment to an eligible hospital as follows.

(a) The agency:

(i) Divides the hospital's ((~~MIPUR~~)) MIUR by the average ((~~MIPUR~~)) MIUR of all LIDSH-eligible hospitals; then

(ii) Multiplies the result derived in (a) of this section by the CMI (see (4)(b) of this section), and then by the discharges (see (4)(c) of this section); then

(iii) Converts the product to a percentage of the sum of all such products for individual hospitals; and

(iv) Multiplies this percentage by the legislatively appropriated amount for LIDSH.

(b) If a hospital's calculated LIDSH payment is more than the hospital-specific DSH cap, the payment to the hospital is limited to the hospital-specific DSH cap, and the agency:

(i) Subtracts the LIDSH payment calculated for the hospital to determine the remaining LIDSH appropriation to distribute to the other qualifying hospitals; and

(ii) Proportionately distributes the remaining LIDSH appropriation under the factors in (a) of this subsection.

(6) A hospital receiving LIDSH payments must comply with an agency request for uninsured logs (uninsured logs are documentation of payments, charges, and other information for uninsured patients) to verify its hospital-specific DSH cap.

(7) The agency will not make changes in the LIDSH payment distribution after the applicable SFY has ended. The agency recalculates the LIDSH payment distribution only when the applicable SFY has not yet ended at the time the alleged need for an LIDSH adjustment is identified, and if the agency considers the recalculation necessary and appropriate under its regulations.

(8) Consistent with the provisions of subsection (7) of this section, the agency applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs under WAC 182-550-4900 (13) through (16).

AMENDATORY SECTION (Amending WSR 12-20-029, filed 9/26/12, effective 10/27/12)

WAC 182-550-5150 Payment method—Medical care services disproportionate share hospital (MCSDSH). (1) A hospital is eligible for the medical care services disproportionate share hospital (MCSDSH) payment if the hospital:

(a) Meets the criteria in WAC 182-550-4900;

(b) Is an in-state or designated bordering city hospital;

(c) Provides services to clients eligible under the medical care services program; and

(d) Has a medicaid inpatient utilization rate (((~~MIPUR~~)) MIUR) of one percent or more.

(2) The medicaid agency determines the MCSDSH payment for each eligible hospital in accordance with WAC 182-550-4800 for inpatient hospital claims submitted for medical care services (MCS) clients.

(3) The agency makes MCSDSH payments to a hospital on a claim-specific basis for inpatient services.

AMENDATORY SECTION (Amending WSR 15-18-065, filed 8/27/15, effective 9/27/15)

WAC 182-550-5200 Payment method—Small rural disproportionate share hospital (SRDSH). (1) The medicaid agency makes small rural disproportionate share hospital (SRDSH) payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRDSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC ((~~182-550-2600 (2)(d)~~)) 182-500-0050;

(c) Meet the criteria in WAC 182-550-4900 (4) and (5);

(d) Have fewer than ((~~seventy-five~~)) 75 acute beds;

(e) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRDSH payments; and

(f) Be 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 state fiscal year (SFY) 2010, which began July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(3) The agency pays hospitals qualifying for SRDSH payments ((~~from a legislatively appropriated pool~~)). The agency determines each hospital's individual SRDSH payment from the total dollars ((~~in the pool~~)) using percentages established as follows:

(a) At the time the SRDSH payment is to be made, the agency calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The agency determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than ((~~one hundred ten~~)) 110 percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The agency:

(i) Identifies the medicaid payment amounts made by the agency to the individual hospital during the SFY two years before the current SFY for which DSH application is being made. These medicaid payment amounts are based on historical data considered to be complete; then

(ii) Multiplies the total medicaid payment amount determined in ((~~subsection (i)~~)) (d)(i) of this subsection by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised medicaid payment amount; and

(iii) Divides the revised medicaid payment amount for the individual hospital by the sum of the revised medicaid payment amounts for all qualifying hospitals during the same period.

(4) The agency's SRDSH payments to a hospital may not exceed ((~~one hundred~~)) 100 percent of the projected cost of care for medicaid

clients and uninsured patients for that hospital unless an exception is required by federal statute or regulation.

(5) The agency reallocates dollars as defined in the state plan.

AMENDATORY SECTION (Amending WSR 12-20-029, filed 9/26/12, effective 10/27/12)

WAC 182-550-5300 Payment method—Children's health program disproportionate share hospital (CHPDSH). (1) Effective July 1, 2011, a hospital is eligible for the children's health program disproportionate share hospital (CHPDSH) payment if funding is legislatively appropriated and if the hospital:

(a) Meets the criteria in WAC 182-550-4900;

(b) Is an in-state or designated bordering city hospital; or

(c) Provides services to low-income, children's health program (CHP) clients who, because of their citizenship status, are not eligible for medicaid nonemergency health coverage and who are encountering a nonemergency medical condition.

(2) Hospitals qualifying for CHPDSH payments will receive a per claim payment for inpatient and outpatient claims at the equivalent medicaid rate.

(3) The agency determines the CHPDSH payment for each eligible hospital in accordance with:

(a) WAC ((~~182-550-2800 for~~)) 182-550-2900 through 182-550-3000 and other sections in chapter 182-550 WAC that pertain to inpatient hospital claims submitted for CHP clients; and

(b) WAC 182-550-7000 through 182-550-7600 and other sections in chapter 182-550 WAC that pertain to outpatient hospital claims submitted for CHP clients.

AMENDATORY SECTION (Amending WSR 15-11-009, filed 5/7/15, effective 6/7/15)

WAC 182-550-5400 Payment method—Public hospital disproportionate share hospital (PHDSH). (1) The medicaid agency's public hospital disproportionate share hospital (PHDSH) program is a certified public expenditure program for government-operated hospitals. To be eligible for PHDSH, a hospital must qualify for disproportionate share hospital (DSH) payments under WAC 182-550-4900 and be:

(a) Operated by a public hospital district in the state of Washington and participating in the "full cost" public hospital certified public expenditure (CPE) payment program described in WAC 182-550-4650;

(b) Harborview Medical Center; or

(c) University of Washington Medical Center.

(2) The PHDSH payments to a hospital eligible under this program may not exceed the hospital's disproportionate share hospital (DSH) cap calculated according to WAC 182-550-4900((~~(10)~~)). The hospital receives only the federal medical assistance percentage of the total computable payment amount.

(3) Hospitals receiving payment under the PHDSH program must provide the local match for the federal funds through certified public expenditures (CPE). Payments are limited to costs incurred by the participating hospitals.

(4) A hospital receiving payment under the PHDSH program must submit to the agency federally required medicaid cost report schedules apportioning inpatient and outpatient costs, beginning with the services provided during state fiscal year 2006. See WAC 182-550-5410.

(5) PHDSH payments are subject to the availability of DSH funds under the statewide DSH cap. If the statewide DSH cap is exceeded, the agency will recoup PHDSH payments first, but only from hospitals that received total inpatient and DSH payments above the hold harmless level, and only to the extent of the excess amount above the hold harmless level. See WAC 182-550-4900 (13) and (14), and 182-550-4670.