RULE-MAKING ORDER
PERMANENT RULE ONLY

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

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STATE OF WASHINGTON
FILED

DATE: June 25, 2025
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WSR 25-14-035

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Purpose: The agency removed outdated subsection citations in WAC 182-550-5000 and removed the definition of DSH reporting data file (DRDF) in WAC 182-550-4900 as it is no longer applicable and is a term that is not used within the chapter. The agency adopted permanent rules under WSR 25-07-061 removing outdated references to DSH reporting data file (DRDF); however, the agency missed correcting citations in 182-550-5000 as a result of the revision and missed removing the associated definition of DRDF in WAC 182-550-4900.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-550-4900, 182-550-5000
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 25-09-072 on April 16, 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Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____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	New	____	Amended	____	Repealed	____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	New	____	Amended	2	Repealed	____

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

	New	____	Amended	2	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	2	Repealed	____

Date Adopted: June 25, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 25-07-061, filed 3/13/25, effective 4/13/25)

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. 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) "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.

(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.

(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.~~

~~(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.

((~~(e)~~)) (d) "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.

((~~(f)~~)) (e) "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 governments, less contractual allowances and discounts, divided by total charges for inpatient services.

((~~(g)~~)) (f) "Medicaid inpatient utilization rate (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 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.

((~~(h)~~)) (g) "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.

((~~(i)~~)) (h) "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 182-500-0050;

(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.

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

((~~(k)~~)) (j) "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.

((~~(l)~~)) (k) "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.

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

(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.

(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.

(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.

(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.

(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 (MIUR) requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have 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 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible clients.

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

(A) Provides inpatient services predominantly to 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 MIUR, the agency uses 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) Public hospital disproportionate share hospital (PHDSH); and

(e) Children's health program disproportionate share hospital (CHPDSH).

(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) SRDSH;

(c) MCSDSH;

(d) CHPDSH; and

(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 25-07-061, filed 3/13/25, effective 4/13/25)

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 (MIUR) as defined in WAC 182-550-4900(3)((~~(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)((~~(h)~~)) that exceeds 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:

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