WSR 26-09-138
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed April 22, 2026, 8:50 a.m., effective May 23, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (agency) amended these rules because the payments for outlier enhancements have exceeded the budget-neutral amount calculated during the 2021 hospital rebasing period. An increase in the outlier threshold from $40,000 to $45,000 allows the state to bring payments more in line with the budget-neutral total calculated in 2021. Additionally, the agency removed subsection (4) of WAC 182-550-3700 because the example table for outlier claim payment calculations was not relevant or necessary.

Citation of Rules Affected by this Order: Amending WAC 182-550-3600 and 182-550-3700.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-07-061 on March 17, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 2, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: April 22, 2026.

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RDS-6843.1

AMENDATORY SECTION (Amending WSR 18-12-043, filed 5/30/18, effective 7/1/18)

WAC 182-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. (1) The rules in this section apply when an eligible client transfers from an acute care hospital or distinct unit to any of the following:

(a) Another acute care hospital or distinct unit;
(b) A skilled nursing facility (SNF);
(c) An intermediate care facility (ICF);
(d) Home care under the medicaid agency's home health program;
(e) A long-term acute care facility (LTAC);
(f) Hospice (facility-based or in the client's home);
(g) A hospital-based, medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 182-550-3000); or

(h) A nursing facility certified under medicaid but not medicare.

(2) The medicaid agency pays a transferring hospital the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) The prorated DRG payment, which the agency calculates by:

(i) Using the average length of stay (ALOS) for the assigned DRG:

(A) The agency uses the ((~~3M~~)) Solventum national average length of stay for paying inpatient claims.

(B) The agency publishes ALOS values on its website;

(ii) Dividing the hospital's allowed payment amount for the assigned DRG by the ALOS in (b)(i) of this subsection;

(iii) Determining the client length of stay as all medically necessary days at the transferring hospital, plus one day; and

(iv) Multiplying the number in (b)(ii) of this subsection by the length of stay determined in (b)(iii) of this subsection.

(3) The agency applies the outlier payment method if a transfer case qualifies as a high outlier. To qualify for a high outlier, the costs (ratio of cost-to-charges multiplied by covered allowed charges) for the transfer must exceed the outlier threshold. The threshold is the prorated DRG amount plus ((~~forty thousand dollars~~)) $45,000. The prorated amount is the lesser of:

(a) The per diem DRG allowed amount (hospital's rate multiplied by relative weight for the DRG code assigned to the claim by the agency) divided by the average length of stay (for the DRG code assigned by the agency for the claim) multiplied by the client's length of stay plus one day; or

(b) The total DRG payment allowed amount calculation for the claim.

(4) The agency does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(5) The agency pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the agency's maximum payment to a discharging hospital.

(6) The agency pays an intervening hospital a per diem payment based on the method described in subsection (2) of this section.

(7) The transfer payment policy described in this section does not apply to claims grouped into DRG classifications the agency pays based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(8) The agency applies the following to the payment for each claim:

(a) All applicable adjustments for client responsibility;

(b) Any third-party liability;

(c) Medicare payments; and

(d) Any other adjustments as determined by the agency.

AMENDATORY SECTION (Amending WSR 18-12-043, filed 5/30/18, effective 7/1/18)

WAC 182-550-3700 DRG high outliers. (1) The medicaid agency identifies a diagnosis-related group (DRG) high outlier claim based on the claim's estimated costs. The agency allows a high outlier payment for claims paid using the DRG payment method when high outlier criteria are met.

(a) To qualify as a DRG high outlier claim, the estimated costs for the claim must be greater than the outlier threshold effective for the date of admission. The outlier threshold amount is depicted in the following table:

Dates of Admission	Pediatric	Nonpediatric
February 1, 2011 - July 31, 2012	Base DRG * 1.50	Base DRG * 1.75
August 1, 2012 - June 30, 2013	Base DRG * 1.429	Base DRG * 1.667
July 1, 2013 - June 30, 2014	Base DRG * 1.563	Base DRG * 1.823
July 1, 2014((~~, and after~~)) - December 31, 2025	Base DRG + $40,000	Base DRG + $40,000
January 1, 2026, and after	Base DRG + $45,000	Base DRG + $45,000

(b) The agency calculates the estimated costs of the claim by multiplying the total submitted charges, minus the nonallowed charges on the claim, by the hospital's ratio of costs-to-charges (RCC).

(c) When a transferring hospital submits a transfer claim to the agency, the high outlier criteria used to determine whether the claim qualifies for high outlier payment is the prorated DRG amount for the claim before the transfer payment.

(2) The agency calculates the high outlier payment by multiplying the hospital's estimated cost above threshold (CAT) by the outlier adjustment factor. The outlier adjustment factors, which vary by dates of admission and inpatient payment policy, are depicted in the table at the end of this subsection.

(a) For inpatient claims paid under the all-patient-diagnosis-related group (AP-DRG), the agency uses a separate outlier adjustment factor for:

(i) Pediatric services, including all claims submitted by children-specialty hospitals;

(ii) Burn services; and

(iii) Nonpediatric services.

(b) For inpatient claims paid under the all-patient refined-DRG (APR-DRG), the agency uses a separate outlier adjustment factor for a:

(i) Severity of illness (SOI) of one or two; or

(ii) SOI of three or four.

AP-DRG Dates of Admission	Pediatric	Burn	Nonpediatric
Before August 1, 2012	CAT * 0.95	CAT * 0.90	CAT * 0.85
August 1, 2012 - June 30, 2013	CAT * 0.998	CAT * 0.945	CAT * 0.893
July 1, 2013 - June 30, 2014	CAT * 0.912	CAT * 0.864	CAT * 0.816
APR-DRG Dates of Admission	**SOI 1 or 2**	**SOI 3 or 4**	
July 1, 2014, and after	CAT * 0.80	CAT * 0.95	

(3) For state-administered programs (SAP), the agency applies the hospital-specific ratable to the outlier adjustment factor.

(4) ((~~This subsection contains examples of outlier claim payment calculations.~~

~~DRG SOI~~	~~DRG Allowed Amount~~	~~Threshold[1]~~	~~Cost[2]~~	~~Outlier Percent~~	~~Ratable~~	~~Base DRG~~	~~Outlier[3]~~	~~Claim Payment[4]~~
~~1~~	~~$10,000~~	~~$50,000~~	~~$100,000~~	~~0.80~~	~~n/a~~	~~$10,000~~	~~$40,000~~	~~$50,000~~
~~3~~	~~$10,000~~	~~$50,000~~	~~$100,000~~	~~0.95~~	~~n/a~~	~~$10,000~~	~~$47,500~~	~~$57,500~~

~~1 Threshold = $40,000 + base DRG~~

~~2 Cost = Billed charges - noncovered charges - denied charges~~

~~3 Outlier = (cost - threshold) * outlier percent~~

~~4 Claim payment = base DRG + outlier~~

~~(5)~~)) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 182-550-3000(8), the agency may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the outlier adjustment factors described in this section.

((~~(6)~~)) (5) The agency applies the following to the payment for each claim:

(a) All applicable adjustments for client responsibility;

(b) Any third-party liability;

(c) Medicare payments; and

(d) Any other adjustments as determined by the agency.