H-1704.2

HOUSE BILL 1850

State of Washington 68th Legislature 2023 Regular Session

By Representatives Macri, Schmick, Tharinger, Stokesbary, Ormsby, Bergquist, Schmidt, Chopp, Berg, Bronoske, and Thai

Read first time 03/27/23. Referred to Committee on Appropriations.

AN ACT Relating to the hospital safety net program; amending RCW 74.60.005, 74.60.010, 74.60.020, 74.60.030, 74.60.040, 74.60.050, 74.60.080, 74.60.090, 74.60.100, 74.60.110, 74.60.120, 74.60.130, 74.60.150, 74.60.160, 74.60.170, and 74.60.900; repealing RCW 74.60.901 and 74.60.903; and providing contingent effective dates.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 74.60.005 and 2021 c 255 s 1 are each amended to read as follows:

(1) The purpose of this chapter is to ((~~provide for a safety net assessment on certain Washington hospitals, which will be used solely to augment funding from all other sources and thereby support additional payments to hospitals for medicaid services as specified in this chapter.~~

~~(2) The legislature finds that federal health care reform will result in an expansion of medicaid enrollment in this state and an increase in federal financial participation.~~

~~(3) In adopting this chapter, it is the intent of the legislature:~~

~~(a) To impose a hospital safety net assessment to be used solely for the purposes specified in this chapter;~~

~~(b) To generate approximately one billion dollars per state fiscal biennium in new state and federal funds by disbursing all of that amount to pay for medicaid hospital services and grants to certified public expenditure and critical access hospitals, except costs of administration as specified in this chapter, in the form of additional payments to hospitals and managed care plans, which may not be a substitute for payments from other sources, but which include quality improvement incentive payments under RCW 74.09.611;~~

~~(c) To generate two hundred ninety-two million dollars per biennium during the 2021-2023 and 2023-2025 biennia in new funds to be used in lieu of state general fund payments for medicaid hospital services;~~

~~(d) That the total amount assessed not exceed the amount needed, in combination with all other available funds, to support the payments authorized by this chapter;~~

~~(e) To condition the assessment on receiving federal approval for receipt of additional federal financial participation and on continuation of other funding sufficient to maintain aggregate payment levels to hospitals for inpatient and outpatient services covered by medicaid, including fee-for-service and managed care, at least at the rates the state paid for those services on July 1, 2015, as adjusted for current enrollment and utilization; and~~

~~(f) For each of the two biennia starting with fiscal year 2022 to generate:~~

~~(i) Four million dollars for new integrated evidence-based psychiatry residency program slots that did not receive state funding prior to 2016 at the integrated psychiatry residency program at the University of Washington; and~~

~~(ii) Eight million two hundred thousand dollars for family medicine residency program slots that did not receive state funding prior to 2016, as directed through the family medicine residency network at the University of Washington, for slots where residents are employed by hospitals.~~)) establish a safety net program, including an assessment on certain nongovernmental medicaid prospective payment system hospitals and critical access hospitals and an allowance for intergovernmental transfers for designated public hospitals, which will be used solely as specified in this chapter to maintain and improve equity of access to and quality of care of hospital services for medicaid clients, including those served by managed care organizations.

(2) The legislature finds that the program established by this chapter will allow the state to more fully realize the benefits of increased federal financial participation in the medicaid program and to address expanded medicaid enrollment resulting from federal health care reform, thereby benefiting medicaid clients.

(3) In adopting this chapter, it is the intent of the legislature:

(a) To condition the assessment as specified in RCW 74.60.150, including: (i) Receipt and continuation of federal approval for payment of additional federal financial participation to support the payments provided for in RCW 74.60.100 through 74.60.130; and (ii) continuation of funding from the state general fund sufficient to maintain aggregate payment levels to hospitals for inpatient and outpatient services covered by medicaid, including fee-for-service and managed care, at least at the rates the state paid for those services on July 1, 2022, as adjusted for current enrollment and utilization;

(b) That funds generated by the assessment will be matched with federal dollars whenever possible to achieve the maximum level of benefits, and that the total amount assessed under this chapter not exceed the amount needed, in combination with all other available funds, to support the payments authorized by this chapter;

(c) That upon satisfaction of the applicable conditions in RCW 74.60.090, the designated public hospitals will be able to receive additional federal matching funds, used only for the purposes specified in this chapter.

Sec. 2. RCW 74.60.010 and 2019 c 318 s 2 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the health care authority.

(2) "Base year" for medicaid fee-for-service payments for state fiscal year ((~~2017~~)) 2024 is state fiscal year ((~~2014~~)) 2021. For each following year's calculations, the base year must be updated to the next following year.

(3) "((~~Bordering city~~)) Border hospital" means, for the purposes of the fee-for-service program under RCW 74.60.120, a hospital as defined in WAC 182-550-1050 and bordering cities as described in WAC 182-501-0175, or successor rules.

(4) ((~~"Certified public expenditure hospital" means a hospital participating in the authority's certified public expenditure payment program as described in WAC 182-550-4650 or successor rule. The eligibility of such hospitals to receive grants under RCW 74.60.090 solely from funds generated under this chapter must remain in effect through the date specified in RCW 74.60.901 and must not be affected by any modification or termination of the federal certified public expenditure program, or reduced by the amount of any federal funds no longer available for that purpose.~~

~~(5)~~)) "Cancer hospital" means a hospital classified as involved extensively in treatment for or research on cancer under section 1886(d)(1)(B)(v) of the social security act.

(5) "Children's hospital" means a hospital primarily serving children, as defined in WAC 182-550-1050 or successor rule.

(6) "Critical access hospital" means a hospital as described in RCW 74.09.5225.

((~~(6)~~)) (7) "Designated public hospital" means a hospital operated by a public hospital district in the state of Washington, not certified by the department of health as a critical access hospital, that:

(a) Has not opted out of the certified public expenditure payment program described in WAC 182-550-4650 or successor rule by June 1, 2023, or in future years by June 1st of the preceding year; or

(b) Is an affiliate of a system of state and county-owned hospitals and is not participating in that system's intergovernmental transfer directed payment program as of June 1, 2023, or in future years by June 1st of the preceding calendar year.

(8) "Director" means the director of the health care authority.

((~~(7) "Eligible new prospective payment hospital" means a prospective payment hospital opened after January 1, 2009, for which a full year of cost report data as described in RCW 74.60.030(2) and a full year of medicaid base year data required for the calculations in RCW 74.60.120(3) are available.~~

~~(8)~~)) (9) "Fund" means the hospital safety net assessment fund established under RCW 74.60.020.

((~~(9)~~)) (10) "High government payer independent hospital" means a prospective payment system hospital which is nonprofit, provides acute care to adults and children, is not governmentally owned or owned or operated by a health system that owns or operates three or more acute care hospitals, and provides services to patients covered

by medicare, medicaid, or other governmental payers as well as the uninsured.

(11) "Hospital" means a facility licensed under chapter 70.41 RCW.

((~~(10)~~)) (12) "Inflation factor" means the centers for medicare and medicaid services inpatient hospital market basket inflation factor using the four quarter rolling average as calculated and available by April 30th of each year or an alternative source required by the centers for medicare and medicaid services.

(13) "Long-term acute care hospital" means a hospital which has an average inpatient length of stay of greater than twenty-five days as determined by the department of health.

((~~(11)~~)) (14) "Managed care organization" means an organization having a certificate of authority or certificate of registration from the office of the insurance commissioner that contracts with the authority under a comprehensive risk contract to provide prepaid health care services to eligible clients under the authority's medicaid managed care programs, including the healthy options program.

((~~(12)~~)) (15) "Medicaid" means the medical assistance program as established in Title XIX of the social security act and as administered in the state of Washington by the authority.

((~~(13)~~)) (16) "Medicaid managed care inpatient discharge" means an inpatient discharge for a medicaid patient, excluding normal newborns, based upon the grouper methodology used by the authority, where the medicaid managed care organization was the primary payer of the patient claim.

(17) "Medicaid managed care outpatient payments" means outpatient services provided to a medicaid patient where a medicaid managed care organization was the primary payer of the patient claim.

(18) "Medicare cost report" means the medicare cost report, form 2552, or successor document.

((~~(14) "Nonmedicare hospital inpatient day" means total hospital inpatient days less medicare inpatient days, including medicare days reported for medicare managed care plans, as reported on the medicare cost report, form 2552, or successor forms, excluding all skilled and nonskilled nursing facility days, skilled and nonskilled swing bed days, nursery days, observation bed days, hospice days, home health agency days, and other days not typically associated with an acute care inpatient hospital stay.~~

~~(15)~~)) (19) "Nonmedicare net patient revenue" means all net patient revenue, less a deduction only of fee-for-service medicare revenue and includes medicare managed care revenue.

(20) "Outpatient services" means services that are provided ((~~classified~~)) as ambulatory payment classification services or successor payment methodologies as defined in WAC ((~~182-550-7050~~)) 182-550-1050 or successor rule and applies to fee-for-service payments and managed care encounter data.

((~~(16) "Prospective~~)) (21) "Medicaid prospective payment system hospital" means a hospital reimbursed for inpatient and outpatient services provided to medicaid beneficiaries under the inpatient prospective payment system and the outpatient prospective payment system as defined in WAC 182-550-1050 or successor rule((~~. For purposes of this chapter, prospective payment system hospital does not include a hospital participating in the certified public expenditure program or a bordering city~~)), excluding any designated public hospital, any state or county-owned hospital, or any hospital located outside of the state of Washington and in one of the bordering cities listed in WAC 182-501-0175 or successor rule((~~.~~

~~(17)~~)), or any hospital owned or operated by a health maintenance organization as defined in RCW 48.46.020. "Medicaid prospective payment system" refers solely to a reimbursement under the state medicaid program and has no bearing on or reference to a hospital's reimbursement classification under federal health care or other payment programs.

(22) "Psychiatric hospital" means a hospital facility licensed as a psychiatric hospital under chapter 71.12 RCW.

((~~(18)~~)) (23) "Rehabilitation hospital" means a medicare-certified freestanding inpatient rehabilitation facility.

((~~(19)~~)) (24) "Small rural disproportionate share hospital payment" means a payment made in accordance with WAC 182-550-5200 or successor rule.

((~~(20)~~)) (25) "Upper payment limit" means the aggregate federal upper payment limit on the amount of the medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in 42 C.F.R. Part 47, as separately determined for inpatient and outpatient hospital services.

Sec. 3. RCW 74.60.020 and 2021 c 255 s 2 are each amended to read as follows:

(1) A dedicated fund is hereby established within the state treasury to be known as the hospital safety net assessment fund. The purpose and use of the fund shall be to receive and disburse funds, together with accrued interest, in accordance with this chapter. Moneys in the fund, including interest earned, shall not be used or disbursed for any purposes other than those specified in this chapter. Any amounts expended from the fund that are later recouped by the authority on audit or otherwise shall be returned to the fund.

(a) Any unexpended balance in the fund at the end of a fiscal year shall carry over into the following fiscal year or that fiscal year and the following fiscal year and shall be applied to reduce the amount of the assessment under RCW 74.60.050(1)(c).

(b) ((~~Any~~)) If the program is discontinued, any amounts remaining in the fund ((~~after July 1, 2025,~~)) shall be refunded to hospitals, pro rata according to the amount paid by the hospital since July 1, ((~~2013~~)) 2018, subject to the limitations of federal law.

(2) All assessments, interest, and penalties collected by the authority under RCW 74.60.030 and 74.60.050 shall be deposited into the fund.

(3) Disbursements from the fund are conditioned upon appropriation and the continued availability of other funds sufficient to maintain aggregate payment levels to hospitals for inpatient and outpatient services covered by medicaid, including fee-for-service and managed care, at least at the levels the state paid for those services on July 1, ((~~2015~~)) 2022, as adjusted for current enrollment and utilization.

(4) Disbursements from the fund may be made only:

(a) To make payments to hospitals and managed care ((~~plans~~)) organizations as specified in this chapter;

(b) To refund erroneous or excessive payments made by hospitals pursuant to this chapter;

(c) For ((~~one million dollars~~)) up to $2,000,000 per biennium for payment of administrative expenses incurred by the authority in performing the activities authorized by this chapter;

(d) For ((~~two hundred ninety-two million dollars~~)) $452,000,000 per biennium, to be used in lieu of state general fund payments for medicaid hospital services of which $160,000,000 per biennium shall be used for appropriation by the legislature for postacute hospital

transitions, provided that if the full amount of the payments required under RCW 74.60.120 and 74.60.130 cannot be distributed in a given fiscal year, this total amount must be reduced proportionately;

(e) To repay the federal government for any excess payments made to hospitals from the fund if the assessments or payment increases set forth in this chapter are deemed out of compliance with federal statutes and regulations in a final determination by a court of competent jurisdiction with all appeals exhausted. In such a case, the authority may require hospitals receiving excess payments to refund the payments in question to the fund. The state in turn shall return funds to the federal government in the same proportion as the original financing. If a hospital is unable to refund payments, the state shall develop either a payment plan, or deduct moneys from future medicaid payments, or both;

(f) To pay an amount sufficient, when combined with the maximum available amount of federal funds necessary to provide a one percent increase in medicaid hospital inpatient rates ((~~to hospitals eligible for quality improvement incentives under RCW 74.09.611. By May 16, 2018, and by each May 16 thereafter, the authority, in cooperation with the department of health, must verify that each hospital eligible to receive quality improvement incentives under the terms of this chapter is in substantial compliance with the reporting requirements in RCW 43.70.052 and 70.01.040 for the prior period. For the purposes of this subsection, "substantial compliance" means, in the prior period, the hospital has submitted at least nine of the twelve monthly reports by the due date. The authority must distribute quality improvement incentives to hospitals that have met these requirements beginning July 1 of 2018 and each July~~)) for medicaid prospective payment system hospitals and designated public hospitals that are eligible for quality improvement incentives under RCW 74.09.611. Only funds collected under RCW 74.60.030 shall be used to generate payments to medicaid prospective payment hospitals. Only funds received under RCW 74.60.090 shall be used to generate payments to designated public hospitals. By May 16, 2018, and by each May 16th thereafter, the authority, in cooperation with the department of health, must verify that all medicaid prospective payment system hospitals and all designated public hospitals are in substantial compliance with the reporting requirements in RCW 43.70.052 and 70.01.040 for the prior period. Safety net assessment funds shall not be used to pay quality improvement incentives to any other hospitals.

For the purposes of this subsection, "substantial compliance" means, in the prior period, the hospital has submitted at least 75 percent of the required reports by the due date. The authority shall distribute quality improvement incentives to hospitals that have met these requirements beginning upon implementation of the programs authorized in this act and each January 1st thereafter; and

(g) For each state fiscal year ((~~2022 through 2025~~)) to ((~~generate~~)) pay:

(i) Two million dollars for integrated evidence-based psychiatry residency program slots that did not receive state funding prior to 2016 at the integrated psychiatry residency program at the University of Washington; and

(ii) Four million one hundred thousand dollars for family medicine residency program slots that did not receive state funding prior to 2016, as directed through the family medicine residency network at the University of Washington, for slots where residents are employed by hospitals.

Sec. 4. RCW 74.60.030 and 2019 c 318 s 4 are each amended to read as follows:

(1)((~~(a)~~)) Upon satisfaction of the conditions in RCW 74.60.150(1), and so long as the conditions in RCW 74.60.150(2) have not occurred, an annual assessment is imposed as set forth in this subsection((~~. Assessment notices must be sent on or about thirty days prior to the end of each quarter and payment is due thirty days thereafter.~~

~~(b) Effective July 1, 2015, and except as provided in RCW 74.60.050:~~

~~(i) Each prospective payment system hospital, except psychiatric and rehabilitation hospitals, shall pay a quarterly assessment. Each quarterly assessment shall be no more than one quarter of three hundred eighty dollars for each annual nonmedicare hospital inpatient day, up to a maximum of fifty-four thousand days per year. For each nonmedicare hospital inpatient day in excess of fifty-four thousand days, each prospective payment system hospital shall pay a quarterly assessment of one quarter of seven dollars for each such day, unless such assessment amount or threshold needs to be modified to comply with applicable federal regulations;~~

~~(ii) Each critical access hospital shall pay a quarterly assessment of one quarter of ten dollars for each annual nonmedicare hospital inpatient day;~~

~~(iii) Each psychiatric hospital shall pay a quarterly assessment of no more than one quarter of seventy-four dollars for each annual nonmedicare hospital inpatient day; and~~

~~(iv) Each rehabilitation hospital shall pay a quarterly assessment of no more than one quarter of seventy-four dollars for each annual nonmedicare hospital inpatient day.~~

~~(2) The authority shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare hospital inpatient days for each hospital that is not exempt from the assessment under RCW 74.60.040. The authority shall obtain inpatient data from the hospital's 2552 cost report data file or successor data file available through the centers for medicare and medicaid services, as of a date to be determined by the authority. For state fiscal year 2021, the authority shall use cost report data for hospitals' fiscal years ending in 2017. For subsequent years, the hospitals' next succeeding fiscal year cost report data must be used.~~

~~(a) With the exception of a prospective payment system hospital commencing operations after January 1, 2009, for any hospital without a cost report for the relevant fiscal year, the authority shall work with the affected hospital to identify appropriate supplemental information that may be used to determine annual nonmedicare hospital inpatient days.~~

~~(b) A prospective payment system hospital commencing operations after January 1, 2009, must be assessed in accordance with this section after becoming an eligible new prospective payment system hospital as defined in RCW 74.60.010~~)), which shall be paid in equal quarterly installments. For calendar year 2024, the first assessment notice shall be sent on or before February 7th unless the conditions in RCW 74.60.150(1) are not satisfied by January 1, 2024, in which case the first assessment notice shall be sent 21 calendar days following satisfaction of those conditions. So long as none of the conditions specified in RCW 74.60.150(2) have occurred, subsequent assessment notices must be sent on or before 45 calendar days prior to the end of each quarter. Hospitals shall pay their assessments within 30 calendar days of receiving any notice.

(2) For calendar year 2024, unless adjusted as provided for in this chapter, the authority, after consultation with the Washington

state hospital association, shall determine inpatient and outpatient assessment rates that, when applied as set forth below, will produce $510,000,000 from the inpatient assessment and $386,400,000 from the outpatient assessment. For subsequent years, the authority, in consultation with the Washington state hospital association, shall adjust the assessment amounts to fund adjustments in directed payments under RCW 74.60.130 and quality incentive payments under RCW 74.09.611.

(3) The authority shall determine standard assessment rates for hospital inpatient and outpatient assessments that are sufficient, when applied to net nonmedicare inpatient and outpatient revenue, to produce the inpatient and outpatient assessment amounts needed to fund the payments in RCW 74.60.020(4). The standard inpatient and outpatient rates must comply with applicable federal law and regulations. If the categories of hospitals described in this section for assessment purposes do not meet federal approval requirements, they may be modified by the mutual agreement of the authority and the Washington state hospital association so that approval may be obtained.

(a) For medicaid prospective payment system hospitals that are rehabilitation hospitals, the assessment rate to be applied to net nonmedicare inpatient revenue shall be 50 percent of the standard inpatient assessment and 50 percent of the standard outpatient assessment;

(b) For medicaid prospective payment system hospitals that are psychiatric hospitals, the assessment rate to be applied to net nonmedicare inpatient revenue shall be 100 percent of the standard inpatient assessment and 50 percent of the standard outpatient assessment;

(c) For medicaid prospective payment system hospitals that are cancer hospitals, the assessment rate to be applied to net nonmedicare revenue shall be 100 percent of the standard rate for inpatient revenue and 40 percent of the standard rate for outpatient revenue;

(d) For medicaid prospective payment system hospitals that are children's hospitals, the assessment rate to be applied to net nonmedicare revenue shall be five percent of the standard rate for inpatient revenue and 20 percent of the standard rate for outpatient revenue;

(e) For medicaid prospective payment system hospitals that are high government payer independent hospitals, the assessment rate to be applied to net nonmedicare revenue shall be 20 percent of the standard rate for inpatient revenue and 90 percent of the standard rate for outpatient revenue;

(f) For any other medicaid prospective payment system hospitals, the assessment rate to be applied to net nonmedicare revenue is 100 percent of the standard rate for inpatient revenue and 100 percent of the standard rate for outpatient revenue;

(g) For each critical access hospital, the assessment rate to be applied to net nonmedicare revenue shall be five percent of the inpatient standard rate and 40 percent of the outpatient standard assessment.

(4) If federal assessment demonstration requirements are not met for either the inpatient or outpatient assessment, the authority shall revise the other assessment in consultation with the Washington state hospital association so as to raise the same total amount of assessments. If the assessment fails federal distributional tests, the authority will work with the Washington state hospital association to develop a threshold to enable passage of the test.

(5) The authority shall determine each nonexempt hospital's annual net nonmedicare revenue from the hospital's cost report data file available through the centers for medicare and medicaid services. For calendar year 2024, the authority shall use cost report data for hospitals' fiscal years ending in 2021. For subsequent years, the cost report for the next succeeding fiscal year data must be used. For any hospital without a cost report for the relevant year, including any recently opened hospital, the authority shall use the most recently available cost report or an annualized partial cost report available by June 1st reflecting at least six months of information, for annual nonmedicare net inpatient and outpatient revenue. For purposes of this subsection, annualized means the total amount divided by actual months, multiplied by 12 months.

Sec. 5. RCW 74.60.040 and 2010 1st sp.s. c 30 s 5 are each amended to read as follows:

The following hospitals are exempt from any assessment under this chapter provided that if and to the extent any exemption is held invalid by a court of competent jurisdiction or by the centers for

medicare and medicaid services, hospitals previously exempted shall be liable for assessments due after the date of final invalidation:

(1) Hospitals owned or operated by an agency of federal ((~~or~~)), state, or county government, including but not limited to western state hospital and eastern state hospital;

(2) ((~~Washington public hospitals that participate in the certified public expenditure program~~)) Designated public hospitals;

(3) Hospitals ((~~that do not charge directly or indirectly for hospital services~~)) owned or operated by health maintenance organizations under chapter 48.46 RCW; and

(4) Long-term acute care hospitals.

Sec. 6. RCW 74.60.050 and 2019 c 318 s 5 are each amended to read as follows:

(1) The authority, in cooperation with the office of financial management, shall develop rules for determining the amount to be assessed to individual hospitals, notifying individual hospitals of the assessed amount, and collecting the amounts due. Such rule making shall specifically include provision for:

(a) Transmittal of notices of assessment by the authority to each hospital informing the hospital of its inpatient and outpatient nonmedicare ((~~hospital inpatient days~~)) net patient revenue and the assessment amount due and payable;

(b) Interest on delinquent assessments at the rate specified in RCW 82.32.050; and

(c) Adjustment of the assessment amounts in accordance with subsection (3) of this section.

(2) For any hospital failing to make an assessment payment within ((~~ninety~~)) 60 calendar days of its due date, the authority ((~~may~~)) shall offset an amount from payments scheduled to be made by the authority to the hospital, reflecting the assessment payments owed by the hospital plus any interest. The authority shall deposit these offset funds into the dedicated hospital safety net assessment fund.

(3) For each state ((~~fiscal~~)) calendar year, the assessment amounts established under RCW 74.60.030 must be adjusted as follows:

(a) If sufficient other funds, including federal funds, are available to make the payments required under this chapter and fund the state portion of the quality incentive payments under RCW 74.09.611 and 74.60.020(4)(f) without utilizing the full assessment

under RCW 74.60.030, the authority shall reduce the amount of the assessment to the minimum levels necessary to support those payments;

(b) If the total amount of inpatient and outpatient supplemental payments under RCW 74.60.120 is in excess of the ((~~upper payment limits~~)) federal limitations to aggregate maximum payment amounts and the entire excess amount cannot be disbursed by additional payments to managed care organizations under RCW 74.60.130, the authority shall proportionately reduce future assessments on medicaid prospective payment hospitals to the level necessary to generate additional payments to hospitals that are consistent with the upper payment limit plus the maximum permissible amount of additional payments to managed care organizations under RCW 74.60.130;

(c) If the amount of payments to managed care organizations under RCW 74.60.130 cannot be distributed because of failure to meet federal actuarial soundness or utilization requirements or other federal requirements, the authority shall apply the amount that cannot be distributed to reduce ((~~future~~)) assessments beginning from the time when that determination is made, to the level necessary to generate additional payments to managed care organizations that are consistent with federal actuarial soundness or utilization requirements or other federal requirements; and

(d) ((~~If required in order to obtain federal matching funds, the maximum number of nonmedicare inpatient days at the higher rate provided under RCW 74.60.030(1)(b)(i) may be adjusted in order to comply with federal requirements;~~

~~(e) If the number of nonmedicare inpatient days applied to the rates provided in RCW 74.60.030 will not produce sufficient funds to support the payments required under this chapter and the state portion of the quality incentive payments under RCW 74.09.611 and 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may be increased proportionately by category of hospital to amounts no greater than necessary in order to produce the required level of funds needed to make the payments specified in this chapter and the state portion of the quality incentive payments under RCW 74.09.611 and 74.60.020(4)(f); and~~

~~(f) Any~~)) After sharing information about the amount in the fund with the Washington state hospital association, any actual or estimated surplus remaining in the fund at the end of the fiscal year ((~~must~~)) may be applied by the authority to reduce the assessment amount for the subsequent ((~~fiscal~~)) calendar year or that ((~~fiscal~~))

calendar year and the following ((~~fiscal~~)) calendar years prior to and including ((~~fiscal~~)) calendar year 2023.

(4)(a) Any adjustment to the assessment amounts pursuant to this section, and the data supporting such adjustment, including, but not limited to, relevant data listed in (b) of this subsection, must be submitted to the Washington state hospital association for review and comment at least ((~~sixty~~)) 60 calendar days prior to implementation of such adjusted assessment amounts. Any review and comment provided by the Washington state hospital association does not limit the ability of the Washington state hospital association or its members to challenge an adjustment or other action by the authority that is not made in accordance with this chapter.

(b) The authority shall provide the following data to the Washington state hospital association ((~~sixty~~)) annually and also 60 calendar days before implementing any revised assessment levels, detailed by ((~~fiscal year, beginning with fiscal year 2011 and extending to the most recent fiscal year, except in connection with the initial assessment under this chapter~~)) calendar year:

(i) The fund balance and the balances remaining for distressed hospitals and designated public hospitals;

(ii) The amount of assessment paid by each hospital and the amount transferred by each designated public hospital;

(iii) The state share, federal share, and total annual medicaid fee-for-service payments for inpatient hospital services made to each hospital under RCW 74.60.120, and the data used to calculate the payments to individual hospitals under that section;

(iv) The state share, federal share, and total annual medicaid fee-for-service payments for outpatient hospital services made to each hospital under RCW 74.60.120, and the data used to calculate annual payments to individual hospitals under that section; and

(v) The annual state share, federal share, and total payments made to each hospital under ((~~each of the following programs: Grants to certified public expenditure hospitals under RCW 74.60.090, for critical access hospital payments~~)) grants to distressed hospitals under RCW 74.60.100((~~,~~)) and disproportionate share programs under RCW 74.60.110((~~,~~

~~(vi) The data used to calculate annual payments to individual hospitals under (b)(v) of this subsection; and~~

~~(vii) The amount of payments made to managed care plans under RCW 74.60.130, including the amount representing additional premium tax, and the data used to calculate those payments~~)).

(c) On a ((~~monthly~~)) quarterly basis, and for the full calendar year, the authority shall provide the Washington state hospital association the amount of payments made to managed care ((~~plans~~)) organizations and directed distribution to hospitals under RCW 74.60.130, including the amount representing additional premium tax, and the data used to calculate those payments.

Sec. 7. RCW 74.60.080 and 2013 2nd sp.s. c 17 s 7 are each amended to read as follows:

In each ((~~fiscal~~)) calendar year and upon satisfaction of the conditions in RCW 74.60.150(1), and so long as none of the conditions in RCW 74.60.150(2) occur, after deducting or reserving amounts authorized to be disbursed under RCW 74.60.020(4) (d), (e), (f), and ((~~(f)~~)) (g), disbursements from the fund must be made as follows:

(1) ((~~For grants to certified public expenditure hospitals in accordance with RCW 74.60.090~~)) $10,000,000 for payments to financially distressed hospitals in accordance with RCW 74.60.100;

(2) For payments to ((~~critical access hospitals in accordance with RCW 74.60.100;~~

~~(3) For~~)) small rural disproportionate share hospitals payments in accordance with RCW 74.60.110;

((~~(4)~~)) (3) For payments to hospitals under RCW 74.60.120; ((~~and~~

~~(5)~~)) (4) For payments to managed care organizations under RCW 74.60.130 for the provision of hospital services; and

(5) For support of payments under RCW 74.09.611 for medicaid prospective payment hospitals and designated public hospitals.

Sec. 8. RCW 74.60.090 and 2021 c 255 s 3 are each amended to read as follows:

(1) In ((~~each fiscal year commencing upon satisfaction of the applicable conditions in RCW 74.60.150(1), funds must be disbursed from the fund and the authority shall make grants to certified public expenditure hospitals, which shall not be considered payments for hospital services, as follows:~~

~~(a) University of Washington medical center: Up to twelve million fifty-five thousand dollars in state fiscal year 2022 through 2025 paid as follows, except if the full amount of the payments required~~

~~under RCW 74.60.120(1) and 74.60.130 cannot be distributed in a given fiscal year, the amounts in this subsection must be reduced proportionately:~~

~~(i) Five million nine hundred fifty-five thousand dollars in state fiscal years 2022 through 2025;~~

~~(ii) Two million dollars to integrated, evidence-based psychiatry residency program slots that did not receive state funding prior to 2016, at the integrated psychiatry residency program at the University of Washington; and~~

~~(iii) Four million one hundred thousand dollars to family medicine residency program slots that did not receive state funding prior to 2016, as directed through the family medicine residency network at the University of Washington, for slots where residents are employed by hospitals;~~

~~(b) Harborview medical center: Ten million two hundred sixty thousand dollars in each state fiscal year 2022 through 2025, except if the full amount of the payments required under RCW 74.60.120(1) and 74.60.130 cannot be distributed in a given fiscal year, the amounts in this subsection must be reduced proportionately;~~

~~(c) All other certified public expenditure hospitals: Five million six hundred fifteen thousand dollars in each state fiscal year 2022 through 2025, except if the full amount of the payments required under RCW 74.60.120(1) and 74.60.130 cannot be distributed in a given fiscal year, the amounts in this subsection must be reduced proportionately. The amount of payments to individual hospitals under this subsection must be determined using a methodology that provides each hospital with a proportional allocation of the group's total amount of medicaid and state children's health insurance program payments determined from claims and encounter data using the same general methodology set forth in RCW 74.60.120 (3) and (4).~~

~~(2) Payments must be made quarterly, before the end of each quarter, taking the total disbursement amount and dividing by four to calculate the quarterly amount. The authority shall provide a quarterly report of such payments to the Washington state hospital association~~)) consultation with the Washington state hospital association, the authority shall design and implement a medicaid directed payment program, consistent with 42 C.F.R. Sec. 438.6(c), intended to promote access to high quality inpatient and outpatient

care provided by designated public hospitals to medicaid beneficiaries enrolled in managed care organizations.

(2) The directed payment program described in subsection (1) of this section shall promote access and improve the equitable distribution of care to underserved populations by increasing payments to managed care organizations for the purpose of increasing reimbursement of designated public hospitals for inpatient and outpatient services provided to managed care enrollees, to 95 percent of the centers for medicare and medicaid services allowable limit, plus an estimated amount to support each eligible hospital's participation in the quality incentive program under RCW 74.09.611, which shall be allocated solely to eligible designated public hospitals pursuant to RCW 74.60.020(4)(f). The authority shall share its federal limit calculations with the Washington state hospital association.

(3) Payments to individual managed care organizations shall be determined by the authority based on each managed care organization's payments made to designated public hospitals for medicaid inpatient and outpatient services. The authority shall make this determination in consultation with the Washington state hospital association.

(4) Managed care organizations shall make directed payments described in this section to designated public hospitals within 21 calendar days of receiving the full amount of funds from the authority.

(5) The managed care organization payments made pursuant to this section shall be derived from intergovernmental transfers voluntarily made by, and accepted from, designated public hospitals.

(a) Participation in the intergovernmental transfers used to fund the program described by this section is voluntary on the part of transferring entities for the purposes of all applicable federal laws.

(b) All funds associated with intergovernmental transfers made and accepted pursuant to this section must be used either to fund additional managed care organization payments under this section to benefit designated public hospitals or, for those designated public hospitals determined to be eligible for payment under RCW 74.09.611, for deposit into the hospital safety net assessment fund established under RCW 74.60.020 solely for the purpose of providing funding, under RCW 74.60.020(4)(f), for payments to designated public hospitals eligible for payment under RCW 74.09.611.

(c) Medicaid managed care organizations shall pay on a quarterly basis 100 percent of any payments made pursuant to this section to designated public hospitals, less an allowance for premium taxes the organization is required to pay under Title 48 RCW, for the purpose of promoting access and increasing the quality of care delivered to medicaid enrollees.

(6) The intergovernmental transfers associated with the direct payments described in this section shall be collected by the authority within a reasonable time frame in relation to the date on which the state is required to furnish each hospital's nonfederal share of expenditures pursuant to the program described by this section and approved by the centers for medicare and medicaid services or after a determination of eligibility is made, for the program described under RCW 74.09.611.

(7) As a condition of participation under this section, medicaid managed care organizations and designated public hospitals shall:

(a) Agree to comply with any requests for information or similar data requirements imposed by the authority for purposes of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals; and

(b) Agree to participate in and provide requested data associated with payment arrangement quality strategy goals and objectives identified by the approved program.

(8) This section shall be implemented only if and to the extent federal financial participation is available and is not otherwise jeopardized, and any necessary federal approvals have been obtained.

(9) To the extent that the director determines that the payments made pursuant to this section do not comply with federal medicaid requirements, the director retains the discretion to return or not accept all or a portion of an intergovernmental transfer, and may adjust payments pursuant to this section as necessary to comply with federal medicaid requirements.

(10) Conditioned upon required federal approvals, the directed payments under this section shall commence January 1, 2024. If federal approval is obtained after January 1, 2024, the payments shall commence within 30 calendar days following the approval.

Sec. 9. RCW 74.60.100 and 2017 c 228 s 7 are each amended to read as follows:

(1) In each ((~~fiscal~~)) calendar year commencing upon satisfaction of the conditions in RCW 74.60.150(1), the authority ((~~shall~~)) may make ((~~access payments to critical access hospitals that do not qualify for or receive a small rural disproportionate share hospital payment in a given fiscal year in the total amount of two million thirty-eight thousand dollars from the fund. The amount of payments to individual hospitals under this section must be determined using a methodology that provides each hospital with a proportional allocation of the group's total amount of medicaid and state children's health insurance program payments determined from claims and encounter data using the same general methodology set forth in RCW 74.60.120 (3) and (4). Payments must be made after the authority determines a hospital's payments under RCW 74.60.110. These payments shall be in addition to any other amount payable with respect to services provided by critical access hospitals and shall not reduce any other payments to critical access hospitals. The authority shall provide a report of such payments to the Washington state hospital association within thirty days after payments are made.~~)) grants to financially distressed hospitals.

(2) To qualify for a grant, a hospital must:

(a) Be located in Washington, and not be part of a system of three or more hospitals;

(b) Serve individuals enrolled in state and federal medical assistance programs;

(c) Continue to provide services to a medicaid population;

(d) Demonstrate a plan for long-term financial sustainability;

(e) Meet one or more of the following criteria at the time of application:

(i) Have 60 or fewer days cash on hand;

(ii) Have negative net income during the prior or current hospital fiscal year; or

(iii) Be at risk of bankruptcy; and

(f) Not have received funds under this section for a period of more than five consecutive years.

(3) The authority shall create an application process that identifies the amount of the request, how the moneys will be used, and includes a brief written response to the items listed in subsections (2)(a) through (d) of this section and documentation evidencing one or more of the criteria in subsection (2)(e) of this section.

(4) The authority shall allocate the funds so as to give proportionately more money to eligible hospitals with more severe financial distress as measured by days cash on hand and that serve a higher proportion of medicaid patients.

(5) If the total of qualified applications from financially distressed hospitals for these funds in a biennium is less than $10,000,000, the balance will be retained in the fund to be used in subsequent years for these purposes.

Sec. 10. RCW 74.60.110 and 2013 2nd sp.s. c 17 s 10 are each amended to read as follows:

In each fiscal year commencing upon satisfaction of the applicable conditions in RCW 74.60.150(1), ((~~one million nine hundred nine thousand dollars~~)) $2,040,000 must be distributed from the fund and, with available federal matching funds, paid to hospitals eligible for small rural disproportionate share payments under WAC 182-550-4900 or successor rule. Payments must be made directly to hospitals by the authority in accordance with that regulation. The authority shall provide a report of such payments to the Washington state hospital association within ((~~thirty~~)) 30 calendar days after payments are made. Any unused funds remaining under this section shall be retained in the fund described under RCW 74.60.020 and used to reduce future assessments.

Sec. 11. RCW 74.60.120 and 2019 c 318 s 7 are each amended to read as follows:

(1) ((~~In~~)) For each ((~~state fiscal~~)) calendar year, ((~~commencing~~)) beginning January 1, 2024, or upon satisfaction of the applicable conditions in RCW 74.60.150(1), whichever is later, the authority shall make supplemental payments directly to Washington hospitals, separately for inpatient and outpatient fee-for-service medicaid services, as follows unless there are federal restrictions on doing so. If there are federal restrictions, to the extent allowed, funds that cannot be paid under (a) of this subsection, should be paid under (b) of this subsection, and funds that cannot be paid under (b) of this subsection, shall be paid under (a) of this subsection:

(a) For inpatient fee-for-service payments for medicaid prospective payment hospitals other than psychiatric or rehabilitation hospitals, ((~~twenty-nine million eight hundred ninety-~~

~~two thousand five hundred dollars~~)) $21,800,000 per ((~~state fiscal~~)) calendar year plus federal matching funds;

(b) For outpatient fee-for-service payments for medicaid prospective payment hospitals other than psychiatric or rehabilitation hospitals, ((~~thirty million dollars~~)) $12,400,000 per ((~~state fiscal~~)) calendar year plus federal matching funds;

(c) For inpatient fee-for-service payments for psychiatric hospitals, ((~~eight hundred seventy-five thousand dollars~~)) $875,000 per ((~~state fiscal~~)) calendar year plus federal matching funds;

(d) For inpatient fee-for-service payments for rehabilitation hospitals, ((~~two hundred twenty-five thousand dollars~~)) $225,000 per ((~~state fiscal~~)) calendar year plus federal matching funds;

(e) For inpatient fee-for-service payments for border hospitals, ((~~two hundred fifty thousand dollars~~)) $250,000 per ((~~state fiscal~~)) calendar year plus federal matching funds; and

(f) For outpatient fee-for-service payments for border hospitals, ((~~two hundred fifty thousand dollars~~)) $250,000 per ((~~state fiscal~~)) calendar year plus federal matching funds.

(2) If the amount of inpatient or outpatient payments under subsection (1) of this section, when combined with federal matching funds, exceeds the upper payment limit, payments to each category of hospital in subsection (1)(a) through (f) of this section must be reduced proportionately to a level where the total payment amount is consistent with the upper payment limit. If funds in excess of the upper payment limit cannot be paid under RCW 74.60.130 and if the payment amount in excess of the upper payment limit exceeds ((~~fifteen million dollars~~)) $15,000,000, the authority shall increase the medicaid prospective payment system hospital outpatient hospital payment rate, for hospitals using the safety net funding and federal matching funds that would otherwise have been used to fund the payments under subsection (1) of this section that exceed the upper payment limit. By January 1st of each year, annually, the authority shall provide to the Washington state hospital association an upper payment limit analysis using the latest available claims data for the historic periods in the calculation. If the analysis shows the payments are projected to exceed the upper payment limit by at least ((~~fifteen million dollars~~)) $15,000,000, the authority shall initiate an outpatient rate increase effective July 1st of that year.

(3) The amount of such fee-for-service inpatient payments to individual hospitals within each of the categories identified in

subsection (1)(a), (c), (d), and (e) of this section must be determined by:

(a) Totaling the inpatient fee-for-service claims payments and inpatient managed care encounter rate payments for each hospital during the base year;

(b) Totaling the inpatient fee-for-service claims payments and inpatient managed care encounter rate payments for all hospitals during the base year; and

(c) Using the amounts calculated under (a) and (b) of this subsection to determine an individual hospital's percentage of the total amount to be distributed to each category of hospital.

(4) The amount of such fee-for-service outpatient payments to individual hospitals within each of the categories identified in subsection (1)(b) and (f) of this section must be determined by:

(a) Totaling the outpatient fee-for-service claims payments and outpatient managed care encounter rate payments for each hospital during the base year;

(b) Totaling the outpatient fee-for-service claims payments and outpatient managed care encounter rate payments for all hospitals during the base year; and

(c) Using the amounts calculated under (a) and (b) of this subsection to determine an individual hospital's percentage of the total amount to be distributed to each category of hospital.

(5) Sixty calendar days before the first payment in each subsequent ((~~fiscal~~)) calendar year, the authority shall provide each hospital and the Washington state hospital association with an explanation of how the amounts due to each hospital under this section were calculated.

(6) Payments must be made in quarterly installments on or about the last day of every quarter, provided that if initial payments are delayed due to federal approval, the initial payment shall include all amounts due from January 1, 2024.

(7) ((~~A prospective payment system hospital commencing operations after January 1, 2009, is eligible to receive payments in accordance with this section after becoming an eligible new prospective payment system hospital as defined in RCW 74.60.010.~~

~~(8)~~)) Payments under this section are supplemental to all other payments and do not reduce any other payments to hospitals.

Sec. 12. RCW 74.60.130 and 2017 c 228 s 9 are each amended to read as follows:

(1) ((~~For state fiscal year 2016 and for each subsequent fiscal year, commencing within thirty days after satisfaction of the conditions in RCW 74.60.150(1) and subsection (5) of this section, the authority shall increase capitation payments in a manner consistent with federal contracting requirements to managed care organizations by an amount at least equal to the amount available from the fund after deducting disbursements authorized by RCW 74.60.020(4) (c) through (f) and payments required by RCW 74.60.080 through 74.60.120. When combined with applicable federal matching funds, the capitation payment under this subsection must be at least three hundred sixty million dollars per year. The initial payment following satisfaction of the conditions in RCW 74.60.150(1) must include all amounts due from July 1, 2015, to the end of the calendar month during which the conditions in RCW 74.60.150(1) are satisfied. Subsequent payments shall be made monthly.~~

~~(2) Payments to individual managed care organizations shall be determined by the authority based on each organization's or network's enrollment relative to the anticipated total enrollment in each program for the fiscal year in question, the anticipated utilization of hospital services by an organization's or network's medicaid enrollees, and such other factors as are reasonable and appropriate to ensure that purposes of this chapter are met.~~

~~(3) If the federal government determines that total payments to managed care organizations under this section exceed what is permitted under applicable medicaid laws and regulations, payments must be reduced to levels that meet such requirements, and the balance remaining must be applied as provided in RCW 74.60.050. Further, in the event a managed care organization is legally obligated to repay amounts distributed to hospitals under this section to the state or federal government, a managed care organization may recoup the amount it is obligated to repay under the medicaid program from individual hospitals by not more than the amount of overpayment each hospital received from that managed care organization.~~

~~(4) Payments under this section do not reduce the amounts that otherwise would be paid to managed care organizations: PROVIDED, That such payments are consistent with actuarial soundness certification and enrollment.~~

~~(5) Before making such payments, the authority shall require medicaid managed care organizations to comply with the following requirements:~~

~~(a) All payments to managed care organizations under this chapter must be expended for hospital services provided by Washington hospitals, which for purposes of this section includes psychiatric and rehabilitation hospitals, in a manner consistent with the purposes and provisions of this chapter, and must be equal to all increased capitation payments under this section received by the organization or network, consistent with actuarial certification and enrollment, less an allowance for any estimated premium taxes the organization is required to pay under Title 48 RCW associated with the payments under this chapter;~~

~~(b) Managed care organizations shall expend the increased capitation payments under this section in a manner consistent with the purposes of this chapter, with the initial expenditures to hospitals to be made within thirty days of receipt of payment from the authority. Subsequent expenditures by the managed care plans are to be made before the end of the quarter in which funds are received from the authority;~~

~~(c) Providing that any delegation or attempted delegation of an organization's or network's obligations under agreements with the authority do not relieve the organization or network of its obligations under this section and related contract provisions.~~

~~(6)~~)) Beginning on the later of January 1, 2024, or 30 calendar days after satisfaction of the conditions in RCW 74.60.150(1) and subsection (3) of this section, and for each subsequent calendar year so long as none of the conditions stated in RCW 74.60.150(2) have occurred, the authority shall make quarterly payments to medicaid managed care organizations as specified herein in a manner consistent with federal contracting requirements. The authority may delay payments under this section as needed if the collection of hospital assessments under RCW 74.60.050 is delayed. The authority shall direct payments from managed care organizations to hospitals and the payments shall support access to hospitals and quality improvement of hospital services.

(a) For the first six months of calendar year 2024, $158,700,000, and for the second six months, $182,500,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed inpatient payments to medicaid prospective payment system

hospitals. For calendar year 2025, $365,000,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed inpatient payments to medicaid prospective payment system hospitals;

(b) For the first six months of calendar year 2024, $99,000,000, and for the second six months $114,000,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to medicaid prospective payment system hospitals. For calendar year 2025, $228,000,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to medicaid prospective payment system hospitals;

(c) For calendar years 2024 and 2025, $400,000 plus federal matching funds to medicaid managed care organizations for directed inpatient payments to critical access hospitals;

(d) For the first six months of calendar year 2024, $8,100,000, and for the second six months $9,300,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to critical access hospitals. For calendar year 2025, $18,600,000 from the fund, plus federal matching funds to medicaid managed care organizations for directed outpatient payments to critical access hospitals;

(e) For subsequent calendar years, including 2025, the authority shall adjust the payments under (a) through (d) of this subsection based on the inflation factor;

(f) The initial payment following satisfaction of the conditions in RCW 74.60.150(1) must include all amounts due from January 1, 2024, to the end of the calendar month during which the conditions in RCW 74.60.150(1) are satisfied. Subsequent payments shall be made quarterly.

(2) The amounts paid to individual managed care organizations under this section shall be determined by the authority based on each organization's payments made for medicaid inpatient and outpatient services as determined under subsection (4)(a) and (b) of this section. These payments do not reduce the amounts that otherwise would be paid to managed care organizations, provided that such payments are consistent with actuarial certification and enrollment. For purposes of this section, medicaid includes both Titles XIX and XXI of the social security act.

(3) Before making such payments, the authority shall modify its contracts with managed care organizations or otherwise require:

(a) Payment of the entire amount payable to hospitals as directed by the authority under subsection (4) of this section, less an allowance for premium taxes the organization is required to pay under Title 48 RCW;

(b) That payments to hospitals be made within 21 calendar days of receipt of payment in full from the authority;

(c) That any delegation or attempted delegation of an organization's obligations under agreements with the authority does not relieve the organization of its obligations under this section and related contract provisions; and

(d) That if funds cannot be paid to hospitals, the managed care organization shall return the funds to the authority, which shall return them to the hospital safety net assessment fund.

(4) The authority shall direct each managed care organization to make quarterly payments to eligible hospitals. Directed inpatient payments shall be a fixed amount per medicaid inpatient discharge, excluding normal newborns, and directed outpatient payments shall be a percentage of medicaid managed care outpatient payments, which the authority shall set so as to pay hospitals the amounts stated in subsection (1) of this section, less premium taxes on the managed care organizations.

(a) Quarterly interim payments shall be made using the authority's encounter data to determine volumes of medicaid discharges and medicaid outpatient payments. The interim payments will be based on volumes of services for each hospital within each medicaid managed care organization for the equivalent period beginning nine months prior to the start of the payment period. Before providing direction to the medicaid managed care organizations the authority shall share the hospital specific data on volumes, proposed payments, and other supporting documentation with the Washington state hospital association.

(b) The authority shall perform an annual reconciliation of amounts paid to each hospital based on its annual encounter data, and direct managed care organizations to make adjusted payments in the subsequent quarter or quarters based on such reconciliation. Before the annual reconciliation, the authority shall send the medicaid managed care inpatient discharges and medicaid managed care

outpatient payments data to each hospital and the Washington state hospital association for verification.

(c) Managed care organizations shall make payments to hospitals within 21 calendar days of receipt of payment in full from the authority.

(d) Any delegation or attempted delegation of an organization's or network's obligations under agreements with the authority does not relieve the organization or network of its obligations under this section and related contract provisions.

(5) If federal restrictions prevent the full amount of payments under this section from being delivered to any class or classes of hospital, the authority, in consultation with the Washington state hospital association, will alter payment rates per medicaid managed care inpatient discharge and per dollar of medicaid managed care outpatient payments in a manner so that in the aggregate each class of hospital receives the same total net benefit as would have otherwise been achieved. If the combined aggregate amount for inpatient and outpatient payments under this section for each class of hospital cannot be paid due to federal requirements, then the payment rates described in this section will be reduced to meet the limitations.

(6) If a managed care organization is legally obligated to repay the state or federal government amounts distributed to hospitals under this section, it may recoup the amount it is obligated to repay from individual hospitals under the medicaid program by not more than the amount of overpayment each hospital received from that managed care organization.

(7) No hospital or managed care organizations may use the payments under this section to gain advantage in negotiations.

((~~(7) No hospital has a claim or cause of action against a managed care organization for monetary compensation based on the amount of payments under subsection (5) of this section.~~))

(8) If funds cannot be used to pay for services in accordance with this chapter the managed care organization or network must return the funds to the authority which shall return them to the hospital safety net assessment fund.

Sec. 13. RCW 74.60.150 and 2017 c 228 s 10 are each amended to read as follows:

(1) The assessment, collection, and disbursement of funds under this chapter shall be conditional upon:

(a) Final approval by the centers for medicare and medicaid services ((~~of any state plan amendments or waiver requests that are necessary~~)) in order to implement the applicable sections of this chapter, except under RCW 74.60.090, including, if necessary, waiver of the broad-based or uniformity requirements as specified under section 1903(w)(3)(E) of the federal social security act and 42 C.F.R. 433.68(e);

(b) To the extent necessary, amendment of contracts between the authority and managed care organizations in order to implement this chapter; and

(c) Certification by the office of financial management that appropriations have been adopted that fully support the rates established in this chapter for the upcoming ((~~fiscal~~)) calendar year.

(2) This chapter does not take effect or ceases to be imposed, and any moneys remaining in the fund shall be refunded to hospitals in proportion to the amounts paid by such hospitals, if and to the extent that any of the following conditions occur:

(a) The federal department of health and human services and a court of competent jurisdiction makes a final determination, with all appeals exhausted, that any element of this chapter, other than RCW ((~~74.60.100~~)) 74.60.090, cannot be validly implemented; or

(b) Funds generated by the assessment for payments to medicaid prospective payment hospitals or managed care organizations are determined to be not eligible for federal matching funds in addition to those federal funds that would be received without the assessment, or the federal government replaces medicaid matching funds with a block grant or grants((~~;~~

~~(c)~~)).

(3) This chapter does not take effect or ceases to be imposed, and any moneys remaining in the fund shall be refunded to hospitals in proportion to the amounts paid by such hospitals, if and to the extent that any of the following conditions occur:

(a) Other funding sufficient to maintain aggregate payment levels to hospitals for inpatient and outpatient services covered by medicaid, including fee-for-service and managed care, at least at the rates the state paid for those services on July 1, ((~~2015~~)) 2022, as

adjusted for current enrollment and utilization is not appropriated or available;

((~~(d)~~)) (b) Payments required by this chapter are reduced, except as specifically authorized in this chapter, or payments are not made in substantial compliance with the time frames set forth in this chapter; or

((~~(e) The fund is~~)) (c) The amount of assessment funds authorized to be used in lieu of state general fund payments for medicaid hospital services is increased above the amount stated in RCW 74.60.020 or the fund is otherwise used as a substitute for or to supplant other funds((~~, except as authorized by RCW 74.60.020~~)).

Sec. 14. RCW 74.60.160 and 2017 c 228 s 11 are each amended to read as follows:

(1) The legislature intends to provide the hospitals with an opportunity to contract with the authority each fiscal biennium to protect the hospitals from future legislative action during the biennium that could result in hospitals receiving less from supplemental payments, increased managed care payments, disproportionate share hospital payments, or access payments than the hospitals expected to receive in return for the assessment based on the biennial appropriations and assessment legislation.

(2) Each odd-numbered year after enactment of the biennial omnibus operating appropriations act, the authority shall extend the existing contract for the period of the fiscal biennium beginning July 1st with a hospital that is required to pay the assessment under this chapter or shall offer to enter into a contract with any hospital subject to this chapter that has not previously been a party to a contract or whose contract has expired. The contract must include the following terms:

(a) The authority must agree not to do any of the following:

(i) Increase the assessment from the level set by the authority pursuant to this chapter on the first day of the contract period for reasons other than ((~~those~~)) as allowed under ((~~RCW 74.60.050(2)(e)~~)) this chapter;

(ii) Reduce aggregate payment levels to hospitals for inpatient and outpatient services covered by medicaid, including fee-for-service and managed care, adjusting for changes in enrollment and utilization, from the levels the state paid for those services on the first day of the contract period;

(iii) For critical access hospitals only, reduce the levels of disproportionate share hospital payments under RCW 74.60.110 or access payments under RCW 74.60.100 for all critical access hospitals below the levels specified in those sections on the first day of the contract period;

(iv) For medicaid prospective payment system, psychiatric, and rehabilitation hospitals only, reduce the levels of supplemental payments under RCW 74.60.120 for all medicaid prospective payment system hospitals below the levels specified in that section on the first day of the contract period unless the supplemental payments are reduced under RCW 74.60.120(2);

(v) For medicaid prospective payment system, psychiatric, and rehabilitation hospitals only, reduce the increased ((~~capitation~~)) payments to managed care organizations under RCW 74.60.130 below the levels specified in that section on the first day of the contract period unless the managed care payments are reduced under RCW 74.60.130(3); or

(vi) Except as specified in this chapter, use assessment revenues for any other purpose than to secure federal medicaid matching funds to support payments to hospitals for medicaid services; and

(b) As long as payment levels are maintained as required under this chapter, the hospital must agree not to challenge the authority's reduction of hospital reimbursement rates to July 1, 2009, levels, which results from the elimination of assessment supported rate restorations and increases, under 42 U.S.C. Sec. 1396a(a)(30)(a) either through administrative appeals or in court during the period of the contract.

(3) If a court finds that the authority has breached an agreement with a hospital under subsection (2)(a) of this section, the authority:

(a) Must immediately refund any assessment payments made subsequent to the breach by that hospital upon receipt; and

(b) May discontinue supplemental payments, increased managed care payments, disproportionate share hospital payments, and access payments made subsequent to the breach for the hospital that are required under this chapter.

(4) The remedies provided in this section are not exclusive of any other remedies and rights that may be available to the hospital whether provided in this chapter or otherwise in law, equity, or statute.

Sec. 15. RCW 74.60.170 and 2017 c 228 s 14 are each amended to read as follows:

(1) The estimated hospital net financial benefit under this chapter shall be determined by the authority by summing the following anticipated hospital payments, including all applicable federal matching funds((~~, specified in RCW 74.60.090 for grants to certified public expenditure hospitals, RCW 74.60.100 for payments to critical access hospitals~~)), RCW 74.60.110 for payments to small rural disproportionate share hospitals, RCW 74.60.120 for ((~~direct~~)) supplemental payments to hospitals, RCW 74.60.130 for ((~~managed care capitation~~)) directed payments, RCW 74.60.020(4)(f) for quality improvement incentives, minus the total assessments paid by all hospitals under RCW 74.60.030 for hospital assessments, and minus any taxes paid on RCW 74.60.130 for managed care payments.

(2) If, for any reason including reduction or elimination of federal matching funds, the estimated hospital net financial benefit falls below one hundred thirty million dollars in any state fiscal year, the office of financial management shall direct the authority to modify the assessment rates provided for in RCW 74.60.030, and the office of financial management is authorized to direct the authority to adjust the amounts disbursed from the fund, including disbursements for payments under RCW 74.60.020(4)(f) and payments to hospitals under RCW 74.60.090 through 74.60.130 and 74.60.020(4)(g), such that the estimated hospital net financial benefit is equal to the amount disbursed from the fund for use in lieu of state general fund payments. Each category of adjusted payments to hospitals under RCW 74.60.090 through 74.60.130 and payments under RCW 74.60.020(4)(g) must bear the same relationship to the total of such adjusted payments as originally provided in this chapter.

Sec. 16. RCW 74.60.900 and 2013 2nd sp.s. c 17 s 16 are each amended to read as follows:

(1) The provisions of ((~~this chapter are not severable: If the conditions in RCW 74.60.150(1) are not satisfied or if any of the circumstances in RCW 74.60.150(2) should occur, this entire chapter shall have no effect from that point forward~~)) RCW 74.60.090 is severable from the remainder of this chapter, unless the condition stated in RCW 74.60.150(3)(c) occurs. The other provisions of this chapter are not severable; if the conditions set forth in RCW 74.60.150(1) cannot be satisfied or if the conditions set forth in

RCW 74.60.150 (2) or (3) occur, this chapter, except for RCW 74.60.090, shall have no effect from that point forward.

(2) In the event that any portion of this chapter shall have been validly implemented and the entire chapter is later rendered ineffective under this section, prior assessments and payments under the validly implemented portions shall not be affected.

NEW SECTION. **Sec. 17.** The following acts or parts of acts are each repealed:

(1) RCW 74.60.901 (Expiration date—2010 1st sp.s. c 30) and 2021 c 255 s 4, 2019 c 318 s 8, 2017 c 228 s 12, 2015 2nd sp.s. c 5 s 11, 2013 2nd sp.s. c 17 s 19, & 2010 1st sp.s. c 30 s 21; and

(2) RCW 74.60.903 (Effective date—2010 1st sp.s. c 30) and 2010 1st sp.s. c 30 s 23.

NEW SECTION. **Sec. 18.** (1) Sections 1 through 7 and 9 through 16 of this act take effect when the conditions specified in RCW 74.60.150(1) are satisfied, but no earlier than January 1, 2024.

(2) Section 8 of this act takes effect when the conditions specified in that section are satisfied, but no earlier than January 1, 2024.

(3) Until the provisions of this act become effective, chapter 74.60 RCW remains in effect, provided that:

(a) Failure to satisfy the conditions specified in section 8 of this act shall not prevent the remainder of this act taking effect; and

(b) In all events, payments under RCW 74.60.090(1)(a)(i), but not RCW 74.60.090(1) (a)(ii) through (iii) or (b), shall cease December 31, 2023.

(4) The authority shall provide written notice of the effective date of each occurrence in subsection (1) of this section to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the authority.

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