
SENATE BILL 5764

State of Washington

68th Legislature

2023 Regular Session

By Senators Robinson and Muzzall

1 AN ACT Relating to the hospital safety net program; amending RCW
2 74.60.005, 74.60.010, 74.60.020, 74.60.030, 74.60.040, 74.60.050,
3 74.60.080, 74.60.090, 74.60.100, 74.60.110, 74.60.120, 74.60.130,
4 74.60.150, 74.60.160, 74.60.170, and 74.60.900; repealing RCW
5 74.60.901 and 74.60.903; and providing contingent effective dates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (c) That upon satisfaction of the applicable conditions in RCW
24 74.60.090, the designated public hospitals will be able to receive
25 additional federal matching funds, used only for the purposes
26 specified in this chapter.

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

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

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

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

36 (3) "~~((Bordering city))~~ Border hospital" means, for the purposes
37 of the fee-for-service program under RCW 74.60.120, a hospital as
38 defined in WAC 182-550-1050 and bordering cities as described in WAC
39 182-501-0175, or successor rules.

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

10 ~~(5))~~ "Cancer hospital" means a hospital classified as involved
11 extensively in treatment for or research on cancer under section
12 1886(d)(1)(B)(v) of the social security act.

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

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

17 ~~((6))~~ (7) "Designated public hospital" means a hospital
18 operated by a public hospital district in the state of Washington,
19 not certified by the department of health as a critical access
20 hospital, that:

21 (a) Has not opted out of the certified public expenditure payment
22 program described in WAC 182-550-4650 or successor rule by June 1,
23 2023, or in future years by June 1st of the preceding year; or

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

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

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

34 ~~(8))~~ (9) "Fund" means the hospital safety net assessment fund
35 established under RCW 74.60.020.

36 ~~((9))~~ (10) "High government payer independent hospital" means a
37 prospective payment system hospital which is nonprofit, provides
38 acute care to adults and children, is not governmentally owned or
39 owned or operated by a health system that owns or operates three or
40 more acute care hospitals, and provides services to patients covered

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

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

5 ~~((10))~~ (12) "Inflation factor" means the centers for medicare
6 and medicaid services inpatient hospital market basket inflation
7 factor using the four quarter rolling average as calculated and
8 available by April 30th of each year or an alternative source
9 required by the centers for medicare and medicaid services.

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

13 ~~((11))~~ (14) "Managed care organization" means an organization
14 having a certificate of authority or certificate of registration from
15 the office of the insurance commissioner that contracts with the
16 authority under a comprehensive risk contract to provide prepaid
17 health care services to eligible clients under the authority's
18 medicaid managed care programs, including the healthy options
19 program.

20 ~~((12))~~ (15) "Medicaid" means the medical assistance program as
21 established in Title XIX of the social security act and as
22 administered in the state of Washington by the authority.

23 ~~((13))~~ (16) "Medicaid managed care inpatient discharge" means
24 an inpatient discharge for a medicaid patient, excluding normal
25 newborns, based upon the grouper methodology used by the authority,
26 where the medicaid managed care organization was the primary payer of
27 the patient claim.

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

31 (18) "Medicare cost report" means the medicare cost report, form
32 2552, or successor document.

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

1 ~~(15))~~ (19) "Nonmedicare net patient revenue" means all net
2 patient revenue, less a deduction only of fee-for-service medicare
3 revenue and includes medicare managed care revenue.

4 (20) "Outpatient services" means services that are provided
5 ((classified)) as ambulatory payment classification services or
6 successor payment methodologies as defined in WAC ((182-550-7050))
7 182-550-1050 or successor rule and applies to fee-for-service
8 payments and managed care encounter data.

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

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

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

28 ~~((18))~~ (23) "Rehabilitation hospital" means a
29 medicare-certified freestanding inpatient rehabilitation facility.

30 ~~((19))~~ (24) "Small rural disproportionate share hospital
31 payment" means a payment made in accordance with WAC 182-550-5200 or
32 successor rule.

33 ~~((20))~~ (25) "Upper payment limit" means the aggregate federal
34 upper payment limit on the amount of the medicaid payment for which
35 federal financial participation is available for a class of service
36 and a class of health care providers, as specified in 42 C.F.R. Part
37 47, as separately determined for inpatient and outpatient hospital
38 services.

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

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

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

15 (b) ~~((Any))~~ If the program is discontinued, any amounts remaining
16 in the fund ~~((after July 1, 2025,))~~ shall be refunded to hospitals,
17 pro rata according to the amount paid by the hospital since July 1,
18 ~~((2013))~~ 2018, subject to the limitations of federal law.

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

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

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

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

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

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

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

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

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

15 (f) To pay an amount sufficient, when combined with the maximum
16 available amount of federal funds necessary to provide a one percent
17 increase in medicaid hospital inpatient rates (~~((to hospitals eligible
18 for quality improvement incentives under RCW 74.09.611. By May 16,
19 2018, and by each May 16 thereafter, the authority, in cooperation
20 with the department of health, must verify that each hospital
21 eligible to receive quality improvement incentives under the terms of
22 this chapter is in substantial compliance with the reporting
23 requirements in RCW 43.70.052 and 70.01.040 for the prior period. For
24 the purposes of this subsection, "substantial compliance" means, in
25 the prior period, the hospital has submitted at least nine of the
26 twelve monthly reports by the due date. The authority must distribute
27 quality improvement incentives to hospitals that have met these
28 requirements beginning July 1 of 2018 and each July)) for medicaid
29 prospective payment system hospitals and designated public hospitals
30 that are eligible for quality improvement incentives under RCW
31 74.09.611. Only funds collected under RCW 74.60.030 shall be used to
32 generate payments to medicaid prospective payment hospitals. Only
33 funds received under RCW 74.60.090 shall be used to generate payments
34 to designated public hospitals. By May 16, 2018, and by each May 16th
35 thereafter, the authority, in cooperation with the department of
36 health, must verify that all medicaid prospective payment system
37 hospitals and all designated public hospitals are in substantial
38 compliance with the reporting requirements in RCW 43.70.052 and
39 70.01.040 for the prior period. Safety net assessment funds shall not
40 be used to pay quality improvement incentives to any other hospitals.~~

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

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

9 (i) Two million dollars for integrated evidence-based psychiatry
10 residency program slots that did not receive state funding prior to
11 2016 at the integrated psychiatry residency program at the University
12 of Washington; and

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

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

20 (1) ~~((a))~~ Upon satisfaction of the conditions in RCW
21 74.60.150(1), and so long as the conditions in RCW 74.60.150(2) have
22 not occurred, an annual assessment is imposed as set forth in this
23 subsection ~~((. Assessment notices must be sent on or about thirty days~~
24 ~~prior to the end of each quarter and payment is due thirty days~~
25 ~~thereafter.~~

26 ~~(b) Effective July 1, 2015, and except as provided in RCW~~
27 ~~74.60.050:~~

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

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

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

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

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

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

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

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

1 state hospital association, shall determine inpatient and outpatient
2 assessment rates that, when applied as set forth below, will produce
3 \$510,000,000 from the inpatient assessment and \$386,400,000 from the
4 outpatient assessment. For subsequent years, the authority, in
5 consultation with the Washington state hospital association, shall
6 adjust the assessment amounts to fund adjustments in directed
7 payments under RCW 74.60.130 and quality incentive payments under RCW
8 74.09.611.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (4) Long-term acute care hospitals.

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

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

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

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

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

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

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

35 (a) If sufficient other funds, including federal funds, are
36 available to make the payments required under this chapter and fund
37 the state portion of the quality incentive payments under RCW
38 74.09.611 and 74.60.020(4)(f) without utilizing the full assessment

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

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

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

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

26 ~~(e) If the number of nonmedicare inpatient days applied to the~~
27 ~~rates provided in RCW 74.60.030 will not produce sufficient funds to~~
28 ~~support the payments required under this chapter and the state~~
29 ~~portion of the quality incentive payments under RCW 74.09.611 and~~
30 ~~74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may~~
31 ~~be increased proportionately by category of hospital to amounts no~~
32 ~~greater than necessary in order to produce the required level of~~
33 ~~funds needed to make the payments specified in this chapter and the~~
34 ~~state portion of the quality incentive payments under RCW 74.09.611~~
35 ~~and 74.60.020(4)(f); and~~

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

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

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

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

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

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

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

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

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

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

1 ~~(vii) The amount of payments made to managed care plans under RCW~~
2 ~~74.60.130, including the amount representing additional premium tax,~~
3 ~~and the data used to calculate those payments)).~~

4 (c) On a ~~((monthly))~~ quarterly basis, and for the full calendar
5 year, the authority shall provide the Washington state hospital
6 association the amount of payments made to managed care ~~((plans))~~
7 organizations and directed distribution to hospitals under RCW
8 74.60.130, including the amount representing additional premium tax,
9 and the data used to calculate those payments.

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

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

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

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

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

24 ~~((4))~~ (3) For payments to hospitals under RCW 74.60.120; ~~((and~~
25 ~~(5))~~ (4) For payments to managed care organizations under RCW
26 74.60.130 for the provision of hospital services; and

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

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

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

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

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

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

6 (ii) Two million dollars to integrated, evidence-based psychiatry
7 residency program slots that did not receive state funding prior to
8 2016, at the integrated psychiatry residency program at the
9 University of Washington; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (iii) Be at risk of bankruptcy; and

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

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

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

5 (5) If the total of qualified applications from financially
6 distressed hospitals for these funds in a biennium is less than
7 \$10,000,000, the balance will be retained in the fund to be used in
8 subsequent years for these purposes.

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

11 In each fiscal year commencing upon satisfaction of the
12 applicable conditions in RCW 74.60.150(1), (~~one million nine hundred~~
13 ~~nine thousand dollars~~) \$2,040,000 must be distributed from the fund
14 and, with available federal matching funds, paid to hospitals
15 eligible for small rural disproportionate share payments under WAC
16 182-550-4900 or successor rule. Payments must be made directly to
17 hospitals by the authority in accordance with that regulation. The
18 authority shall provide a report of such payments to the Washington
19 state hospital association within (~~thirty~~) 30 calendar days after
20 payments are made. Any unused funds remaining under this section
21 shall be retained in the fund described under RCW 74.60.020 and used
22 to reduce future assessments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (1) ~~((For state fiscal year 2016 and for each subsequent fiscal~~
4 ~~year, commencing within thirty days after satisfaction of the~~
5 ~~conditions in RCW 74.60.150(1) and subsection (5) of this section,~~
6 ~~the authority shall increase capitation payments in a manner~~
7 ~~consistent with federal contracting requirements to managed care~~
8 ~~organizations by an amount at least equal to the amount available~~
9 ~~from the fund after deducting disbursements authorized by RCW~~
10 ~~74.60.020(4) (c) through (f) and payments required by RCW 74.60.080~~
11 ~~through 74.60.120. When combined with applicable federal matching~~
12 ~~funds, the capitation payment under this subsection must be at least~~
13 ~~three hundred sixty million dollars per year. The initial payment~~
14 ~~following satisfaction of the conditions in RCW 74.60.150(1) must~~
15 ~~include all amounts due from July 1, 2015, to the end of the calendar~~
16 ~~month during which the conditions in RCW 74.60.150(1) are satisfied.~~
17 ~~Subsequent payments shall be made monthly.~~

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

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

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

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

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

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

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

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

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

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

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

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

16 (d) For the first six months of calendar year 2024, \$8,100,000,
17 and for the second six months \$9,300,000 from the fund, plus federal
18 matching funds to medicaid managed care organizations for directed
19 outpatient payments to critical access hospitals. For calendar year
20 2025, \$18,600,000 from the fund, plus federal matching funds to
21 medicaid managed care organizations for directed outpatient payments
22 to critical access hospitals;

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

26 (f) The initial payment following satisfaction of the conditions
27 in RCW 74.60.150(1) must include all amounts due from January 1,
28 2024, to the end of the calendar month during which the conditions in
29 RCW 74.60.150(1) are satisfied. Subsequent payments shall be made
30 quarterly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (a) The federal department of health and human services and a
22 court of competent jurisdiction makes a final determination, with all
23 appeals exhausted, that any element of this chapter, other than RCW
24 (~~(74.60.100)~~) 74.60.090, cannot be validly implemented; or

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

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

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

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

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

7 ~~((e) The fund is)~~ (c) The amount of assessment funds authorized
8 to be used in lieu of state general fund payments for medicaid
9 hospital services is increased above the amount stated in RCW
10 74.60.020 or the fund is otherwise used as a substitute for or to
11 supplant other funds~~((, except as authorized by RCW 74.60.020))~~.

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

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

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

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

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

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

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

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

12 (v) For medicaid prospective payment system, psychiatric, and
13 rehabilitation hospitals only, reduce the increased (~~capitation~~)
14 payments to managed care organizations under RCW 74.60.130 below the
15 levels specified in that section on the first day of the contract
16 period unless the managed care payments are reduced under RCW
17 74.60.130(3); or

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

21 (b) As long as payment levels are maintained as required under
22 this chapter, the hospital must agree not to challenge the
23 authority's reduction of hospital reimbursement rates to July 1,
24 2009, levels, which results from the elimination of assessment
25 supported rate restorations and increases, under 42 U.S.C. Sec.
26 1396a(a)(30)(a) either through administrative appeals or in court
27 during the period of the contract.

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

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

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

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

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

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

15 (2) If, for any reason including reduction or elimination of
16 federal matching funds, the estimated hospital net financial benefit
17 falls below one hundred thirty million dollars in any state fiscal
18 year, the office of financial management shall direct the authority
19 to modify the assessment rates provided for in RCW 74.60.030, and the
20 office of financial management is authorized to direct the authority
21 to adjust the amounts disbursed from the fund, including
22 disbursements for payments under RCW 74.60.020(4)(f) and payments to
23 hospitals under RCW 74.60.090 through 74.60.130 and 74.60.020(4)(g),
24 such that the estimated hospital net financial benefit is equal to
25 the amount disbursed from the fund for use in lieu of state general
26 fund payments. Each category of adjusted payments to hospitals under
27 RCW 74.60.090 through 74.60.130 and payments under RCW
28 74.60.020(4)(g) must bear the same relationship to the total of such
29 adjusted payments as originally provided in this chapter.

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

32 (1) The provisions of (~~this chapter are not severable: If the~~
33 ~~conditions in RCW 74.60.150(1) are not satisfied or if any of the~~
34 ~~circumstances in RCW 74.60.150(2) should occur, this entire chapter~~
35 ~~shall have no effect from that point forward)) RCW 74.60.090 is
36 severable from the remainder of this chapter, unless the condition
37 stated in RCW 74.60.150(3)(c) occurs. The other provisions of this
38 chapter are not severable; if the conditions set forth in RCW
39 74.60.150(1) cannot be satisfied or if the conditions set forth in~~

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

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

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

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

12 (2) RCW 74.60.903 (Effective date—2010 1st sp.s. c 30) and 2010
13 1st sp.s. c 30 s 23.

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

17 (2) Section 8 of this act takes effect when the conditions
18 specified in that section are satisfied, but no earlier than January
19 1, 2024.

20 (3) Until the provisions of this act become effective, chapter
21 74.60 RCW remains in effect, provided that:

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

25 (b) In all events, payments under RCW 74.60.090(1)(a)(i), but not
26 RCW 74.60.090(1)(a)(ii) through (iii) or (b), shall cease December
27 31, 2023.

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

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