RCW 74.60.120 Direct supplemental payments to hospitals. ***(Contingent expiration date.)*** (1) In each state fiscal year, commencing upon satisfaction of the applicable conditions in RCW 74.60.150(1), 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 prospective payment hospitals other than psychiatric or rehabilitation hospitals, twenty-nine million eight hundred ninety-two thousand five hundred dollars per state fiscal year plus federal matching funds;

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

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

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

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

(f) For outpatient fee-for-service payments for border hospitals, two hundred fifty thousand dollars per state fiscal 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, the authority shall increase the 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, 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, 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 days before the first payment in each subsequent fiscal 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.

(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. [2019 c 318 s 7; 2017 c 228 s 8; 2015 2nd sp.s. c 5 s 7; 2014 c 143 s 2; 2013 2nd sp.s. c 17 s 11; 2010 1st sp.s. c 30 s 13.]

Effective date—2019 c 318: See note following RCW 74.60.005.

Effective date—2017 c 228: See note following RCW 74.60.005.

Effective date—2015 2nd sp.s. c 5: See note following RCW 74.60.005.

Effective date—2014 c 143: See note following RCW 74.60.030.

Effective date—2013 2nd sp.s. c 17: See note following RCW 74.60.005.

RCW 74.60.120 Direct supplemental payments to hospitals. *(Contingent effective date.)* (1) For each calendar year, 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, $21,800,000 per calendar year plus federal matching funds;

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

(c) For inpatient fee-for-service payments for psychiatric hospitals, $875,000 per calendar year plus federal matching funds;

(d) For inpatient fee-for-service payments for rehabilitation hospitals, $225,000 per calendar year plus federal matching funds;

(e) For inpatient fee-for-service payments for border hospitals, $250,000 per calendar year plus federal matching funds; and

(f) For outpatient fee-for-service payments for border hospitals, $250,000 per 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 $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 $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 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) Payments under this section are supplemental to all other payments and do not reduce any other payments to hospitals. [2023 c 430 s 11; 2019 c 318 s 7; 2017 c 228 s 8; 2015 2nd sp.s. c 5 s 7; 2014 c 143 s 2; 2013 2nd sp.s. c 17 s 11; 2010 1st sp.s. c 30 s 13.]

Contingent effective date—2023 c 430: See note following RCW 74.60.005.

Effective date—2019 c 318: See note following RCW 74.60.005.

Effective date—2017 c 228: See note following RCW 74.60.005.

Effective date—2015 2nd sp.s. c 5: See note following RCW 74.60.005.

Effective date—2014 c 143: See note following RCW 74.60.030.

Effective date—2013 2nd sp.s. c 17: See note following RCW 74.60.005.