RCW 74.60.150 Conditions. ***(Contingent expiration date.)*** (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 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 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, cannot be validly implemented;

(b) Funds generated by the assessment for payments to 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) 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 is not appropriated or available;

(d) 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 used as a substitute for or to supplant other funds, except as authorized by RCW 74.60.020. [2017 c 228 s 10; 2015 2nd sp.s. c 5 s 9; 2013 2nd sp.s. c 17 s 15; 2010 1st sp.s. c 30 s 17.]

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

RCW 74.60.150 Conditions. ***(Contingent effective date.)*** (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 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 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 74.60.090, 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.

(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, 2022, as adjusted for current enrollment and utilization is not appropriated or available;

(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

(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. [2023 c 430 s 13; 2017 c 228 s 10; 2015 2nd sp.s. c 5 s 9; 2013 2nd sp.s. c 17 s 15; 2010 1st sp.s. c 30 s 17.]

Contingent effective date—2023 c 430: 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—2013 2nd sp.s. c 17: See note following RCW 74.60.005.