

FILED  
SUPREME COURT  
STATE OF WASHINGTON  
4/10/2020 2:28 PM  
BY SUSAN L. CARLSON  
CLERK

FILED  
SUPREME COURT  
STATE OF WASHINGTON  
4/22/2020  
BY SUSAN L. CARLSON  
CLERK

No. 975574

IN THE SUPREME COURT  
OF THE STATE OF WASHINGTON

---

PEACEHEALTH ST. JOSEPH MEDICAL CENTER AND  
PEACEHEALTH ST. JOHN MEDICAL CENTER,

Appellants,

v.

STATE OF WASHINGTON, DEPARTMENT OF REVENUE,  
Respondent.

---

AMICUS CURIAE MEMORANDUM OF THE WASHINGTON STATE  
HOSPITAL ASSOCIATION

---

COUNSEL

Carla DewBerry, WSBA No. 15746  
Christopher Wyant, WSBA No. 35561  
K&L Gates LLP  
925 Fourth Ave., Suite 2900  
Seattle, Washington 98104-1158  
Phone: 206-370-8317  
Fax: 206-370-6239  
Email: [carla.dewberry@klgates.com](mailto:carla.dewberry@klgates.com)  
[christopher.wyant@klgates.com](mailto:christopher.wyant@klgates.com)

*Attorneys for Amicus Curiae Washington State Hospital Association*

**TABLE OF CONTENTS**

	<b>Page</b>
I. IDENTITY OF AMICUS AND STATEMENT OF INTEREST .....	1
II. INTRODUCTION .....	1
III. ARGUMENT .....	2
A. The Deduction Claimed by the Hospitals is Consistent with the Legislative Intent .....	2
B. The Department’s Reliance on <i>Kentucky v. Davis</i> Is Based on A False Narrative; The <i>Davis</i> Exclusion from Commerce Clause Scrutiny Does Not Apply.....	3
C. The Deduction is Consistent with Washington State’s Federal Medicaid Obligations and the State’s Contractual Relationship with Other States.....	8
(1) <i>Medicaid is a Federal Program; Access for Out Of State Medicaid Beneficiaries is Mandatory</i> .....	9
(2) <i>Home is Not Irrelevant but it Does Not Define Medicaid Residency</i> .....	10
(3) <i>Washington Has Achieved Administrative Simplicity by Contracting with Other States</i> .....	13
(4) <i>CMS Adopted a Physical Presence Residency Standard for Certain Children, and Washington Has Embraced This Standard</i> .....	16
(5) <i>Washington Has Focused Arrangements with its Cross-Border States</i> .....	19
IV. CONCLUSION .....	20

## TABLE OF AUTHORITIES

	Page(s)
<b>Federal Cases</b>	
<i>Dep't of Revenue of Ky. v. Davis</i> , 553 U.S. 328, 128 S. Ct. 1801, 137 L. Ed. 2d 685 (2008).....	1, 4, 5, 7
<i>Wilder v. Virginia Hosp. Ass'n</i> , 496 U.S. 498, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990).....	9
<b>State Cases</b>	
<i>Mississippi Dep't of Revenue v. AT&amp;T Corp.</i> , 202 So.3d 1207 (Miss. 2016).....	5
<i>Multicare Medical Center v. State, Dept. of Social &amp; Health Servs.</i> , 114 Wash. 2d 572 P.2d 124 (1990).....	6, 7
<b>Federal Statutes</b>	
42 U.S.C. § 1396a(48) .....	12
<b>State Statutes</b>	
RCW 74.09.171 .....	19
RCW 74.09.470 .....	9
RCW 82.04.4297 .....	7
RCW 82.04.4311 .....	16
RCWA Chapter 70.39 .....	6
<b>Regulations</b>	
42 C.F.R. § 430.10 .....	10
42 C.F.R. § 431.52 .....	10, 14

42 C.F.R. § 431.52(b) .....	11
42 C.F.R. § 431.52(c).....	12
42 C.F.R. § 435.403 .....	13
42 C.F.R. § 435.403(d) .....	13
42 C.F.R. § 435.403(e) through (i) .....	13
42 C.F.R. § 435.403(j) .....	12
42 C.F.R. § 435.403(k) .....	15
42 C.F.R. § 435.403(m) .....	12
42 C.F.R. § 435.900 .....	17
42 C.F.R. § 435.909 .....	17
47 Fed. Reg. 28652-01 (July 1, 1982) .....	14, 15
WAC § 110-60-0050.....	17
WAC § 110-60-0060.....	17
WAC § 388-27-0030.....	17

## **I. IDENTITY OF AMICUS AND STATEMENT OF INTEREST**

The Washington State Hospital Association (“WSHA”) is a Washington member-led association representing hospitals and health systems advocating on their behalf to achieve the mission of improving the health of Washington’s communities. As set out more fully in our Motion to File an Amicus Curiae Brief, the Washington State Legislature has repeatedly recognized the key role that WSHA plays in the public discourse on health care systems operating in Washington. The Court’s decision in this case will impact multiple hospitals and patient’s through-out the State.

WSHA wishes to address the arguments of the Department of Revenue (the “Department”) about the Legislative intent of the deduction at issue in this case, the “government support” exception to Commerce Clause scrutiny, exemplified by *Dep’t of Revenue of Ky. v. Davis*, 553 U.S. 328, 128 S. Ct. 1801, 137 L. Ed. 2d 685 (2008), as well as both federal Medicaid law and actions taken by Washington to incorporate services provided to non-Washington residents within State programs established under RCW 74.09.

## **II. INTRODUCTION**

At issue in this case is whether monies received by Petitioners are deductible from income subject to the business and occupation (“B&O”) tax under RCW 82.04.4311. RCW 82.04.4311 provides that certain nonprofit hospitals “may deduct from the measure of tax amounts received as

compensation for health care services covered under ... medical assistance, children's health, or other program under chapter 74.09 RCW.”

### III. ARGUMENT

#### A. The Deduction Claimed by the Hospitals is Consistent with the Legislative Intent.

The Department begins its Supplemental Brief by misstating the Legislature’s history in tax policy regarding nonprofit hospitals. The hospital-specific exemptions and deductions have always been broader than “healthcare and social services subsidized by the State of Washington and the federal government.” Department’s Supp. Br. at 1. It is true, a B&O tax deduction for non-profit hospitals was as enacted in Laws of 1980, ch. 37. In fact the act included three pertinent deductions. Section 10 provided a general deduction for patient care monies received by a nonprofit hospital, Section 9 created an equivalent deduction for a hospital operated by the United States or any of its instrumentalities, or by the state or any of its political subdivisions, and Section 17 provided a deduction for government payments to “health and social welfare organization[s]” that was not targeted at or limited to hospitals. The deduction in Section 10 overlaid a pre-existing exemption for all patient-service income of non-profit hospitals under RCW 82.04.4289, which was not repealed until 1993. The unifying thread of pre-1993 policy was to bolster community hospitals by not taxing patient service revenues at all, without regard to

government-subsidized programs. The current hospital-specific deduction is found in RCW 82.04.4311. When this statute was adopted the Legislature clearly expressed its intent stating as follows:

The legislature finds that the provision of health services to those people who receive federal or state subsidized health care benefits by reason of age, disability, or lack of income is a recognized, necessary, and vital governmental function. As a result, the legislature finds that it would be inconsistent with that governmental function to tax amounts received by a public hospital or nonprofit hospital qualifying as a health and social welfare organization, when the amounts are paid under a health service program *subsidized by federal or state government*.

Laws of 2002, ch. 314, § 1. (emphasis added).

It is undisputed that Medicaid payments from every state are subsidized by the federal government. Thus the deduction for Medicaid monies paid to Washington hospitals by other states' Medicaid plans is clearly within the Legislative intent and consistent with the broader tax relief targeted at hospitals via the exemption and deductions available until 1993.

**B. The Department's Reliance on *Kentucky v. Davis* Is Based on A False Narrative; The *Davis* Exclusion from Commerce Clause Scrutiny Does Not Apply.**

The Department's arguments concerning the "government support" exception to Commerce Clause scrutiny, exemplified by *Dep't of Revenue of Ky. v. Davis*, 553 U.S. 328, 128 S. Ct. 1801, 137 L. Ed. 2d 685 (2008), are not supported by that decision, as shown by PeaceHealth in its Response Brief (page 33) and by a closer look at the reasoning of *Davis*.

The Department both misrepresents the scope of *Davis*'s exemption from Commerce Clause review and misapplies the case, because the Department continues to mischaracterize how the Washington deduction relates to the financing of State Medicaid and CHIP programs.

In *Davis*, Kentucky law provided an income tax exemption for residents for interest paid on Kentucky's own state and municipal bonds but denied the exemption for interest paid on other states' bonds. The Supreme Court observed that, in practical terms, "the Commonwealth's tax benefit to residents who buy its bonds makes lower interest rates acceptable [in comparison with corporate bonds], while limiting the exception to Kentucky bonds raises in-state demand for them without also subsidizing other issuers." *Id.* at 333-34. In other words, Kentucky's differential tax treatment had a direct and tangible impact on public borrowing in the state.

The Court explained that an exception from standard dormant Commerce Clause scrutiny applies "to laws *favoring* a State's municipal bonds, given that the issuance of debt securities to pay for public projects is a quintessentially public function." *Id.* at 341-42 (emphasis added). The taxpayers argued that Kentucky had assumed a regulatory role via its tax system, which is customarily subject to Commerce Clause review. *Id.* at 343-44 (citing *Camps Newfound/Owatonna, Inc. v. Town of Harrison, Me.*, 520 U.S. 564, 117 S. Ct. 190, 137 L. Ed. 2d 852 (1997)). The Court acknowledged

that it was “a fair point” that if Kentucky is “looked at as a taxing authority it seems to invite dormant Commerce Clause scrutiny of its regulatory activity.” *Id.* at 344. But the Court held that the economics of the State’s scheme demonstrated how the law tangibly “favored” the public function of financing public facilities and services:

But there is no ignoring the fact that imposing the differential tax scheme makes sense *only* because Kentucky is also a bond issuer. The Commonwealth has entered the market for debt securities . . . . [W]hen Kentucky exempts its bond interest, it is competing in the market for limited investment dollars, alongside private bond issuers and its sister States, and its tax structure is one of the tools of competition.

*Id.* at 344-45 (emphasis added) (footnote omitted).

Contrary to the Department’s argument that “[t]he Court in *Davis* focused solely on the ‘public character’ of the activity supported by the deduction,” Department’s Supp. Br. at 15, the Court held that Kentucky’s differential tax scheme was excluded from Commerce Clause scrutiny because it demonstrably helped the State achieve its aims. The tax differential made sense “only” because the State was directly benefiting from the incentive it created as the seller of bonds. *Davis*, 553 U.S. at 344. As the Mississippi Supreme Court has noted, “*Davis* involved a tax scheme which benefitted the state and local governments in Kentucky by *incentivizing* the purchase of intrastate bonds.” *Mississippi Dep’t of Revenue v. AT&T Corp.*, 202 So.3d 1207, 1217 (Miss. 2016) (emphasis added).

The Department has not shown that its interpretation of RCW 82.04.4311 in fact creates incentives useful to State health programs or “favors” the public function in any other tangible way. There is no factual basis for claiming that the economics of Kentucky’s tax scheme are analogous to the Department’s position on RCW 82.04.4311.

As this Court is aware, the basis for calculating Medicaid reimbursements and the ultimate burden of the program has nothing to do with special revenue accounts or B&O tax deductions. *See Multicare Medical Center v. State, Dept. of Social & Health Servs.*, 114 Wash. 2d 572, 575-78, 790 P.2d 124 (1990) (describing the changing basis over time for, and repeated reduction of, Medicaid reimbursements in the 1980s). During the years at issue in *Multicare* the Washington State Hospital Commission regulated hospital rates to benefit all buyers of hospital services. However, the State relied on RCW 70.39.140(c)<sup>1</sup> to pay hospitals less than the Commission approved rates (“Any hospital may charge rates as negotiated with or established by the department of social and health services ... Rates negotiated or established under this subsection (c) are not subject to review of approval by the Commission under this chapter.”). The Department’s adoption of Medicaid reimbursement rates based on “diagnosis-related groups,” which began in 1985

---

<sup>1</sup> See Chapter 70.39 RCWA, attached as Appendix, Ex. A-1.

as described in *Multicare*, *see id.* at 578, was still the general framework used by the State when this appeal began, though it evolved over time. *See* AR 39 (Decl. of Andrew Busz at 1 (citing WAC § 182-550-3840)).

Public and nonprofit hospitals were exempt from B&O tax from the initial adoption of the tax in 1935 until 1993. *See* 1935 Laws, ch. 180, § 11(i); 1993 Laws, ch. 492, § 305. Neither the federal nor state enactment of Medicaid in 1965 relied on the state tax system in relation to hospitals. As PeaceHealth has pointed out, the original health or social welfare deduction under RCW 82.04.4297 was adopted in 1980, without regard to hospitals, which were then exempt from tax. *See* Appellants' Supp. Br. at 17 (citing 1980 Laws, ch. 37, sec. 17). That deduction, like RCW 82.04.4311, listed *federal* compensation for health or social welfare services as the first category of deductible income. Neither enactment, unlike the differential tax scheme for state bonds in *Davis*, "makes sense only because" the State is purchasing Medicaid services. *Davis*, 553 U.S. at 334.

The B&O tax deduction has no unique impact on the Medicaid outlay by the State. AR 40. The Department appears to admit this fact. *See* Department's Supp. Br. at 16. The deduction in RCW 82.04.4311 was not adopted to, and does not, "favor" the State's health programs.

The Department's claim that its interpretation is aligned with the "forty years" of history of the health or social welfare deduction is a historical fiction.

See Department's Supp. Br. at 1. The Department's claim that, in enacting RCW 82.04.4311, "the Legislature simply chooses not tax [sic] its own subsidies" is a legal fiction. *Id.* at 15. The scope of RCW 82.04.4311, in granting a deduction first for all for federally subsidized compensation, shows that its overriding purpose is to regulate the cost structure of health care provided by qualified hospitals organizations and not to enhance the State's competitive position in the hospital care market. This law is regulatory. It does not directly "support" the State's public functions. The *Davis* exclusion from Commerce Clause scrutiny does not apply.

C. **The Deduction is Consistent with Washington State's Federal Medicaid Obligations and the State's Contractual Relationship with Other States.**

Viewing the Washington Medicaid program in the context of the federal Medicaid law and the State's contracts with other states shows clear entitlement to the deduction.

The Department's argument that the monies at issue in this case were not received under the programs established under 74.09 RCW conflicts with: (1) federal Medicaid access laws, (2) Medicaid residency standards, (3) Washington's inter-state agreements and compacts with almost every other state in the nation, (4) Medicaid's physical presence residency standards for children, and (5) Washington laws to achieve cross-border Medicaid reciprocity. We discuss each of these factors, below.

(1) *Medicaid is a Federal Program; Access for Out Of State Medicaid Beneficiaries is Mandatory*

Medicaid is a federal program. “Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the [Social Security] Act and regulations promulgated by the Secretary of Health and Human Services (Secretary). To qualify for federal assistance, a State must submit to the Secretary and have approved a plan for medical assistance that contains a comprehensive statement describing the nature and scope of the State's Medicaid program.” *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990) (internal citations omitted).

The starting place for understanding Washington’s Medicaid programs is federal law and the Washington State Plan. Washington intends for its plan to comply with federal law, and RCW 74.09.470 requires the Medicaid and CHIP programs to operate in accordance with the State Plan, providing as follows:

There is hereby established a new program of federal-aid assistance to be known as medical assistance to be administered by the authority. The authority is authorized to comply with the federal requirements for the medical assistance program provided in the social security act and particularly Title XIX of Public Law (89-97), as amended, in order to secure federal matching funds for such program.

...

In administering the [apple health for kids] program, the authority shall take such actions as may be necessary to ensure the receipt of federal financial participation under the medical assistance program, as codified

at Title XIX of the federal social security act, the state children's health insurance program, as codified at Title XXI of the federal social security ...

Under federal regulations, the State Plan is a comprehensive agreement between a state and the federal government. *See* 42 C.F.R. § 430.10<sup>2</sup>

Federal regulation 42 C.F.R. § 431.52 imposes requirements on Washington with respect to out-of-state Medicaid patients. 42 C.F.R. § 431.52; *see also* Appendix, Ex. A-2. (“**The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State’s plan**”) (emphasis added). Federal Medicaid law requires each state to assure that non-residents present in the state have access to health care services. Access to care under the federal Medicaid program is not tied to state citizenship or limited to care provided in the patient’s home state. Further, the concept of a “home state” is ultimately illusory, as home is transitory.

(2) *Home is Not Irrelevant but it Does Not Define Medicaid Residency*

---

<sup>2</sup> “The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.” 42 C.F.R. § 430.10.

A patient's initial home state is a factor for determining how a patient enrolls in Medicaid and what state issues that patient a Medicaid coverage card. However, the federal rules are practical and they are consistent with the reality that Medicaid patients are mobile, may lack a permanent home, may be institutionalized outside of the home state, and in the case of certain children may be far from kinship following an adoption or foster family placement.

Federal Medicaid law anticipates that Medicaid patients will be mobile and the Medicaid program was designed to assure continued access to care when Medicaid patients relocate. It is well recognized that Medicaid patients commonly receive health care services across state lines. 42 C.F.R. § 431.52(b) ("It is general practice for beneficiaries in a particular locality to use medical resources in another State"). Federal regulations are designed to assure that Medicaid recipients do not lose access to coverage when they move or are away from home, and importantly they are to have access to needed care throughout the country.

In pursuit of these objectives, and as discussed more fully below, the federal Medicaid rules: (1) require a state to facilitate the furnishing of medical services to patients even if the patient is enrolled in another state's Medicaid

plan<sup>3</sup>, (2) prohibit a state from conditioning enrollment in the a state's Medicaid plan based on a required residency period<sup>4</sup>, (3) provide that for some patients, mere presence in Washington results in automatic enrollment in the Washington Medicaid plan without the need for actual application, and (4) requires states to provide Medicaid eligibility cards to patients so that they have proof of coverage.<sup>5</sup>

Federal Medicaid law recognizes the administrative burden states have in assuring this coverage and access, and therefore, federal law provides a set of rules that define which state should issue a Medicaid card to a patient. However, if a patient with an out-of-state Medicaid card needs care and the states cannot agree on residency, the location of the patient is the tie breaker. 42 C.F.R. § 435.403(m) ("Where two or more States cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence").

Because home is only a factor for making Medicaid residency determinations, states can enter into interstate agreements and use their own

---

<sup>3</sup> "Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan." 42 C.F.R. § 431.52(c).

<sup>4</sup> An "agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period." 42 C.F.R. § 435.403(j).

<sup>5</sup> "A State plan for medical assistance must ... provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address." 42 U.S.C. § 1396a(48).

standards. Absent an interstate agreement, “a resident of a state is any individual who: (1) meets the conditions in 42 C.F.R. § 435.403(e) through (i); or (2) meets the criteria specified in an interstate agreement.” 42 C.F.R. § 435.403(d).

The federal residency rules are complex and residency is not the same as state citizenship, nor is it consistent with the lay concept of residency. 42 C.F.R. § 435.403(d) (*see* Appendix, Ex. A-3) sets out the federal Medicaid residency rules. For example, a person with no home base other than in Washington might, under the rules, be a Medicaid resident of one state or the other state simply depending on what type of facility the patient is occupying. *See* 42 C.F.R. § 435.403, which provides that “an individual ... placed in an institution located in another State by the agency” is a resident of the arranging state.

Under the federal rules, residency is thus situational and dependent on a number of factors such as age of the patient, enrollment in other federal programs, institutionalization, and access to a job. In light of these complexities, Washington has entered into agreements with other states.

*(3) Washington Has Achieved Administrative Simplicity by Contracting with Other States*

The Centers of Medicare and Medicaid Services (“CMS”) has acknowledged that the federal residency rules create practical problems for

patients and states, and thus it allows states to enter into agreements to override the regulatory standards for determining residency and the need to re-enroll patients when they move from one state to another. CMS acknowledged the problems when Medicaid patients travel with a Medicaid card from another state, stating that “the problems include--

- For the beneficiary, locating a sufficient number of providers willing to accept out-of-State Medicaid cards. (Some providers may be reluctant because of their unfamiliarity with the requirements of another Medicaid agency.)
- For the originating state, administrative difficulties as it attempts to guarantee service coverage and provider compliance across state lines.”

47 Fed. Reg. 28652-01 (July 1, 1982). (See Appendix, Ex. A-4.)

CMS also recognized that there were difficulties for the non-resident state (i.e. the “receiving State”), in light of its duty to establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State’s plan. The receiving State is required to address these provisions in its State Plan. 42 C.F.R. § 431.52 (“The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State’s plan.”). The Medicaid state plan must discuss its processes. CMS did not attempt to solve the practical problems associated with the issuing of Medicaid cards and making residency determinations, stating instead:

We are not currently developing procedures to solve potential administrative problems that may result from this requirement because we believe that States should be free to agree among themselves on procedures. A State may enter into an agreement with another State to facilitate the provision of Medicaid for title IV-E children who move to a second State.

Two States can agree, for example, that the receiving State would issue its Medicaid card and provide its program of Medicaid coverage, so long as the receiving State's program includes the services provided by the originating State. The two States may decide that the originating State should reimburse the receiving State for the Medicaid costs ...

Although we encourage the use of interstate agreements, for the benefit of both beneficiaries and State Medicaid agencies, the statute does not require that States develop those agreements. Section 101(a)(4)(B) of Pub. L. 96-272 [codified at 42 U.S.C. § 673a] provides that any such interstate compacts "are hereby approved by Congress".

47 Fed. Reg. 28652-01 (July 1, 1982).

CMS adopted 42 C.F.R. § 435.403(k) to support interstate agreements addressing residency determinations. It provides as follows:

A State may have a written agreement with another State setting forth rules and procedures resolving cases of disputed residency. ... The agreements must contain a procedure for providing Medicaid to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of title IV-E individuals when the child and his or her adoptive parent(s) move into another State.

Washington has done exactly what CMS encouraged; it entered into interstate agreements with every state other than New York and Wyoming. Those agreements are described in Washington's State Plan <https://www.hca.wa.gov/assets/program/MAGI-Related-Pages.pdf>, at pg. 40

(“The state has Interstate Agreements with the following selected states ...”). Washington’s interstate agreements are approved components of Washington’s 74.09 Medicaid program pursuant to 42 U.S.C. § 673a (Interstate compacts “are hereby approved by Congress”).

Thus, in accordance with the leeway provided by federal law, Washington, has made arrangements with virtually every other state to address issues that arise when a Medicaid eligible person from another state receives care in Washington. Those arrangements are part of Washington’s Medicaid state plan and are thus a component of the programs described by 74.09 RCW. Medicaid monies from other states are therefore *received* by hospitals with regards to “health care services covered under the ... medical assistance, children’s health, or other program under chapter 74.09 RCW.” RCW 82.04.4311.

(4) *CMS Adopted a Physical Presence Residency Standard for Certain Children, and Washington Has Embraced This Standard*

Many years after CMS addressed the utility of interstate agreements, Congress adopted The Fostering Connections to Success and Increasing Adoptions Act of 2008, Public Law (Pub. L.) 110–351, codified in Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b). Title IV-E provides for automatic Medicaid coverage by the state where a child with federal financial assistance under Title IV-E finds him/herself. Thus, these children are

automatically covered by the Washington Medicaid program when they come to Washington. *See*, 42 C.F.R. § 435.900 (“This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid”).

These children do not need to apply for a Washington Medicaid card when they move here and Washington cannot require these children to submit a Washington Medicaid application. Requiring an application violates federal law. 42 C.F.R. § 435.909 (“The agency must not require a separate application for Medicaid from an individual ...”). Thus, a Title IV-E child coming to Washington from Oregon may have an Oregon Medicaid card, but Washington Medicaid is responsible under the federal rules to pay for that child’s care. Oregon and Washington can however make other arrangements between themselves.

However, even before passage of the Pub. L. 110–351, states recognized the special concerns attendant on Medicaid coverage for Title VI-E children, resulting in the drafting of Interstate Compact on Adoption and Medical Assistance (the “Compact”). Washington State became a member of Interstate Compact on Placement of Children (“ICPC”) and the Interstate Compact on Adoption and Medical Assistance. *See* WAC § 388-27-0030, WSR 01-08-047, filed 3/30/01, effective 4/30/01, recodified as WAC § 110-60-0060. *See*, also WAC § 110-60-0050 (“The department [of social and health services] administers the interstate compact on the placement of children

(ICPC) and the interstate compact on adoption and medical assistance (ICAMA) and cooperates, upon request, with other state and tribal child welfare agencies in adoptive planning for children.”). Federal Medicaid law endorses the Compact by requiring that:

The Secretary of Health and Human Services shall take all possible steps to encourage and assist the various States to enter into interstate compacts (which are hereby approved by the Congress) under which the interests of any adopted child with respect to whom an adoption assistance agreement has been entered into by a State under section 673 of this title will be adequately protected, on a reasonable and equitable basis which is approved by the Secretary, if and when the child and his or her adoptive parent (or parents) move to another State.

42 U.S.C. § 673a.

In accordance with the Compact, Washington Medicaid coverage is a mandatory entitlement for a child with Title IV-E funding who comes to Washington and Washington is required to “process and pay medical assistance claims thereon as it would any other medical assistance claims of eligible residents.” Compact V(C), Appendix Ex. A-5. However, there is no required process to assure that these children receive Medicaid cards from Washington. The adoptive parents or custodians of a child may not apply for a Washington Medicaid card, particularly if the child has a card from another state. Although the Association of Administrators of the Compact “envision that, through a nationwide network of cooperation between state ICAMA Professionals, every child in an inter-jurisdictional adoption or Title IV-E

guardianship placement will have uninterrupted access to available medical services which support family permanency and stability”, <https://aaicama.org/cms/>, last accessed April 9, 2020, the reality is that the work of moving a Title IV-E child onto the Medicaid plan in the receiving State requires action by the parent/custodian; issuance of a new card is not automatic. As stated by the North American Council on Adoptable Children, “[f]amilies planning to move or adopt a child from out of state need to be proactive, check out the guidelines for receiving services and/or Medicaid in the state where they will reside, and apply as soon as they can.” <https://www.nacac.org/resource/eligibility-benefits-federal-assistance>, last accessed April 1, 2020. There are doubtless many Title IV-E children who carry a Medicaid card from their former home state.

(5) *Washington Has Focused Arrangements with its Cross-Border States*

Finally, Washington has gone beyond the national federal initiatives for interstate compacts and has elected to intertwine the Washington state Medicaid 74.09 RCW plans with plans across its state borders. The Legislature required the establishment of special reciprocal relationships with Washington’s border states under negotiated agreements. *See* RCW 74.09.171 (The Health Care Authority and the Department of Social and Health Services “must collaborate and seek opportunities to expand access to care for enrollees

in the medicaid programs identified in subsection (1) of this section living in border communities that may require contractual agreements with providers across the state border when care is appropriate, available, and cost effective.” Accordingly, all agreements with Medicaid providers “issued or renewed after July 1, 2014, must include provisions that allow for care to be accessed across-borders ensuring timely access to necessary care, including inpatient and outpatient services. The contracts must include reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.”)

#### IV. CONCLUSION

Amicus Curiae, Washington State Hospital Association, respectfully requests that the Washington Supreme Court reverse the decision of the Court of Appeals.

DATED this 10th day of April, 2020.

K&L GATES LLP

By: Carla DewBerry

Carla DewBerry, WSBA No. 15746

K&L Gates LLP

925 Fourth Ave., Suite 2900

Seattle, Washington 98104-1158

Email: [carla.dewberry@klgates.com](mailto:carla.dewberry@klgates.com)

*Attorneys for Amicus Curiae*

## APPENDIX

	<b>Page</b>
Ex. A-1, Chapter 70.39 RCWA .....	6
Ex. A-2, 42 C.F.R. § 431.52 .....	10
Ex. A-3, 42 C.F.R. § 435.403 .....	13
Ex. A-4, 47 Fed. Reg. 28652-01 (July 1, 1982).....	14
Ex. A-5, Interstate Compact on Adoption and Medical Assistance.....	18

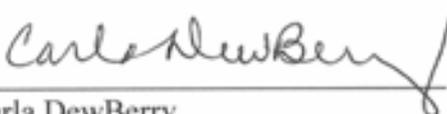
## CERTIFICATE OF SERVICE

I hereby certify that on April 10, 2020, I caused a true and correct copy of the foregoing document to be served electronically via Washington Supreme Court e-filing application, to:

<b>Petitioners:</b>	<b>Respondent:</b>
<p>PeaceHealth St. Joseph Medical Center Dirk Jay Giseburt Michele G. Radosevich David Maas Davis Wright Tremaine LLP 920 5th Avenue, Suite 3300 Seattle, WA 98104-1610</p> <p><a href="mailto:davidmaas@dwt.com">davidmaas@dwt.com</a> <a href="mailto:dirkgiseburt@dwt.com">dirkgiseburt@dwt.com</a> <a href="mailto:elainehuckabee@dwt.com">elainehuckabee@dwt.com</a> <a href="mailto:ginachan@dwt.com">ginachan@dwt.com</a> <a href="mailto:micheleradosevich@dwt.com">micheleradosevich@dwt.com</a></p>	<p>Department of Revenue Rosann Fitzpatrick Washington Attorney General P.O. Box 40123 Olympia, WA 98504-0123</p> <p><a href="mailto:rosann.fitzpatrick@atg.wa.gov">rosann.fitzpatrick@atg.wa.gov</a> <a href="mailto:wendyo@atg.wa.gov">wendyo@atg.wa.gov</a></p> <p>Department of Revenue Tera Heintz Washington Attorney General 1125 Washington Street SE P.O. Box 40100 Olympia, WA 98504-0001</p> <p><a href="mailto:tera.heintz@agt.wa.gov">tera.heintz@agt.wa.gov</a></p> <p>Dept. of Revenue A.G. Office Attorney at Law 7141 Cleanwater Lane SW P O Box 40123 Olympia, WA 98504-0123</p> <p>Email: <a href="mailto:revolyef@atg.wa.gov">revolyef@atg.wa.gov</a></p>

<p><b>Amicus Curiae:</b></p> <p>Harborview Medical Center Daniel R. Baker Attorney General's Office - UW Division 4333 Brooklyn Ave NE Seattle, WA 98195-9475</p> <p><a href="mailto:daniel.baker@atg.wa.gov">daniel.baker@atg.wa.gov</a></p>	<p><b>Amicus Curiae:</b></p> <p>Seattle Cancer Care Alliance and Seattle Children's Hospital Robert Lee Mahon, III Erin Earl Perkins Coie LLP 1201 3rd Ave., Ste. 4900 Seattle, WA 98101-3095</p> <p><a href="mailto:rmahon@perkinscoie.com">rmahon@perkinscoie.com</a> <a href="mailto:EEarl@perkinscoie.com">EEarl@perkinscoie.com</a> <a href="mailto:JFlesner@perkinscoie.com">JFlesner@perkinscoie.com</a></p>
---	---

Signed this 10th day of April, 2020, at Seattle, King County, Washington.

  
\_\_\_\_\_  
Carla DewBerry

Ex. A-1, Chapter 70.39 RCWA

## Chapter 70.39 RCW Dispositions

### HOSPITAL HEALTH CARE SERVICES — HOSPITAL COMMISSION

#### Sections

**70.39.010 Purpose of chapter — Intent of 1984 amendments.**

[1984 c 288 § 1; 1973 1st ex.s. c 5 § 2.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.020 Definitions.**

[1984 c 288 § 2; 1973 1st ex.s. c 5 § 3.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.030 Hospital commission — Created — Membership.**

[1984 c 288 § 3; 1973 1st ex.s. c 5 § 4.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.040 Hospital commission — Terms — Vacancies.**

[1984 c 288 § 4; 1977 c 36 § 1; 1973 1st ex.s. c 5 § 5.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.050 Hospital commission — Officers — Meetings — Compensation and travel expenses.**

[1984 c 288 § 5; 1984 c 287 § 104; 1973 1st ex.s. c 5 § 6.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.060 Hospital commission — Exempt staff — Other staff — Services.**

[1984 c 288 § 6; 1977 c 35 § 1; 1973 1st ex.s. c 5 § 7.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.070 Technical advisory committee — Members — Terms — Officers — Meetings — Expenses.**

[1984 c 288 § 7; 1984 c 125 § 17; 1973 1st ex.s. c 5 § 8.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.080 Technical advisory committee — Duties.**

[1984 c 288 § 8; 1973 1st ex.s. c 5 § 9.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.090 Hospital commission — Subcommittees.**

[1984 c 288 § 9; 1973 1st ex.s. c 5 § 10.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.100 Uniform system of hospital accounting and reporting — Collection of patient discharge data.**

[1984 c 288 § 10; 1973 1st ex.s. c 5 § 11.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.110 Annual reports by hospitals.**

[1984 c 288 § 11; 1973 1st ex.s. c 5 § 12.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.120 Hospital costs and finances — Analyses and studies — Reports.**

[1984 c 288 § 12; 1973 1st ex.s. c 5 § 13.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.125 Entities to furnish information to commission.**

[1984 c 288 § 24.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.130 Report to governor and legislature.**

[1987 c 505 § 58; 1984 c 288 § 13; 1977 c 75 § 82; 1973 1st ex.s. c 5 § 14.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.140 Hospital rates — Negotiated rates — Requirements — Review and investigation — Costs — Establishment of rates — Expression of rates — Hospital reimbursement control system — Certain admission practices or policies barred — Coordination with federal programs.**

[1988 c 118 § 1; 1984 c 288 § 14; 1974 ex.s. c 163 § 1; 1973 1st ex.s. c 5 § 15.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.144 Exemption from RCW 70.39.140 — Effect.**

[1988 c 262 § 1.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.150 Powers and duties of commission.**

[1984 c 288 § 18; 1977 ex.s. c 154 § 1; 1973 1st ex.s. c 5 § 16.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.160 Changes in rates — Procedure.**

[1984 c 288 § 19; 1973 1st ex.s. c 5 § 17.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.165 Identification of charity care patients — Definition of residual bad debt.**

[1984 c 288 § 15.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.170 Budget — Expenses — Assessments — Hospital commission account — Earnings.**

[1985 c 57 § 67; 1973 1st ex.s. c 5 § 18.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**Notes:**

**Reviser's note:** RCW 70.39.170 was amended by 1991 sp.s. c 13 § 1 without reference to its repeal by 1982 c 223 § 10, effective June 30, 1990. It has been decodified for publication purposes under RCW 1.12.025.

**70.39.180 Rules and regulations — Public hearings — Investigations — Subpoena power.**

[1973 1st ex.s. c 5 § 19.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.190 Review.**

[1973 1st ex.s. c 5 § 20.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.195 Schedule of hospital rates.**

[1984 c 288 § 23.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.200 Penalties for violations.**

[1984 c 288 § 20; 1973 1st ex.s. c 5 § 21.]  
Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.900 Severability — 1973 1st ex.s. c 5.**

[1973 1st ex.s. c 5 § 22.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.910 Liberal construction — 1973 1st ex.s. c 5.**

[1973 1st ex.s. c 5 § 23.]

Repealed by 1982 c 223 § 10, effective June 30, 1990.

**70.39.920 References — 1989 1st ex.s. c 9.**

Cross-reference section, decodified September 1991.

## Washington Statutes Annotated - 1990

West's RCWA T. 70, Ch. 70.39, Refs & Annos  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### HISTORICAL NOTES

#### REVISER'S NOTE—SUNSET ACT APPLICATION

1990 Pocket Part Reviser's Note—Sunset Act application

<The hospital commission is subject to review, termination, and possible extension under chapter 43.131 RCW, the Sunset Act. See RCW 43.131.253, RCW 70.39.010, 70.39.020, 70.39.030, 70.39.040, 70.39.050, 70.39.060, 70.39.070, 70.39.080, 70.39.090, 70.39.100, 70.39.110, 70.39.120, 70.39.130, 70.39.140, 70.39.150, 70.39.160, 70.39.170, 70.39.180, 70.39.190, 70.39.200, 70.39.900, and 70.39.910 are scheduled for future repeal under RCW 43.131.254.>

### REFERENCES

#### LIBRARY REFERENCES

1990 Pocket Part Library References

Hospitals ~~§~~ 3.  
C.J.S. Hospitals § 5.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.010  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.010. Purpose of chapter—Intent of 1984 amendments

The primary purpose of this chapter is to promote the economic delivery of high quality, necessary, and effective health care services to the people by establishing a hospital commission with authority over financial disclosure, budget, prospective rate approval, and other related matters, including authority to develop a hospital reimbursement control system, which will assure all purchasers of health care services that total hospital costs are reasonably related to total services, that costs do not exceed those that are necessary for prudently and reasonably managed hospitals, that hospital rates are reasonably related to aggregate costs, and that such rates are set equitably among all purchasers of these services without undue discrimination.

The legislature finds and declares that rising hospital costs are a vital concern to the people of this state because of the danger which is posed that hospital and health care services are fast becoming out of the economic reach of the majority of our population. It is further declared that health care is a right of the people and one of the primary purposes for which governments are established, and it is, therefore, essential that an effective cost control program be established. It is the legislative intent, in pursuance of this declared public policy, to provide for uniform measures on a state-wide basis to control hospital rates without the sacrifice of quality of service or reasonable access to necessary health care.

The legislature further finds and declares that: (1) There is an increased need for comprehensive public oversight of the costs of and expenditures for health care services; (2) no one should be denied access to necessary health care because of poverty or unemployment; (3) access to necessary health care in rural areas must be assured; (4) the hospital commission and the public need additional information to make better-informed decisions about health care costs and charges; (5) there is a need to encourage market penetration of alternative health care delivery systems that have internal incentives to control costs and stimulate market competition, and that some regulatory policies have impeded health care cost containment by unduly restricting competition; (6) there is a need for more effective assessment of the impact of technology on the cost and delivery of health care services so that appropriate public policies may be adopted; and (7) the hospital commission should be more representative of a diversity of public interests so that it can more effectively carry out its mission.

It is the intent of the 1984 amendments to this chapter to strengthen certain regulatory policies which have had limited success in containing hospital costs since this chapter was enacted, and to promote constructive competition among health care delivery systems.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 1.

### HISTORICAL NOTES

### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** "If any provision of this act or its application to any person or circumstance is held

invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.” [Laws 1984, ch. 288, § 27.]

#### 1975 Main Volume Historical and Statutory Notes

##### Main Volume Text

70.39.010. PurposeThe primary purpose of this chapter is to promote the economic delivery of high quality and effective hospital health care services to the people by establishing a hospital commission with authority over financial disclosure and budget and prospective rate review and other related matters, which will assure all purchasers of hospital health care services that total hospital costs are reasonably related to total services, that hospital rates are reasonably related to aggregate costs, and that such rates are set equitably among all purchasers of these services without undue discrimination.The legislature finds and declares that rising hospital costs are a vital concern to the people of this state because of the danger which is posed that hospital and health care services are fast becoming out of the economic reach of the majority of our population. It is further declared that health care is a right of the people and one of the primary purposes for which governments are established, and it is, therefore, essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs. It is the legislative intent, in pursuance of this declared public policy, to provide for uniform measures on a state-wide basis to control hospital costs without the sacrifice of quality of service.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 2.

#### REFERENCES

#### LIBRARY REFERENCES

##### 1975 Main Volume Library References

Hospitals ~~3~~3.  
C.J.S. Hospitals § 5.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.020  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.020. Definitions

As used in this chapter:

- (1) "Commission" means the hospital commission of the state of Washington as created by this chapter;
- (2) "Consumer" means any person whose occupation is other than the administration of health activities or the providing of health services, who has no fiduciary obligation to a health facility of other health agency, and who has no material financial interest in the rendering of health services;
- (3) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under chapter 71.12 RCW, but shall not include beds utilized by a comprehensive cancer center for cancer research, or any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.
- (4) "Diagnosis-related groups" is a classification system that groups hospital patients according to principal and secondary diagnosis, presence or absence of a surgical procedure, age, presence or absence of significant comorbidities or complications, and other relevant criteria, an example of which has been adopted as the basis for prospective payment under the federal medicare program by the social security amendments of 1983, Public Law 98-21.
- (5) "Medical technology" means the drugs, devices, and medical or surgical procedures used in the delivery of health care, and the organizational or supportive systems within which such care is provided.
- (6) "Technology assessment" means a comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications, including the indirect, unintended, or delayed social or economic impacts. In health care, such analysis must evaluate efficacy and safety as well as efficiency.
- (7) "Charity care" means necessary hospital health care rendered to indigent persons, to the extent that the persons are unable to pay for the care or to pay deductibles or co-insurance amounts required by a third-party payer, as determined by the commission.
- (8) "Rate" means the maximum revenue which a hospital may receive for each unit of service, as determined by the commission.
- (9) "Comprehensive cancer center" means an institution and its research programs as recognized by the National Cancer Institute prior to April 20, 1983.
- (10) "Region" means one the health service areas established pursuant to RCW 70.38.085, except that King county shall be considered a separate region for the purposes of this chapter.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 2.

### HISTORICAL NOTES

### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.020. Definitions As used in this chapter: (1) "Commission" means the hospital commission of the state of Washington as created by this chapter; (2) "Consumer" means any person whose occupation is other than the administration of health activities or the providing of health services, who has no fiduciary obligation to a health facility or other health agency, and who has no material financial interest in the rendering of health services; (3) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under chapter 71.12 RCW, but shall not include any health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 3.

ANNOTATIONS

ATTORNEY GENERAL'S OPINIONS

1990 Pocket Part Attorney General's Opinions

The hospital commission may not, under current law, require hospitals to bill their patients and/or payors on the basis of prospective fixed charges for a particular treatment as opposed to charges based on actual goods and services rendered. Op. Atty. Gen. 1983, No. 26.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.030  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.030. Hospital commission—Created—Membership

- (1) There is hereby created a hospital commission, which shall be a separate and independent commission of the state. The commission shall be composed of nine members appointed by the governor as follows:
- (a) Three members representing consumers of health care services, at least one of whom represents the interests of low-income persons;
  - (b) One member representing private employers;
  - (c) One member representing labor;
  - (d) One member representing hospitals, but in cases in which rates for an osteopathic hospital are to be considered, the representative of osteopathic hospitals on the technical advisory committee shall replace the hospital representative on the commission;
  - (e) One member representing health care professionals licensed under Title 18 RCW;
  - (f) One member representing commercial health insurers or health care service contractors; and
  - (g) The secretary of social and health services, representing the interests of the state as a major purchaser of health care services. The secretary may delegate a permanent designee in the secretary's absence.
- (2) Except for the members designated in subsection (1)(d) and (e) of this section, members shall not have any fiduciary obligation to any health care facility or any material financial interest in the provision of health care services.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 3.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

#### 1990 Pocket Part Historical and Statutory Notes

**Reviser's Note—Sunset Act application:** The hospital commission is subject to review, termination, and possible extension under chapter 43.131 RCW, the Sunset Act. See RCW 43.131.253. RCW 70.39.010, 70.39.020, 70.39.030, 70.39.040, 70.39.050, 70.39.060, 70.39.070, 70.39.080, 70.39.090, 70.39.100, 70.39.110, 70.39.120, 70.39.125, 70.39.130, 70.39.140, 70.39.150, 70.39.160, 70.39.165, 70.39.170, 70.39.180, 70.39.190, 70.39.195, 70.39.200, 70.39.900, and 70.39.910 are scheduled for future repeal under RCW 43.131.254.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

#### 1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.030. Hospital commission—Created—Membership There is hereby created a hospital commission, which shall be a separate and independent commission of the state. The commission shall be composed of five members appointed by the governor, and generally representative of the public as consumers, labor, business, and hospitals, and shall be individuals concerned with the delivery of quality health care; but in no event shall more than two members have any fiduciary obligation to a health facility or other health agency, nor any direct financial interest in the rendering of health services. In cases when proposed rate increases for osteopathic hospitals are to be considered, the representative of osteopathic hospitals on the technical advisory committee shall replace a hospital representative on the commission. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 4.

REFERENCES

LIBRARY REFERENCES

1975 Main Volume Library References

Hospitals  3.  
C.J.S. Hospitals § 5.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.040  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.040. Hospital commission—Terms—Vacancies

Except for the secretary of social and health services or the secretary's designee, members of the commission shall serve for four-year terms. Appointments shall require senate confirmation. No member shall serve on the commission for more than two consecutive terms. A vacancy shall be filled by appointment for the remainder of the unexpired term and the initial appointments and vacancies shall not require senate confirmation until the legislature next convenes. Of the three additional members, other than the secretary, appointed after June 7, 1984, two shall initially be appointed for two-year terms and one for a three-year term.

1990 Pocket Part Credit(s)

Amended by Laws 1977, ch. 36, § 1; Laws 1984, ch. 288, § 4.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.040. Hospital commission—Terms—VacanciesMembers of the commission shall serve for four-year terms and shall require senate confirmation. No member shall serve on the commission for more than two consecutive terms. A vacancy shall be filled by appointment for the remainder of the unexpired term and the initial appointments and vacancies shall not require senate confirmation until the legislature next convenes.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 5.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.050  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.050. Hospital commission—Officers—Meetings—Compensation and travel expenses

The member representing consumers of health care services shall serve as chairman. The commission shall elect from its members a vice-chairman biennially. Meetings of the commission shall be held as frequently as its duties require. The commission shall keep minutes of its meetings and adopt procedures for the governing of its meetings, minutes, and transactions.

Three members shall constitute a quorum, but a vacancy on the commission shall not impair its power to act. No action of the commission shall be effective unless three members concur therein.

The members of the commission shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses in accordance with RCW 43.03.050 and 43.03.060.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 287, § 104, eff. July 1, 1985.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Reviser's Note:** RCW 70.39.050 was amended twice during the 1984 regular session of the legislature, each without reference to the other.

For rule of construction concerning sections amended more than once at any session of the same legislature, see RCW 1.12.025.

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

**Legislative findings—Severability—Effective date—Laws 1984, ch. 287:** See Historical Note following § 43.03.220.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.050. Hospital commission—Officers—Meetings—CompensationThe member representing consumers of health care services shall serve as chairman. The commission shall elect from its members a vice-chairman biennially. Meetings of the commission shall be held as frequently as its duties require. The commission shall keep minutes of its meetings and adopt procedures for the governing of its meetings, minutes, and transactions. Three members shall constitute a quorum, but a vacancy on the commission shall not impair its power to act. No action of the commission shall be effective unless three members concur therein. The members of the commission shall receive no compensation but shall be reimbursed for their expenses while attending meetings of the commission in the same manner as legislators engaged in interim committee business as in RCW 44.04.120. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 6.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.060  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.060. Hospital commission—Exempt staff—Other staff—Services

The commission may employ a full time executive director, a deputy director, an associate director for budget and rate review, an associate director for program planning and research, and a confidential secretary who shall be exempt from the civil service law, chapter 41.06 RCW and who shall perform the duties delegated by the commission. The executive director shall be the chief administrative officer of the commission and shall be subject to its direction.

The commission shall employ such other staff as are necessary to fulfill the responsibilities and duties of the commission, such staff to be subject to the civil service law, chapter 41.06 RCW, and under the supervision of the executive director. In addition, the commission may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise.

Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility, without specific permission of the commission.

The commission may apply for and receive and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to hospital health care costs.

#### 1990 Pocket Part Credit(s)

Amended by Laws 1977, ch. 35, § 1; Laws 1984, ch. 288, § 6.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

#### 1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

#### 1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.060. Hospital commission—Director—Secretary—Staff—ServicesThe commission shall appoint a full time executive director and a deputy director and confidential secretary who shall be exempt from the civil service law, chapter 41.06 RCW and who shall perform the duties delegated by the commission. The executive director shall be the chief administrative officer of the commission and shall be subject to its direction.The secretary of the department of social and health services

shall employ and furnish such other staff as are necessary to fulfill the responsibilities and duties of the commission, such staff to be subject to the civil service law, chapter 41.06 RCW, and under the supervision of the commission and its executive director. In addition, the commission may contract with third parties for services necessary to carry out its activities where this will promote economy, avoid duplication of effort, and make best use of available expertise. Any such contractor or consultant shall be prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility, without specific permission of the commission. The commission may apply for and receive and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and may make arrangements as to the use of these receipts, including the undertaking of special studies and other projects relating to hospital health care costs. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 7.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.070  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.070. Technical advisory committee—Members—Terms—Officers—Meetings—Expenses

<Text of section as amended by Laws 1984, ch. 125, § 17>

In order to assist the commission in carrying out its duties, the governor shall appoint a technical advisory committee, hereinafter referred to as "committee", which shall consist of ten members as follows:

- (1) One member who shall be a certified public accountant licensed pursuant to chapter 18.04 RCW and who shall be knowledgeable in the financial affairs of hospitals.
- (2) One member who shall be a health care practitioner licensed under the laws of this state and who shall be knowledgeable in hospital administration.
- (3) Five members who shall be representative of the interest of investor-owned, district, not-for-profit, osteopathic, and university hospitals.
- (4) One member who shall be representative of consumers of health care.
- (5) One member who shall be the secretary of social and health services, or his designee, to provide continuing liaison, data and support from those functions of the department which may affect the responsibilities of the commission.
- (6) One member of the commission, elected by the commission.

The members shall serve concurrently and shall have four-year terms. Any vacancy shall be filled by appointment by the governor and an appointee selected to fill such vacancy shall hold office for the balance of the term for which his predecessor was appointed. The committee shall elect from its members a chairman and a vice-chairman to serve concurrently with the chairman. The executive director of the commission shall act as executive secretary to the committee, and the commission shall otherwise offer such staff services and supplies as the committee may require to carry out its responsibilities.

The committee shall meet on call of the chairman of the commission, or on request of a majority of the commission. Members of the committee shall serve without compensation but shall be reimbursed for their expenses in the same manner as members of the commission.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 125, § 17, eff. June 30, 1984.

<For text of section as amended by Laws 1984, ch. 288, § 7, see § 70.39.070, post.>

## Washington Statutes Annotated - 1990

West's RCWA 70.39.070  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

70.39.070. Technical advisory committee—Members—Terms—Officers—Meetings—Expenses

<Text of section as amended by Laws 1984, ch. 288, § 7>

In order to assist the commission in carrying out its duties, the governor shall appoint a technical advisory committee, hereinafter referred to as "committee", which shall consist of seventeen members as follows:

- (1) One member who shall be a certified public accountant licensed pursuant to chapter 18.04 RCW and who shall be knowledgeable in the financial affairs of hospitals.
- (2) Two members who shall be health care practitioners, one of whom shall be a physician, licensed under the laws of this state and who shall be knowledgeable in hospital administration.
- (3) Six members who shall be representative of the interest of investor-owned, district, not-for-profit, osteopathic, university, and rural hospitals.
- (4) One member who shall be representative of consumers of health care.
- (5) One member who shall be the secretary of the department of social and health services, or the secretary's designee, to provide continuing liaison, data and support from those functions of the department which may affect the responsibilities of the commission and to represent the department as a purchaser of health care services.
- (6) One member who shall be the executive director of the state health coordinating council established under RCW 70.38.055.
- (7) One member of the commission, elected by the commission.
- (8) One member who shall be representative of private employers.
- (9) One member who shall be representative of commercial health insurers registered and doing business in the state under Title 48 RCW.
- (10) One member who shall be representative of health care service contractors, as defined in RCW 48.44.010.
- (11) One member who shall be representative of health maintenance organizations, as defined in RCW 48.46.030.

Except for the members designated in subsections (2), (3), (10), and (11) of this section, members of the committee shall not have any fiduciary obligation to any health care facility or any material financial interest in the provision of health care services.

With the exception of members designated in subsections (5) and (6) of this section, the members shall serve concurrently and shall have four-year terms. Any vacancy shall be filled by appointment by the governor and an appointee selected to fill such vacancy shall hold office for the balance of the term for which his predecessor was appointed. The committee shall elect from its members a chairman and a vice-chairman to serve concurrently with the chairman. The executive director of the commission shall act as executive secretary to the committee, and the commission shall otherwise offer such staff services and supplies as the committee may require to carry out its responsibilities.

The committee shall meet on call of the chairman of the commission, or on request of a majority of the commission. Members of the committee shall serve without compensation for their service as members but, except for those designated in subsections (5) and (6) of this section, shall be reimbursed for their expenses in the same manner as members of the commission.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 7.

<For text of section as amended by Laws 1984, ch. 125, § 17, see § 70.39.070, ante.>

## HISTORICAL NOTES

### HISTORICAL AND STATUTORY NOTES

#### 1990 Pocket Part Historical and Statutory Notes

**Reviser's Note:** RCW 70.39.070 was amended twice during the 1984 regular session of the legislature, each without reference to the other.

For rule of construction concerning sections amended more than once at any session of the same legislature, see RCW 1.12.025.

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

**Severability—Headings—Effective date—Laws 1984, ch. 125:** See §§ 43.63A.901 through 43.63A.903.

#### 1975 Main Volume Historical and Statutory Notes

##### Main Volume Text

70.39.070. Technical advisory committee—Members—Terms—Officers—Meetings—ExpensesIn order to assist the commission in carrying out its duties, the governor shall appoint a technical advisory committee, hereinafter referred to as "committee", which shall consist of eleven members as follows:(1) One member who shall be a certified public accountant licensed pursuant to chapter 18.04 RCW and who shall be knowledgeable in the financial affairs of hospitals.(2) One member who shall be a health care practitioner licensed under the laws of this state and who shall be knowledgeable in hospital administration.(3) Five members who shall be representative of the interest of investor-owned, district, not-for-profit, osteopathic, and university hospitals.(4) One member who shall be representative of consumers of health care.(5) One member who shall be the secretary of the department of social and health services, or his designee, to provide continuing liaison, data and support from those functions of the department which may affect the responsibilities of the commission.(6) One member who shall be the director of the planning and community affairs agency, or his designee, to provide continuing liaison with the planning efforts of the comprehensive health planning council.(7) One member of the commission, elected by the commission.The members shall serve concurrently and shall have four-year terms. Any vacancy shall be filled by appointment by the governor and an appointee selected to fill such vacancy shall hold office for the balance of the term for which his predecessor was appointed. The committee shall elect from its members a chairman and a vice-chairman to serve concurrently with the chairman. The executive director of the commission shall act as executive secretary to the committee, and the commission shall otherwise offer such staff services and supplies as the committee may require to carry out its responsibilities.The committee shall meet on call of the chairman of the commission, or on request of a majority of the commission. Members of the committee shall serve without compensation but shall be reimbursed for their expenses in the same manner as members of the commission.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 8.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.080  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.080. Technical advisory committee—Duties

The committee shall have the duty upon the request of the commission to consult with and make recommendations to the commission:

- (1) On matters of public policy related to the delivery of health care services;
- (2) On rules and regulations proposed by the commission to implement this chapter;
- (3) On analyses and studies of hospital health care costs and related matters which may be undertaken by the commission;
- (4) On any issue related to medical technology or technology assessment in the area of health care; and
- (5) On such other matters as the commission may refer.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 8.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.080. Technical advisory committee—DutiesThe committee shall have the duty upon the request of the commission to consult with and make recommendations to the commission:(1) On matters of policy;(2) On rules and regulations proposed by the commission to implement this chapter;(3) On analyses and studies of hospital health care costs and related matters which may be undertaken by the commission; and(4) On such other matters as the commission may refer.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Sess 1973, ch. 5 § 9.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.090  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.090. Hospital commission—Subcommittees

To further the purposes of this chapter, the commission may create committees from its membership, and may create such ad hoc advisory committees in specialized fields, related to the functions of hospitals, the delivery of health care services, economic issues concerning health care, technology assessment, and such other subjects as it deems necessary, to supplement the resources provided by the technical advisory committee.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 9.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.090. Hospital commission—Subcommittees To further the purposes of this chapter, the commission may create committees from its membership, and may create such ad hoc advisory committees in specialized fields, related to the functions of hospitals, as it deems necessary, to supplement the resources provided by the technical advisory committee. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 10.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.100  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.100. Uniform system of hospital accounting and reporting—Collection of patient discharge data

- (1) The commission, after study and in consultation with advisory committees, if any, shall establish by the promulgation of rules and regulations pursuant to the Administrative Procedure Act, chapter 34.05 RCW, a uniform system of accounting and financial reporting, including such cost allocation methods as it may prescribe, by which hospitals shall record and report to the commission their revenues, expenses, other income, other outlays, assets and liabilities, and units of service. All hospitals shall adopt the system for their fiscal year period to be effective at such time and date as the commission shall direct. In determining the effective date for reporting requirements, the commission shall be mindful both of the immediate need for a uniform hospital reporting information to effectuate the purposes of this chapter and the administrative and economic difficulties which hospitals may encounter in conversion, but in no event shall such effective date be later than two and one-half years from the date of the formation of the commission.
- (2) In establishing such accounting systems and uniform reporting procedures, the commission shall take into consideration:
- (a) Existing systems of accounting and reporting presently utilized by hospitals;
  - (b) Differences among hospitals according to size; financial structure; methods of payment for services; and scope, type, and method of providing services; and
  - (c) Other pertinent distinguishing factors.
- (3) The commission shall, where appropriate, provide for modification, consistent with the purposes of this chapter, of reporting requirements to correctly reflect these differences among hospitals, and to avoid otherwise unduly burdensome costs in meeting the requirements of the uniform system of accounting and financial reporting.
- (4) The accounting system, where appropriate, shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred with reference to educational research and other nonpatient-related activities including but not limited to charitable activities of such hospitals.
- (5) The commission shall collect and maintain patient discharge data, including data necessary for identification of discharges by diagnosis-related groups. So far as possible, the data collection procedures shall be coordinated with any similar procedures or requirements of the federal department of health and human services for the medicare program and the needs of the department of social and health services in gathering public health statistics, in order to minimize any unduly burdensome reporting requirements imposed on hospitals.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 10.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

Severability—Laws 1984, ch. 288: See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.100. Uniform system of hospital accounting and reporting(1) The commission, after study and in consultation with advisory committees, if any, shall establish by the promulgation of rules and regulations pursuant to the Administrative Procedure Act, chapter 34.04 RCW, a uniform system of accounting and financial reporting, including such cost allocation methods as it may prescribe, by which hospitals shall record their revenues, expenses, other income, other outlays, assets and liabilities, and units of service. All hospitals shall adopt the system for their fiscal year period to be effective at such time and date as the commission shall direct. In determining the effective date for reporting requirements, the commission shall be mindful both of the immediate need for uniform hospital reporting information to effectuate the purposes of this chapter and the administrative and economic difficulties which hospitals may encounter in conversion, but in no event shall such effective date be later than two and one-half years from the date of the formation of the commission.(2) In establishing such accounting systems and uniform reporting procedures, the commission shall take into consideration:(a) Existing systems of accounting and reporting presently utilized by hospitals;(b) Differences among hospitals according to size; financial structure; methods of payment for services; and scope, type, and method of providing services; and(c) Other pertinent distinguishing factors.(3) The commission shall, where appropriate, provide for modification, consistent with the purposes of this chapter, of reporting requirements to correctly reflect these differences among hospitals, and to avoid otherwise unduly burdensome costs in meeting the requirements of the uniform system of accounting and financial reporting.(4) The accounting system, where appropriate, shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred with reference to educational research and other nonpatient-related activities including but not limited to charitable activities of such hospitals.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 11.

REFERENCES

ADMINISTRATIVE CODE REFERENCES

1990 Pocket Part Administrative Code References

In general, see WAC 261-02-010 et seq.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.110  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.110. Annual reports by hospitals

- (1) Each hospital shall file annually, at such time as the commission may prescribe, its proposed budget for the next fiscal year, showing projected revenues and expenses and including such further information as the commission may require to implement the purposes of this chapter.
- (2) Each hospital shall file annually with the commission after the close of the fiscal year:
  - (a) A balance sheet detailing the assets, liabilities, and net worth of the hospital;
  - (b) A statement of income and expenses; and
  - (c) Such other reports of the costs incurred in rendering services as the commission may prescribe.
- (3) Where more than one licensed hospital is operated by the reporting organization, the information required by this section shall be reported for each hospital separately.
- (4) The commission shall require certification of specified financial reports by the hospital's certified public accountant, and may require attestation as to such statements from responsible officials of the hospital that such reports have to the best of their knowledge and belief been prepared in accordance with the prescribed system of accounting and reporting.
- (5) All reports, except privileged medical information, filed under this chapter shall be available for public inspection and copying under RCW 42.17.250 through 42.17.340.
- (6) The commission shall inspect hospital books, audits, and records as reasonably necessary to implement the policies and purposes of this chapter.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 11.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.110. Annual reports by hospitals(1) Each hospital shall file annually with the commission after the close of the fiscal

year:(a) A balance sheet detailing the assets, liabilities, and net worth of the hospital;(b) A statement of income and expenses;(c) Such other reports of the costs incurred in rendering services as the commission may prescribe.(2) Where more than one licensed hospital is operated by the reporting organization, the information required by this section shall be reported for each hospital separately.(3) The commission shall require certification of specified financial reports by the hospital's certified public accountant, and may require attestation as to such statements from responsible officials of the hospital that such reports have to the best of their knowledge and belief been prepared in accordance with the prescribed system of accounting and reporting.(4) All reports, except privileged medical information, filed under this chapter shall be open to public inspection.(5) The commission shall have the right of inspection of hospital books, audits, and records as reasonably necessary to verify hospital reports.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 12.

## ANNOTATIONS

### ATTORNEY GENERAL'S OPINIONS

#### 1990 Pocket Part Attorney General's Opinions

The Washington state hospital commission is not authorized to require hospitals to provide it with data involving diagnosis, procedures, age and sex of patients, total charges and file tracer numbers, unrelated to any currently authorized function or activity of the commission. Op.Atty.Gen.1983, No. 26.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.120  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.120. Hospital costs and finances—Analyses and studies—Reports

- (1) The commission shall from time to time undertake analyses and studies relating to the need for and delivery of health care services, the availability of such services, hospital rates, health care costs, and the financial status of any hospital or hospitals subject to the provisions of this chapter, and may publish and disseminate such information as it deems desirable in the public interest. It shall further publish information concerning the need for health care services identified by area-wide and state comprehensive health planning agencies under chapter 70.38 RCW and the extent to which such needs are being met.
- (2) The commission shall also prepare and file such summaries and compilations or other supplementary reports based on the information filed with the commission hereunder as will advance the purposes of this chapter.
- (3) The commission shall furnish a copy of any report regarding any hospital to the chief executive officer of the hospital and the presiding officer of the hospital's governing body.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 12.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.120. Hospital costs and finances—Analyses and studies—Reports(1) The commission shall from time to time undertake analyses and studies relating to hospital health care costs and to the financial status of any hospital or hospitals subject to the provisions of this chapter, and may publish and disseminate such information as it deems desirable in the public interest. It shall further require the filing of information concerning the total financial needs of each hospital and the resources available or expected to become available to meet such needs, including the effect of proposals made by area-wide and state comprehensive health planning agencies.(2) The commission shall also prepare and file such summaries and compilations or other supplementary reports based on the information filed with the commission hereunder as will advance the purposes of this chapter.Main Volume Historical and Statutory Notes

## Washington Statutes Annotated - 1990

West's RCWA 70.39.125  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.125. Entities to furnish information to commission

Every commercial health insurer registered and doing business in the state under Title 48 RCW, every health care service contractor as defined in RCW 48.44.010, and the department of social and health services shall, upon request by the commission but not more frequently than annually, furnish to the commission such information as is readily available which may assist the commission in developing cost containment proposals with respect to the fees of licensed health care practitioners. The commission may request such information from the entities identified in this section, and from the federal department of health and human services, if and when the commission deems appropriate to accord with any requirements of federal law which may be imposed.

1990 Pocket Part Credit(s)

Enacted by Laws 1984, ch. 288, § 24.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Historical Note following § 70.39.030.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.130  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.130. Report to governor and legislature

Subject to RCW 40.07.040, the commission shall prepare and transmit each biennium to the governor and to the legislature a report of commission operations and activities for the preceding fiscal period. This report shall include such findings and recommendations as the commission believes will further the legislative goal of cost containment in the delivery of good quality health care services, including cost-containment programs that have been or might be adopted, and issues of access to good quality care. The report shall also include data on the amount and proportion of charity care provided by each hospital. The commission's report for 1986, to be submitted in January 1987, shall include an analysis of the impacts of RCW 70.39.165 on (1) the use by indigent persons of health care settings other than hospitals and (2) the caseloads and costs associated with the limited casualty program for medical indigents under RCW 74.09.700. The department of social and health services and the health systems agencies established under chapter 70.38 RCW shall provide such information and assistance as the commission may reasonably require in preparing the report on the impact of RCW 70.39.165.

#### 1990 Pocket Part Credit(s)

Amended by Laws 1977, ch. 75, § 82; Laws 1984, ch. 288, § 13; Laws 1987, ch. 505, § 58.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

#### 1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

#### 1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.130. Report to governor and legislature The commission shall prepare and, prior to each legislative session beginning in January, transmit to the governor and to members of the legislature an annual report of commission operations and activities for the preceding fiscal year. This report shall include a compilation of all summaries and reports required by this chapter, together with such findings and recommendations as the commission deems necessary. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 14.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.140  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

70.39.140. Hospital rates—Negotiated rates—Requirements—Review and investigation—Costs—Establishment of rates—Expression of rates—Hospital reimbursement control system—Certain admission practices or policies barred—Coordination with federal programs

(1)(a) From and after a date not less than twelve months but not more than twenty-four months after the adoption of the uniform system of accounting and financial reporting required by RCW 70.39.100, as the commission may direct, the commission shall have the power to initiate such reviews or investigations as may be necessary to assure all purchasers of health care services that the total costs of a hospital are reasonably related to the total services offered by that hospital, that costs do not exceed those that are necessary for prudently and reasonably managed hospitals, that the hospital's rates are reasonably related to the hospital's aggregate costs; and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference. Effective July 1, 1985, this chapter does not preclude any hospital from negotiating with and charging any particular payer or purchaser rates that are less than those approved by the commission, if:

(i) The rates are cost justified and do not result in any shifting of costs to other payers or purchasers in the current or any subsequent year; and

(ii) All the terms of such negotiated rates are filed with the commission within ten working days and made available for public inspection.

(b) The commission may retrospectively disapprove such negotiated rates in accordance with procedures established by the commission if such rates are found to contravene any provision of this section.

(c) Any hospital may charge rates as negotiated with or established by the department of social and health services. Rates negotiated or established under this subsection (c) are not subject to (a) or (b) of this subsection. Rates negotiated or established under this subsection (c) are not subject to any review or approval by the commission under this chapter.

(2) In order to properly discharge these obligations, the commission shall have full power to review projected annual revenues and approve the reasonableness of rates proposed to generate that revenue established or requested by any hospital subject to the provisions of this chapter. No hospital shall charge for services at rates exceeding those established in accordance with the procedures established hereunder. After June 30, 1985, rates for inpatient care shall be expressed using an appropriate measure of hospital efficiency, such as that based on diagnosis-related groups, and, if necessary for federal medicare participation in a hospital reimbursement control system, hospitals shall charge for such care at rates prospectively established and expressed in terms of a comparable unit of total payment, such as diagnosis-related groups. In the event any hospital reimbursement control system is implemented, children's hospitals shall be exempted until such time as a pediatric based classification system which reflects the unique resource consumption by patients of a children's hospital is perfected. For the purposes of this exemption, children's hospitals are defined as hospitals whose patients are predominantly under eighteen years of age.

(3) In the interest of promoting the most efficient and effective use of health care service, and providing greater promise of hospital cost containment, the commission may develop a hospital reimbursement control system in which all payers or purchasers participate, that includes procedures for establishing prospective rates, that deals equitably with the costs of providing charity care, and that shall include the participation of the federal medicare program under the social security amendments of 1983, Public Law 98-21. The commission shall have the authority to require utilization reviews of patient care to ensure that hospital admissions and services provided are medically justified. The commission may seek approval, concurrence, or participation in such a system from any federal agency, such as the department of health and human services, prior to securing legislative approval pursuant to concurrent resolution for implementation of any hospital reimbursement control system developed pursuant to this section. The commission shall involve the legislature in the development of any plan for a hospital reimbursement control system.

(4) The commission shall assure that no hospital or its medical staff either adopts or maintains admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage and who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is or is likely to be less than the anticipated charges for or costs of such services; or

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

(5) The commission shall serve as the state agency responsible for coordinating state actions and otherwise responding and relating to the efforts of the federal department of health and human services in planning and implementing federal cost containment programs with respect to hospitals and related health care institutions as authorized by the social security amendments of 1983, as now or hereafter amended, or other federal law, and any rules or regulations promulgated thereto. In carrying out this responsibility, the commission may assume any function or role authorized by appropriate federal regulations implementing the social security amendments of 1983; or assume any combination of such roles or functions as it may determine will most effectively contain the rising costs of the varying kinds of hospitals and related health care institutions in Washington state. In determining its functions or roles in relation to federal efforts, the commission shall seek to ensure coordination, and the reduction of duplicatory cost containment efforts, by the state and federal governments, as well as the diligent fulfillment of the purposes of this chapter and declared public policy and legislative intent herein.

Nothing in this chapter limits the ability of the department of social and health services to establish or negotiate hospital payment rates pursuant to RCW 74.09.120 or in accord with a federally approvable state plan under Title XIX of the federal social security act.<sup>1</sup>

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 14; Laws 1988, ch. 118, § 1, eff. March 18, 1988.

<sup>1</sup> 42 U.S.C.A. § 300w et seq.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.140. Hospital rates—Review and investigation—Costs—Establishment of rates—Coordination with federal programs—From and after a date not less than twelve months but not more than twenty-four months after the adoption of the uniform system of accounting and financial reporting required by RCW 70.39.100, as the commission may direct, the commission shall have the power to initiate such reviews or investigations as may be necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered by that hospital, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs; and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or

preference. In order to properly discharge these obligations, the commission shall have full power to review projected annual revenues and approve the reasonableness of rates proposed to generate that revenue established or requested by any hospital subject to the provisions of this chapter. No hospital shall charge for services at rates other than those established in accordance with the procedures established hereunder. In the interest of promoting the most efficient and effective use of hospital health care service, the commission may promote and approve alternative methods of rate determination any payment of an experimental nature that may be in the public interest and consistent with the purposes of this chapter. The commission shall serve as the state agency responsible for coordinating state actions and otherwise responding and relating to the efforts of the cost of living council, or its successor, in planning and implementing federal cost containment programs with respect to hospitals and related health care institutions as authorized by the Federal Economic Stabilization Act of 1970,<sup>1</sup> as now or hereafter amended, and any rules or regulations promulgated thereto. In carrying out this responsibility, the commission may serve as the state agency responsible for recommending increases in rates for hospitals and related health care institutions to the cost of living council, or its successor; may apply to the cost of living council for authorization to administer a control program in Washington state in lieu of the federal controls established and otherwise administered by the cost of living council; may assume another function or role authorized by appropriate federal regulations implementing the Federal Economic Stabilization Act of 1970; or assume any combination of such roles or functions as it may determine will most effectively contain the rising costs of the varying kinds of hospitals and related health care institutions in Washington state. In determining its functions or roles in relation to the efforts to the cost of living council, or its successor, the commission shall seek to ensure coordination, and the reduction of duplicatory cost containment efforts, by the state and federal governments, as well as the diligent fulfillment of the purposes of this chapter and declared public policy and legislative intent herein: *Provided, however,* That in cases where the rates of nursing homes or similar health institutions are subject to review pursuant to the provisions of the Federal Economic Stabilization Act of 1970 or any rules or regulations promulgated thereto, the members of the commission representing hospitals shall not sit in the proceedings nor vote, and the governor shall appoint an ad hoc member representing nursing homes or similar health institutions in lieu thereof, who shall have the same powers as the other members with respect to such review only.<sup>1</sup> **Note:**—For “Federal Economic Stabilization Act of 1970,” see 12 USCA § 1904 note, 12 USCS § 1904 note. Main Volume Historical and Statutory Notes

1. Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 15.

2. Amended by Laws 1st Ex.Sess., 1974, ch. 163 § 1, effective April 29, 1974, substituting the last paragraph for the former last paragraph which read: “For the purposes of the Federal Economic Stabilization Act of 1970, as now or hereafter amended, the commission shall serve as the state agency responsible for recommending increases in rates for hospital and related health care institutions to the federal price commission or its successor: *Provided, however,* That in cases where the rates of nursing homes or similar health institutions are subject to federal review the members of the commission representing hospitals shall not sit in the proceedings nor vote, and the governor shall appoint an ad hoc member representing nursing homes or similar health institutions in lieu thereof, who shall have the same powers as the other members with respect to such federal review only.”

## REFERENCES

### CROSS REFERENCES

#### 1990 Pocket Part Cross References

Exemption for certain hospitals, see § 70.39.144.

### ADMINISTRATIVE CODE REFERENCES

#### 1990 Pocket Part Administrative Code References

Review and approval of annual budget submittals, rates, rate schedules, and charges, see WAC 261-40-010 et seq.

ANNOTATIONS

ATTORNEY GENERAL'S OPINIONS

1990 Pocket Part Attorney General's Opinions

A public hospital district meeting requirements of this section may give a percentage discount on its public rates approved by State Hospital Commission. Op.Atty.Gen. 1986, No. 8.

The hospital commission may not, under current law, require all payors, including health care contractors, indemnity insurance carriers, and self-insured or private payors, to reimburse hospitals on the basis of prospective fixed charges for a particular treatment as opposed to charges based on actual goods and services rendered. Op.Atty.Gen.1983, No. 26.

Assuming a system of reimbursement based upon prospective fixed charges for a particular treatment, the hospital commission may not, under current law, permit a hospital to retain excess revenues generated as a result of cost efficient practices by the hospital. Op.Atty.Gen.1983, No. 26.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.144  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.144. Exemption from RCW 70.39.140—Effects

- (1) The commission shall exempt a hospital from the rate review and approval provisions of RCW 70.39.140 if:
- (a) The hospital is located within fifteen miles of one or more hospitals located in a jurisdiction that is not subject to RCW 70.39.140; and
  - (b) The hospital or hospitals not subject to RCW 70.39.140 have the existing capacity to absorb twenty-five percent or more of the patients served by the hospital exempted under this section.
- (2) The exemption provided by this section shall not affect the exempted hospital's responsibility to make on a timely basis all filings required by the commission pursuant to this chapter. In addition, an exempted hospital shall provide on a timely basis other pertinent data that may be requested from time to time by the commission.
- (3) This section shall expire June 30, 1991.

1990 Pocket Part Credit(s)

Enacted by Laws 1988, ch. 262, § 1.

### EXPIRATION

<This section expires June 30, 1991, by its own terms>

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.150  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.150. Powers and duties of commission

To properly carry out its authority the commission shall:

- (1) Compile and maintain all relevant financial, accounting, and patient discharge data in order to have available the statistical information necessary to properly conduct rate review and approval. Such data shall include necessary operating expenses, appropriate expenses incurred for charity care and for rendering services to patients who do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved. The commission shall define and describe by rule and regulation the types and classes of charges which cannot be changed except as provided by the procedure contained in RCW 70.39.160 and it shall also obtain from each such hospital a current rate schedule as well as any subsequent amendments or modifications of that schedule as it may require. So far as possible, the commission shall compile and maintain the same patient discharge data with respect to all patients as that required under the federal medicare program and the uniform billing procedures applicable to third-party payers.
- (2) Permit any hospital subject to the provisions of this chapter to charge reasonable rates which will permit the hospital to render necessary, effective, and efficient service in the public interest.
- (3) Take into account, in the determination of reasonable rates under this section, that it is its obligation to assure access to necessary, effective, economically viable, and efficient hospital health care capability throughout the state, rather than the solvency or profitability of any individual hospital subject to this chapter except where the insolvency of a hospital would seriously threaten the access of the rural public to basic health care services.
- (4) Take into account, in the determination of reasonable rates under this section for each hospital, the recommendations of appropriate area-wide and state comprehensive health planning agencies to ensure compliance with Washington comprehensive health planning law, chapter 70.38 RCW.
- (5) Permit any hospital, whether proprietary, district, public, or not-for-profit, to retain the excess of its revenues, if any, that exceed the actual cost of providing services, generated as a result of cost-effective practices, if the hospital charges do not exceed rates permitted by the commission.
- (6) On or before October 1 of each year, after notice and public hearing, and in full consideration of the intent and purpose of this chapter as expressed in RCW 70.39.010, adopt a target dollar amount of total state-wide hospital revenue for the ensuing calendar year. To set the target amount, the commission shall develop a standard methodology that considers such factors as changes in the economy, affordability of hospital care, cost of hospital-purchased goods, numbers and age of the population, technology, and severity of illness of hospital patients. The commission shall endeavor, in establishing rates, to assure that total hospital revenues do not exceed the target amount for the applicable year.

1990 Pocket Part Credit(s)

Amended by Laws 1977, Ex.Sess., ch. 154, § 1; Laws 1984, ch. 288, § 18.

### HISTORICAL NOTES

### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

## 1975 Main Volume Historical and Statutory Notes

### Main Volume Text

70.39.150. Powers and duties of commission To properly carry out its authority the commission shall: (1) Immediately upon July 16, 1973 begin to compile all relevant financial and accounting data in order to have available the statistical information necessary to properly conduct rate review and approval. Such data shall include necessary operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved. The commission shall define and prescribe by rule and regulation the types and classes of charges which cannot be changed except as provided by the procedure contained in RCW 70.39.160 and it shall also contain from each such hospital a current rate schedule as well as any subsequent amendments or modifications of that schedule as it may require. (2) Permit any nonprofit hospital subject to the provisions of this chapter to charge reasonable rates which will permit the hospital to render effective and efficient service in the public interest and on a solvent basis. (3) Permit any proprietary profit-making hospital subject to the provisions of this chapter to charge reasonable rates which will permit the hospital to render effective and efficient service in the public interest and which includes an allowance for a fair return to stockholders based upon actual investment or the fair value of the investment, whichever is less. (4) Take into account, in the determination of reasonable rates under this section for each hospital, the recommendations of appropriate area-wide and state comprehensive health planning agencies to ensure compliance with Washington comprehensive health planning law, chapter 70.38 RCW. (5) Permit, in considering a request for change in or initiating a review of rate schedules or other charges, any hospital subject to the provisions of this chapter to charge rates which will in the aggregate produce sufficient total revenue for the hospital to meet all of the reasonable obligations specified in this chapter. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 16.

### ANNOTATIONS

#### ATTORNEY GENERAL'S OPINIONS

##### 1990 Pocket Part Attorney General's Opinions

The hospital commission may not, under current law, require hospitals to bill their patients and/or payors on the basis of prospective fixed charges for a particular treatment as opposed to charges based on actual goods and services rendered. Op.Atty.Gen.1983, No. 26.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.160  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.160. Changes in rates—Procedure

From and after the date determined by the commission pursuant to RCW 70.39.140, no hospital subject to the provisions of this chapter shall change or amend that schedule of rates and charges of the type and class which cannot be changed without prior approval of the commission, except in accordance with the following procedure:

(1) Any request for a change in rate schedules or other charges must be filed in writing in the form and content prescribed by the commission and with such supporting data as the hospital seeking the change deems appropriate. Unless the commission orders otherwise as provided for in subsection (4) of this section, no hospital shall establish such changes except after publication and notice to the commission of at least thirty days from the time the rate is intended to go into effect. All proposed changes shall be plainly indicated on the schedule effective at that time and shall be open to public inspection. Upon receipt of notice, the commission may suspend the effective date of any proposed change. In any such case a formal written statement of the reasons for the suspension will be promptly submitted to the hospital. Unless suspended, any proposed change shall go into effect upon the date specified in the application.

(2) In any case where such action is deemed necessary, the commission shall promptly, but in any event within thirty days, institute proceedings as to the reasonableness of the proposed changes. The suspension may extend for a period of not more than thirty days beyond the date the change would otherwise go into effect: *Provided*, That should it be necessary, the commission may extend the suspension for an additional thirty days. After the expiration of ninety days from the date the rate is intended to go into effect the new rate will go into effect, if the commission does not approve, disapprove, or modify the request by that time.

(3) Such proposed changes shall be considered at a public hearing, the time and place of which shall be determined by the commission. The hearing shall be conducted by the commission. Evidence for and against the requested change may be introduced at the time of the hearing by any interested party and witnesses may be heard. The hearing may be conducted without compliance with formal rules of evidence.

(4) The commission may, in its discretion, permit any hospital to make a temporary change in rates which shall be effective immediately upon filing and in advance of any review procedure when it deems it in the public interest to do so. Notwithstanding such temporary change in rates, the review procedures set out in this section shall be conducted by the commission as soon thereafter as is practicable.

(5) Every decision and order of the commission in any contested proceeding shall be in writing and shall state the grounds for the commission's conclusions. The effects of such orders shall be prospective in nature.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 19.

### HISTORICAL NOTES

### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.160. Changes in rates—Procedure From and after the date determined by the commission pursuant to RCW 70.39.140, no hospital subject to the provisions of this chapter shall change or amend that schedule of rates and charges of the type and class which cannot be changed without prior approval of the commission, except in accordance with the following procedure:(1) Any request for a change in rate schedules or other charges must be filed in writing in the form and content prescribed by the commission and with such supporting data as the hospital seeking the change deems appropriate. Unless the commission orders otherwise as provided for in subsection (4) of this section, no hospital shall establish such changes except after notice to the commission of at least thirty days from the time the rate is intended to go into effect. Upon receipt of notice, the commission may suspend the effective date of any proposed change. In any such case a formal written statement of the reasons for the suspension will be promptly submitted to the hospital. Unless suspended, any proposed change shall go into effect upon the date specified in the application.(2) In any case where such action is deemed necessary, the commission shall promptly, but in any event within thirty days, institute proceedings as to the reasonableness of the proposed changes. The suspension may extend for a period of not more than thirty days beyond the date the change would otherwise go into effect: *Provided*, That should it be necessary, the commission may extend the suspension for an additional thirty days. After the expiration of ninety days from the date the rate is intended to go into effect the new rate will go into effect, if the commission does not approve, disapprove, or modify the request by that time.(3) Such proposed changes shall be considered at a public hearing, the time and place of which shall be determined by the commission. The hearing shall be conducted by the commission. Evidence for and against the requested change may be introduced at the time of the hearing by any interested party and witnesses may be heard. The hearing may be conducted without compliance with formal rules of evidence.(4) The commission may, in its discretion, permit any hospital to make a temporary change in rates which shall be effective immediately upon filing and in advance of any review procedure when it deems it in the public interest to do so. Notwithstanding such temporary change in rates, the review procedures set out in this section shall be conducted by the commission as soon thereafter as is practicable.(5) Every decision and order of the commission in any contested proceeding shall be in writing and shall state the grounds for the commission's conclusions. The effects of such orders shall be prospective in nature.

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 17.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.165  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.165. Identification of charity care patients—Definition of residual bad debt

Within six months of June 7, 1984, the commission shall establish by rule, consistent with the definition of charity care under RCW 70.39.020, the following:

- (1) Uniform procedures, data requirements, and criteria for identifying patients receiving charity care;
- (2) A definition of residual bad debt as a component of hospital rate-setting and budget review, including reasonable and uniform standards for collection procedures to be used in efforts to collect the unpaid portions of hospital charges that are the patient's responsibility.

1990 Pocket Part Credit(s)

Enacted by Laws 1984, ch. 288, § 15.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Historical Note following § 70.39.030.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.170  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.170. Budget—Expenses—Assessments—Hospital commission account—Earnings

The commission shall biennially prepare a budget which shall include its estimated income and expenditures for administration and operation for the biennium, to be submitted to the governor for transmittal to the legislature for approval. Expenses of the commission shall be financed by assessment against hospitals in an amount to be determined biennially by the commission, but not to exceed four one-hundredths of one percent of each hospital's gross operating costs to be levied and collected from and after July 1, 1973 for the provision of hospital services for its last fiscal year ending on or before June 30th of the preceding calendar year. Budgetary requirements in excess of that limit may be financed by a general fund appropriation by the legislature. All moneys collected are to be deposited by the state treasurer in the hospital commission account which is hereby created in the state treasury. All earnings of investments of balances in the hospital commission account shall be credited to the general fund.

Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the commission in succeeding years.

1990 Pocket Part Credit(s)

Amended by Laws 1985, ch. 57, § 67, eff. July 1, 1985.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

**Effective Date—Laws 1986, ch. 57:** See Historical Note following § 15.52.030.

1975 Main Volume Historical and Statutory Notes

Main Volume Text

70.39.170. Budget—Expenses—Assessments—Hospital commission accountThe commission shall biennially prepare a budget which shall include its estimated income and expenditures for administration and operation for the biennium, to be submitted to the governor for transmittal to the legislature for approval.Expenses of the commission shall be financed by assessment against hospitals in an amount to be determined biennially by the commission, but not to exceed four one-hundredths of one percent of each hospital's gross operating costs to be levied and collected from and after July 1, 1973 for the provision of hospital services for its last fiscal year ending on or before June 30th of the preceding calendar year.

Budgetary requirements in excess of that limit may be financed by a general fund appropriation by the legislature. All moneys collected are to be deposited by the state treasurer in the hospital commission account in the general fund which is hereby created. Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the commission in succeeding years. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 18.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.180  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.180. Rules and regulations—Public hearings—Investigations—Subpoena power

In addition to the powers granted to the commission elsewhere in this chapter, the commission may:

- (1) Adopt, amend, and repeal rules and regulations respecting the exercise of the powers conferred by this chapter, subject to the provisions of the Administrative Procedure Act, chapter 34.04 RCW applicable to the promulgation of rules and regulations.
- (2) Hold public hearings, conduct investigations, and subpoena witnesses, papers, records, and documents in connection therewith. The commission may administer oaths or affirmations in any hearing or investigation.
- (3) Exercise, subject to the limitations and restrictions herein imposed, all other powers which are reasonably necessary or essential to carry out the expressed objects and purposes of this chapter.

#### HISTORICAL NOTES

##### HISTORICAL AND STATUTORY NOTES

###### 1990 Pocket Part Historical and Statutory Notes

**Reviser's Note:** Effective July 1, 1989, references in this section to chapter 34.04 RCW will be changed to chapter 34.05 RCW pursuant to 1988 c 288 § 706.

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

###### 1975 Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 19.

#### REFERENCES

##### ADMINISTRATIVE CODE REFERENCES

###### 1990 Pocket Part Administrative Code References

In general, see WAC 261-02-010 et seq.

#### LIBRARY REFERENCES

## Washington Statutes Annotated - 1990

West's RCWA 70.39.190  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.190. Review

Any person aggrieved by a final determination of the commission as to any rule, regulation, or determination under the provisions of this chapter shall be entitled to an administrative hearing and judicial review in accordance with the Administrative Procedure Act, chapter 34.04 RCW.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Reviser's Note:** Effective July 1, 1989, references in this section to chapter 34.04 RCW will be changed to chapter 34.05 RCW pursuant to 1988 c 288 § 706.

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 20.

### REFERENCES

#### LIBRARY REFERENCES

1975 Main Volume Library References

Hospitals  3.  
C.J.S. Hospitals § 5.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.195  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.195. Schedule of hospital rates

Each hospital under this chapter shall print and make available for public inspection as prescribed by the commission by rule a schedule of its rates as approved by the commission.

1990 Pocket Part Credit(s)

Enacted by Laws 1984, ch. 288, § 23.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Historical Note following § 70.39.030.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.200  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.200. Penalties for violations

Every person who shall violate or knowingly aid and abet the violation of this chapter or any valid orders, rules, or regulations thereunder, or who fails to perform any act which it is herein made his duty to perform shall be guilty of a misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation. The commission has authority to levy civil penalties not exceeding one thousand dollars for violations of this chapter.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 20.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.200. Penalties for violationsEvery person who shall violate or knowingly aid and abet the violation of this chapter or any valid orders, rules, or regulations thereunder, or who fails to perform any act which it is herein made his duty to perform shall be guilty of a misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation.Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 21.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.900  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

70.39.900. Severability—1973 1st ex.s. c 5

If any provision of this 1973 act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 22.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.910  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

70.39.910. Liberal construction—1973 1st ex.s. c 5

Consistent with the purposes enumerated in RCW 70.39.010, the provisions of this chapter shall be liberally construed, and shall not be limited by any rule of strict construction.

### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Reviser's Note preceding § 70.39.010.

1975 Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 23.

### REFERENCES

#### LIBRARY REFERENCES

1975 Main Volume Library References

Hospitals  3.  
C.J.S. Hospitals § 5.

---

End of Document

© 2020 Thomson Reuters. No claim to original U.S. Government Works.

## Washington Statutes Annotated - 1990

West's RCWA 70.39.200  
WEST'S REVISED CODE OF WASHINGTON ANNOTATED  
TITLE 70. PUBLIC HEALTH AND SAFETY  
CHAPTER 70.39—HOSPITAL HEALTH CARE SERVICES—HOSPITAL COMMISSION

### 70.39.200. Penalties for violations

Every person who shall violate or knowingly aid and abet the violation of this chapter or any valid orders, rules, or regulations thereunder, or who fails to perform any act which it is herein made his duty to perform shall be guilty of a misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation. The commission has authority to levy civil penalties not exceeding one thousand dollars for violations of this chapter.

1990 Pocket Part Credit(s)

Amended by Laws 1984, ch. 288, § 20.

#### HISTORICAL NOTES

#### HISTORICAL AND STATUTORY NOTES

1990 Pocket Part Historical and Statutory Notes

**Sunset Act application:** See Revisor's Note preceding § 70.39.010.

**Severability—Laws 1984, ch. 288:** See Historical Note following § 70.39.010.

1975 Main Volume Historical and Statutory Notes

#### Main Volume Text

70.39.200. Penalties for violations Every person who shall violate or knowingly aid and abet the violation of this chapter or any valid orders, rules, or regulations thereunder, or who fails to perform any act which it is herein made his duty to perform shall be guilty of a misdemeanor. Following official notice to the accused by the commission of the existence of an alleged violation, each day upon which a violation occurs shall constitute a separate violation. Any person violating the provisions of this chapter may be enjoined from continuing such violation. Main Volume Historical and Statutory Notes

Enacted by Laws 1st Ex.Sess., 1973, ch. 5 § 21.

Exhibit A-2, 42 CFR 431.52

### § 431.52

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers; or

(3) Subject to paragraph (b)(2) of this section, restricting recipients' free choice of providers in accordance with one or more of the exceptions set forth in § 431.54, or under a waiver as provided in § 431.55; or

(4) Limiting the providers who are available to furnish targeted case management services defined in § 440.169 of this chapter to target groups that consist solely of individuals with developmental disabilities or with chronic mental illness. This limitation may only be permitted so that the providers of case management services for eligible individuals with developmental disabilities or with chronic mental illness are capable of ensuring that those individuals receive needed services.

(d) *Certification requirement*—(1) *Content of certification.* If a State implements a project under one of the exceptions allowed under § 431.54 (d), (e) or (f), it must certify to CMS that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met.

(2) *Timing of certification.* (i) For an exception under § 431.54(d), the State may not institute the project until after it has submitted the certification and CMS has made the findings required under the Act, and so notified the State.

(ii) For exceptions under § 431.54 (e) or (f), the State must submit the certificate by the end of the quarter in which it implements the project.

[56 FR 8847, Mar. 1, 1991, as amended at 67 FR 41094, June 14, 2002; 72 FR 68091, Dec. 4, 2007]

### § 431.52 Payments for services furnished out of State.

(a) *Statutory basis.* Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) *Payment for services.* A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a

### 42 CFR Ch. IV (10–1–11 Edition)

recipient who is a resident of the State, and any of the following conditions is met:

(1) Medical services are needed because of a medical emergency;

(2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

(c) *Cooperation among States.* The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

### § 431.53 Assurance of transportation.

A State plan must—

(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and

(b) Describe the methods that the agency will use to meet this requirement.

[74 FR 31195, June 30, 2009]

### § 431.54 Exceptions to certain State plan requirements.

(a) *Statutory basis*—(1) Section 1915(a) of the Act provides that a State shall not be deemed to be out of compliance with the requirements of sections 1902(a)(1), (10), or (23) of the Act solely because it has elected any of the exceptions set forth in paragraphs (b) and (d) through (f) of this section.

(2) Section 1915(g) of the Act provides that a State may provide, as medical assistance, targeted case management services under the plan without regard to the requirements of sections 1902(a)(1) and 1902(a)(10)(B) of the Act.

(b) *Additional services under a prepayment system.* If the Medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the State plan, the agency may restrict the provision of the additional services to

Exhibit A-3, 42 CFR 435.403

**§ 435.402**

categories specified by the agency under § 435.121.

**§ 435.402 [Reserved]**

**§ 435.403 State residence.**

(a) *Requirement.* The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in § 431.52 of this chapter.

(b) *Definition.* For purposes of this section—*Institution* has the same meaning as *Institution* and *Medical institution*, as defined in § 435.1010. For purposes of State placement, the term also includes *foster care homes*, licensed as set forth in 45 CFR 1355.20, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

(c) *Incapability of indicating intent.* For purposes of this section, an individual is considered incapable of indicating intent if the individual—

(1) Has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the mental retardation agency in the State;

(2) Is judged legally incompetent; or

(3) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of mental retardation.

(d) *Who is a State resident.* A resident of a State is any individual who:

(1) Meets the conditions in paragraphs (e) through (i) of this section; or

(2) Meets the criteria specified in an interstate agreement under paragraph (k) of this section.

(e) *Placement by a State in an out-of-State institution—(1) General rule.* Any agency of the State, including an entity recognized under State law as being under contract with the State for such purposes, that arranges for an individual to be placed in an institution located in another State, is recognized as acting on behalf of the State in making a placement. The State arranging or actually making the placement is considered as the individual's State of residence.

**42 CFR Ch. IV (10–1–11 Edition)**

(2) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a State placement. However, the following actions do not constitute State placement:

(i) Providing basic information to individuals about another State's Medicaid program, and information about the availability of health care services and facilities in another State.

(ii) Assisting an individual in locating an institution in another State, provided the individual is capable of indicating intent and independently decides to move.

(3) When a competent individual leaves the facility in which the individual is placed by a State, that individual's State of residence for Medicaid purposes is the State where the individual is physically located.

(4) Where a placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence for Medicaid purposes.

(f) *Individuals receiving a State supplementary payment (SSP).* For individuals of any age who are receiving an SSP, the State of residence is the State paying the SSP.

(g) *Individuals receiving Title IV-E payments.* For individuals of any age who are receiving Federal payments for foster care and adoption assistance under title IV-E of the Social Security Act, the State of residence is the State where the child lives.

(h) *Individuals under Age 21.* (1) For any individual who is emancipated from his or her parents or who is married and capable of indicating intent, the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(2) For any individual not residing in an institution as defined in paragraph (b) whose Medicaid eligibility is based on blindness or disability, the State of residence is the State in which the individual is living.

(3) For any other non-institutionalized individual not subject to paragraph (h)(1) or (h)(2) of this section, the

State of residence is determined in accordance with 45 CFR 233.40, the rules governing residence under the AFDC program.

(4) For any institutionalized individual who is neither married nor emancipated, the State of residence is—

(i) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or

(ii) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's).

(iii) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(i) *Individuals Age 21 and over.* (1) For any individual not residing in an institution as defined in paragraph (b), the State of residence is the State where the individual is—

(i) Living with the intention to remain there permanently or for an indefinite period (or if incapable of stating intent, where the individual is living); or

(ii) Living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is—

(i) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate States (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's);

(ii) The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the

guardian is used instead of the parent's); or

(iii) The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's).

(iv) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(3) For any institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement.

(4) For any other institutionalized individual, the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(j) *Specific prohibitions.* (1) The agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period.

(2) The agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in the State before entering the institution.

(3) The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

(k) *Interstate agreements.* A State may have a written agreement with another State setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in paragraphs (c) through (i) of this section, but must not include criteria that result in loss of residency in both

**§ 435.404**

**42 CFR Ch. IV (10–1–11 Edition)**

States or that are prohibited by paragraph (j) of this section. The agreements must contain a procedure for providing Medicaid to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of title IV-E individuals when the child and his or her adoptive parent(s) move into another State.

(l) *Continued Medicaid for institutionalized recipients.* If an agency is providing Medicaid to an institutionalized recipient who, as a result of this section, would be considered a resident of a different State—

(1) The agency must continue to provide Medicaid to that recipient from June 24, 1983 until July 5, 1984, unless it makes arrangements with another State of residence to provide Medicaid at an earlier date; and

(2) Those arrangements must not include provisions prohibited by paragraph (h) of this section.

(m) *Cases of disputed residency.* Where two or more States cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence.

[49 FR 13531, Apr. 5, 1984, as amended at 55 FR 48609, Nov. 21, 1990; 71 FR 39222, July 12, 2006]

**§ 435.404 Applicant's choice of category.**

The agency must allow an individual who would be eligible under more than one category to have his eligibility determined for the category he selects.

**§ 435.406 Citizenship and alienage.**

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—

(1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and

(ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407.

(iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in para-

graphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and recipients under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.

(iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.

(v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.

(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(b) The agency must provide payment for the services described in § 440.255(c) of this chapter to residents of the State

Ex. A-4, 47 Fed. Reg. 28652-01 (July 1, 1982)

are broadly representative of the health service area. The consumer majority must include individuals representing the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area and major purchasers of health care in the area.

(i) The purpose of the requirements of this subparagraph is to ensure that each health systems agency will be governed by a body with a consumer majority which, looked at as a whole, includes and may reasonably be expected to consider and articulate the interests of all segments of the population of its health service area in carrying out its health planning functions. Accordingly, while no specific quotas or percentages of representation are required, the Secretary must be satisfied that the consumer majority of the governing body is broadly representative of the entire population of the area. In particular, the following groups must be represented on the consumer majority:

- (A) Each identifiable racial or linguistic population group which constitutes at least ten percent of the population of the area;
- (B) Lower, middle and upper income economic groups;
- (C) Women;
- (D) Persons age 65 and over; and
- (E) The handicapped, as that term is defined in Section 504 of the Rehabilitation Act of 1973 (see also paragraph (b)(3)(iv) of this section).

(ii) In order to be considered a representative of a specific population group, an individual must either be a member of that group or have been selected as a representative by an organization composed primarily of members of that group.

(iii) For purposes of this paragraph, "major purchaser of health care" means an entity (including a labor organization or a business corporation), other than an entity described in paragraph (b)(2) of this section, which either directly or indirectly (such as through the purchase of group health insurance or hospital or medical service benefits) provides health care for its employees, members, or beneficiaries.

(2) *Provider composition requirements.* The remainder of the members shall be residents of, or individuals whose principal place of business is in, the health service area served by the agency who are providers of health care and who represent:

- (i) Physicians (particularly practicing physicians), dentists, nurses, optometrists, podiatrists, physician assistants, and other health professionals;

- (ii) Health care institutions (particularly hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, and health maintenance organizations);

- (iii) Health care insurers;
- (iv) Health professional schools (which include schools of medicine, dentistry, osteopathy, optometry, podiatry, pharmacy and veterinary medicine as defined in section 724(4) of the Act, and schools of nursing as defined in section 853 of the Act);

- (v) The allied health professions; and
- (vi) Other providers of health care. At least one-half of the providers of health care who are members of the governing body shall be direct providers of health care, at least one of whom must be a person engaged in the administration of a hospital.

(3) *Miscellaneous composition requirements.* The total membership as described in paragraphs (b)(1) and (b)(2) of this section shall:

- (i) Include (either through consumer or provider members) at least one public elected official and at least one other representative of a unit of general purpose local government in the agency's health service area. To be considered a representative of a unit of general purpose local government, an individual must be appointed by that unit or a combination of such units. Where the health service area of the agency includes an entire State, the government of that State shall be deemed to be a unit of general purpose local government for purposes of this subsection;

- (ii) Include representatives of public and private agencies in the area concerned with health;

- (iii) Include a percentage of individuals who reside in nonmetropolitan areas within the health service area that is at least equal to the percentage of residents of the area who reside in nonmetropolitan areas;

- (iv) Include at least one consumer and one provider member who are knowledgeable about mental health services. The requirement of this subsection pertaining to consumer membership and the requirement of paragraph (b)(1)(i)(E) pertaining to representation of the handicapped may not be satisfied by the designation of a single individual to serve in both capacities;

- (v) If the agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans Administration, include, as a nonvoting, ex officio member, an individual whom the Chief Medical Director of the Veterans Administration

shall have designated for that purpose. A member appointed under this subsection shall not be considered in determining the number of members of the governing body for purposes of the numerical limits prescribed by paragraph (c) of this section; and

- (vi) If the agency serves a health service area in which there is located one or more health maintenance organizations, include at least one member who is representative of such organizations. For purposes of this subsection, a health maintenance organization shall be considered to be "located in" a health service area if (A) more of the HMO's enrollees reside in the area than in any other health service area, or (B) a health service delivery facility owned or operated by the organization is located in the area, or (C) a substantial number of area residents are enrollees of a health maintenance organization, or (D) a number of physicians are providing health care services to HMO members in the health service area through an independent practice association model health maintenance organization.

#### § 122.104 [Amended]

2. Section 122.104(b)(1)(iii)(D) is removed.

[Sec. 1512(a) of the Public Health Service Act (42 U.S.C. 300f-1(a)).

[FR Doc. 82-17948 Filed 5-30-82; 8:45 am]

BILLING CODE 4160-15-M

#### Health Care Financing Administration 42 CFR Parts 431, 435, and 436

#### Medicaid Program; Entitlement of Children for Whom Payments Are Made Under the Foster Care Maintenance Payments Program or the Adoption Assistance Program

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Final rule.

**SUMMARY:** These final regulations implement the Medicaid provisions of the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272). That law established a new title IV-E of the Social Security Act, providing for adoption subsidies for certain hard-to-place children and for an expanded foster care program. Under the law, children for whom adoption assistance of foster care maintenance payments are made are entitled to Medicaid. These final regulations specify that the State making payments for a child under its

title IV-E program is also responsible for Medicaid for that child.

**EFFECTIVE DATE:** September 29, 1982.

**FOR FURTHER INFORMATION CONTACT:** Marinos T. Svolos, (301) 594-9052.

**SUPPLEMENTARY INFORMATION:**

**A. Background**

The Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272), enacted June 17, 1980, seeks to assure adequate planning and services to—(1) alleviate family problems that would otherwise result in a child's removal from home; and (2) provide alternative care for a child who cannot return home. The law created a new title IV-E of the Social Security Act (the Act), which replaces the foster care program under title IV-A (Aid to Families with Dependent Children (AFDC)) and establishes an adoption assistance program that provides continuing adoption subsidies, Medicaid, and title XX (social services) benefits for hard-to-place children with special needs. (Additional changes were made by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, which amended title XX to create the Social Services Block Grant and gave States flexibility to determine whether to provide social services to title IV-E individuals.)

The children covered under the adoption program are those who are eligible for AFDC, title IV-E foster care maintenance payments, or Supplemental Security Income (SSI). Regulations implementing the adoption assistance program will be published separately by the Office of Human Development Services.

In addition to providing Federal funds to finance continuing adoption assistance for hard-to-place SSI, AFDC, and title IV-E foster care children with special needs, Pub. L. 96-272 also entitles two new groups to benefits under the foster care maintenance payment program: (1) certain children voluntarily removed from their homes; and (2) children in public non-detention-type child-care facilities that house no more than 25 children. Previously, the law had provided reimbursement for foster care only for children removed from their homes as a result of a judicial determination, and did not permit Federal funds for foster care provided for children in public institutions.

The new provisions of law mandate Medicaid eligibility for all children for whom payments are made under the foster care maintenance payments program or the adoption assistance program. These children are deemed to be recipients of AFDC under title IV-A of the Act. This is required by sections

472(h) and 473(b) of the Act which were added by section 101 of Pub. L. 96-272. (Effective October 1, 1983, section 472(h) will be redesignated as 472(d)). Since AFDC recipients are automatically eligible for Medicaid by virtue of their AFDC recipient status, Pub. L. 96-272, by providing for "deemed" AFDC recipient status, provides mandatory Medicaid coverage for these individuals.

Usually, when a recipient of a cash assistance program that is linked to Medicaid moves to another State, the individual loses eligibility for that cash assistance program (and Medicaid) in the originating State, and is covered for both programs by the new State if he or she meets that State's requirements.

However, section 475(3)(B) of the Act and section 101(a)(4)(A) of Pub. L. 96-272 require that, for adoption assistance agreements between State social service agencies and adoptive parents entered into on or after October 1, 1983, the agreement must remain in effect regardless of the State in which the adoptive parents reside at any given time. Thus, the originating State will remain responsible for continuing the adoption assistance payments even if the family moves. (Before that date, if the family moves to another State, the originating State may either continue the payments or end the agreement.)

Section 2171 of the 1981 Omnibus Budget Reconciliation Act, Pub. L. 97-35, subsequently amended section 1902(a)(10)(A) of the Act to require a Medicaid agency to provide Medicaid coverage for all children receiving aid or assistance under the State's title IV-E programs. Therefore, so long as a State continues to provide title IV-E assistance, the State is required to continue Medicaid, even if a child moves to a second State.

**B. Proposed Regulations**

We issued a Notice of Proposed Rulemaking (NPRM) on December 31, 1980 (45 FR 82254). In that document, published before the enactment of Pub. L. 97-35, we proposed that the State making the foster care maintenance payments or the adoption assistance payments would be required to retain responsibility for Medicaid. This was consistent with HCFA policy requiring the State that provides cash assistance resulting in Medicaid eligibility also to have responsibility for Medicaid for the individuals involved. (42 CFR 435.110, 435.120, 435.130, and 436.110 state this policy.) The proposal also represented a continuation of policy in effect under the title IV-A AFDC foster care program, which required that the State with initial responsibility for foster care payments retain that financial responsibility,

including Medicaid, when the foster care placement is made out-of-State. As explained above, the policy of requiring that a Medicaid agency provide coverage for all children receiving aid or assistance under the States' title IV-E program was subsequently legislated by section 2171 of Pub. L. 97-35.

**C. Final Regulations**

Since the Omnibus Budget Reconciliation Act of 1981 mandates the policy we proposed, these final regulations require States to provide Medicaid coverage for all children for whom payments are made under the State's title IV-E program, even if the child moves to another State. We are making the following changes in current regulations:

(1) 42 CFR 431.52, regulations on payments for Medicaid services furnished out of State, is changed to clarify that the originating State retains financial responsibility for Medicaid when a child whose eligibility is based on receipt of title IV-E payments from that State moves to another State.

(2) We are adding 42 CFR 435.118 and 42 CFR 436.118 to require Medicaid coverage of children for whom title IV-E payments are made.

(3) We are amending the definitions relating to institutional status (42 CFR 435.1009) to implement the provision concerning public child-care institutions that accommodate no more than 25 children. Since AFDC-foster care under title IV-A will not be completely phased out until October 1, 1982, the provision applies both to that program and to the foster care maintenance program under title IV-E.

Because 42 CFR 435.1008 prohibits Federal matching in expenditures for services provided to individuals who are inmates of public institutions, we are clarifying the definition of public institution to exclude from this prohibition the non-detention type institutions serving children in foster care who are entitled to Medicaid.

**D. Public Comments**

We received 24 comments on the NPRM. Twelve of the comments were from child advocacy groups, ten from State agencies, and two from an association representing welfare administrators. The specific comments and our responses are as follows:

**1. Responsibility for Medicaid—**

*Comment:* Nine commenters agreed that the originating State should be fiscally responsible for the cost of Medicaid when a title IV-E child moves to a second State. However, two commenters recommended that the

receiving State should provide a Medicaid identification card and be fiscally responsible for the Medicaid benefits the child receives in that State. Eleven commenters believe that the use of an out-of-State Medicaid card from the originating State may create unnecessary problems. The problems include—

- For the beneficiary, locating a sufficient number of providers willing to accept out-of-State Medicaid cards. (Some providers may be reluctant because of their unfamiliarity with the requirements of another Medicaid agency.)

- For the originating State, administrative difficulties as it attempts to guarantee service coverage and provider compliance across State lines.

Four commenters supported the use of interstate agreements to address difficulties in providing Medicaid across State lines. Other commenters recommended that interstate agreements be required, or that HCFA develop procedures to resolve these problems.

*Response:* As a result of the amendment made by Pub. L. 97-35, section 1902(a)(10)(A) of the Act is clear in requiring that the State providing the title IV-E assistance must provide Medicaid. Section 475(3) of the Act requires that as of October 1, 1983, the adoption assistance agreement remain in effect regardless of the State the family resides in at any given time. Therefore, the statute requires the originating State to continue Medicaid even if an eligible child moves to another State. (Our actuaries estimate that fewer than 350 children for whom adoption assistance payments are made will move to another State during the next five years.)

We are not currently developing procedures to solve potential administrative problems that may result from this requirement because we believe that States should be free to agree among themselves on procedures. A State may enter into an agreement with another State to facilitate the provision of Medicaid for title IV-E children who move to a second State. Two States can agree, for example, that the receiving State would issue its Medicaid card and provide its program of Medicaid coverage, so long as the receiving State's program includes the services provided by the originating State. The two States may decide that the originating State should reimburse the receiving State for the Medicaid cost.

States might also agree to accept providers certified by the receiving State. Such an agreement relieves the

burden that a provider might have in completing a second State's certification process.

Although we encourage the use of interstate agreements, for the benefit of both beneficiaries and State Medicaid agencies, the statute does not require that States develop those agreements. Section 101(a)(4)(B) of Pub. L. 96-272 provides that any such interstate compacts "are hereby approved by Congress".

#### 2. Regulatory location of Medicaid revisions—

*Comment:* Two commenters recommended that we not amend current Medicaid regulations that deal with residency. We proposed to amend §§ 435.403 and 436.403, regulations on State residence, to clarify that a child receiving payments under title IV-E of the Act remains a resident of the State making those payments, even if the child moves to another State. The commenters suggested that the necessary changes be made in other sections of the regulations because, as proposed, the changes in the residency sections might encourage some States to exclude children from public school unless non-resident tuition was paid (in the case of a child who, for Medicaid purposes only, is considered to be a resident of another State).

*Response:* The purpose of Medicaid residency requirements is to assure that individuals are not denied eligibility due to a situation in which no State assumes responsibility for the individual's Medicaid services.

We believe that, with the change in section 1902(a)(10)(A) of the Act, which clearly connects responsibility for Medicaid to the State providing the title IV-E assistance, there is now no need to change the residency sections of the Medicaid regulations.

#### 3. Private health insurance—

*Comment:* One State agency suggested that, to reduce Medicaid costs, an adoptive parent with health insurance coverage be required to pursue extension of that coverage for an adopted child.

*Response:* There is no authority in either Pub. L. 96-272 or the Act to require that individuals purchase health insurance. Thus, it would be inconsistent with the Medicaid statute, as well the policy objectives of Pub. L. 96-272 of encouraging adoptions and foster homes for these children, for us to adopt this suggestion. However, Medicaid's responsibility for payment of medical care is only for that portion of covered services not covered by any other third parties. (A third party is any individual, entity or program that is or may be liable to pay all or part of the medical cost of a Medicaid beneficiary.

Medicaid third party liability regulations are contained in 42 CFR Part 433, Subpart D.) Therefore, if an adopted child is covered by the parents' insurance, the usual Medicaid rules will apply.

#### 4. Requirement for adoption assistance payments—

*Comment:* Three commenters objected to the provisions that cash payments be required to trigger Medicaid eligibility. They suggested that any assistance made under a title IV-E adoption assistance agreement for the benefit of the child (such as payment for a wheelchair) should trigger Medicaid eligibility for the duration of the adoption assistance agreement. The commenters argued that a requirement for continuing adoption assistance payments is administratively burdensome.

*Response:* Section 473 of the Act authorizes States to make adoption assistance cash payments on behalf of eligible children. Section 473(b) of the Act allows only the adoption assistance cash payments under the adoption assistance agreement to trigger Medicaid eligibility for these children. Under the provisions of the adoption assistance agreement, States will indicate the amounts of the adoption assistance cash payments, however minimal, and the duration of the agreement.

### E. Impact Analyses

#### Executive Order 12291

We have determined that these final rules do not meet the criteria for a major rule as defined in section 1(b) of Executive Order 12291. That is, these rules will not have an annual effect on the economy of \$100 million or more; or cause a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions; or cause significant adverse effects on business or employment.

We do not anticipate any additional Medicaid costs as a result of Medicaid coverage for children for whom payments are made under the adoption assistance program because all those children were previously eligible for cash assistance and Medicaid. Since these children are considered hard-to-place children for various reasons (age, disabilities, etc.), and the States have unsuccessfully attempted to place the children, it is unlikely that they would be adopted or otherwise removed from Medicaid eligibility, and therefore would have remained on the Medicaid rolls. We expect that in some cases, adoptive parents will include the

children under their private medical insurance, thus reducing Medicaid costs.

We estimate that Medicaid costs for the two new groups of foster care children will amount to approximately \$307,000 per year. This is based on estimates of approximately 1,000 children in foster care placement and \$307 in medical expenditures per child. (The average projected cost per eligible AFDC child under Medicaid for fiscal year 1982, is \$307.)

#### Regulatory Flexibility Act

The Regulatory Flexibility Act of 1980, Pub. L. 96-354, requires that an agency prepare a regulatory flexibility analysis for a proposed rule, or a final rule issued after a proposal, if a rule would have a significant economic impact on a substantial number of small businesses, small non-profit organizations, or small governmental jurisdictions. However, this requirement does not apply to final rules for which a proposed rule was published before January 1, 1981 (section 4 of the Regulatory Flexibility Act). Because the proposed rule that preceded this final rule was published earlier, an analysis is not required under the Regulatory Flexibility Act.

However, we expect that the additional annual cost of the States and Federal government will total less than \$1 million per year. Therefore, the Secretary certifies, under section 605(b) of Title 5, United States Code, that this final rule will not have a significant economic impact on a substantial number of small entities.

#### List of Subjects

##### 42 CFR Part 431

Adoption assistance, Administrative practice and procedure, Contracts (agreements), Fair hearings, Federal financial participation, Foster care maintenance payments, Grant-in-aid program—health, Health facilities, Health maintenance organizations (HMO), Indians, Information [disclosure], Medicaid, Mental health centers, Prepaid health plans, Privacy, Quality control, Reporting requirement.

##### 42 CFR Part 435

Adoption assistance, Aid to families with dependent children, Aliens, Categorically needy, Contracts (agreements—state plan), Eligibility, Foster care maintenance payments,

Grant-in-aid program—health, Health facilities, Medicaid, Medically needy, Reporting requirements, Spend-down, Supplemental security income (SSI).

##### 42 CFR Part 436

Adoption assistance; Aid to families with dependent children, Aliens, Contracts (agreements), Eligibility, Foster care maintenance payments, Grant-in-aid program—health, Guam, Health facilities, Medicaid, Puerto Rico, Supplemental security income (SSI), Virgin Islands.

42 CFR Chapter IV is amended as set forth below:

#### PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

The authority citation for Part 431 reads as follows: Section 1102 of the Social Security Act (42 U.S.C. 1302).

A. Section 431.52 is amended by revising paragraphs (a) and (b) to read as follows:

##### § 431.52 Payments for services furnished out of State.

(a) Basis and purpose. This section implements—(1) Section 1902(a)(18) of the Act, which authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State; and

(2) Section 1902(a)(10)(A) of the Act, which requires a State plan to provide for Medicaid for all individuals receiving assistance under the State's title IV-E plan.

(b) *Payment for services.* A State plan must provide that the State will furnish Medicaid to—(1) A recipient who is a resident of the State while that recipient is in another State, to the same extent that Medicaid is furnished to residents in the State, when—

(i) Medical services are needed because of a medical emergency;

(ii) Medical services are needed because the recipient's health would be endangered if he were required to travel to his State of residence;

(iii) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or

(iv) It is general practice for recipients in a particular locality to use medical resources in another State; and

(2) A child for whom the State makes adoption assistance or foster care maintenance payments under title IV-E of the Act.

#### PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA AND THE NORTHERN MARIANA ISLANDS

B. Part 435 is amended as follows:

1. The table of contents for Part 435 is amended by adding under Subpart B a new center heading following § 435.115, and a new § 435.118 to read as follows:

##### Subpart B—Mandatory Coverage of the Categorically Needy

##### Mandatory Coverage of Adoption Assistance and Foster Care Children

Sec.  
435.118 Children for whom adoption assistance or foster care maintenance payments are made.

Authority: Sec. 1102, Social Security Act [42 U.S.C. 1302].

2. A new center heading and § 435.118 are added in Subpart B to read as follows:

##### Mandatory Coverage of Adoption Assistance and Foster Care Children

§ 435.118 Children for whom adoption assistance or foster care maintenance payments are made.

The agency must provide Medicaid to children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Act.

3. Section 435.1009 is amended by reprinting the introductory language, adding in alphabetical order the definition of "child-care institution", and revising the definition of "public institution" as follows:

##### § 435.1009 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

"Child-care institution" means a nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children

who are determined to be delinquent.

"Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include (1) a medical institution as defined in this section; (2) an intermediate care facility as defined in §§ 440.140 and 440.150 of this chapter; (3) a publicly operated community residence that serves no more than 16 residents, as defined in this section; or (4) a child-care institution as defined in this section with respect to (i) children for whom foster care maintenance payments are made under title IV-E of the Act; and (ii) children receiving AFDC—foster care under title IV-A of the Act.

**PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS**

C. Part 436 is amended as follows:

1. The table of contents for Part 436 is amended by adding under Subpart B a new § 436.118 to read as follows:

**Subpart B—Mandatory Coverage of the Categorically Needy**

Sec. 436.118 Children for whom adoption assistance or foster care maintenance payments are made.

Authority: Sec. 1102, Social Security Act (42 U.S.C. 1302)

2. A new § 436.118 is added to read as follows:

§ 436.118 Children for whom adoption assistance or foster care maintenance payments are made.

The agency must provide Medicaid to children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Act.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: April 28, 1982.

Carolyn K. Davis  
Administrator, Health Care Financing Administration.

Approved: June 14, 1982.

Richard S. Schweiker,  
Secretary.

[FR Doc. 82-17750 Filed 6-30-82; 8:45 am]

BILLING CODE 4120-03-M

**DEPARTMENT OF THE INTERIOR**

**Bureau of Land Management  
43 CFR Public Land Order 6290**

[M 013681(SD), et al.]

**South Dakota; Partial Revocation of Public Land Orders Nos. 1168, 1343, 1344, 1429, 1744, 2165, 2285, 2965, and 3072**

**AGENCY:** Bureau of Land Management, Interior.

**ACTION:** Public Land Order.

**SUMMARY:** This action will restore approximately 1,600 acres of land in the Black Hills National Forest to operation of the mining laws and to such disposition as may by law be made of national forest lands.

**EFFECTIVE DATE:** July 28, 1982.

**FOR FURTHER INFORMATION CONTACT:** Roland F. Lee, Montana State Office, 408-657-0291.

By virtue of the authority vested in the Secretary of the Interior, by section 204 of the Federal Land Policy and Management Act of 1976, 90 Stat. 2751; 43 U.S.C. 1714, it is ordered as follows:

1. The following identified public land orders which withdrew certain lands for use by the Forest Service as administrative sites, camp, picnic, ranger, and recreation areas, a lookout and a water system site, are hereby partially revoked insofar as they affect the lands described below:

**Black Hills Meridian**

*Black Hills National Forest*

M 013681(SD)—Public Land Order No. 1168 dated June 15, 1955

**East Spearfish Creek Camp and Picnic Area**

T. 4 N., R. 2 E.,  
Sec. 26, W½NE½SW¼, SE½NW¼SW¼, and SE½SW¼;  
Sec. 35, E½NE½NW¼.

The above areas aggregate 90 acres, more or less, in Lawrence County.

M 019660(SD)—Public Land Order No. 1343, dated October 1, 1958

**Deer Creek Picnic Ground**

T. 2 N., R. 5 E.,  
Sec. 27, N½SE½SW¼ (less patented homestead entries).

**Headwaters Picnic Ground**

T. 2 N., R. 2 E.,  
Sec. 4, SW¼NE½SE½, SE½NW¼SE½, NE½SW¼SE½, and SE½SE½.

**Deerdale Campground**

T. 2 N., R. 2 E.,  
Sec. 12, NE½SE½ (less patented homestead entry).

**Rochford Administrative Site**

T. 2 N., R. 3 E.,  
Sec. 23, E½E½NE½NE½, and E½NE½ SE½NE½;  
Sec. 24, NW¼NW¼, and NW¼SW¼NW¼.

The above areas aggregate 195 acres, more or less, in Lawrence and Pennington Counties.

M 020550(SD)—Public Land Order No. 1344 dated October 10, 1956

**Boulder Park Picnic Ground**

T. 5 N., R. 4 E.,  
Sec. 15, SE½SE½SW¼, and SW¼SW¼SE½;  
Sec. 22, NW¼NW¼NE½, and NE½NE½ NW¼.

**Vanocker Picnic Ground**

T. 5 N., R. 5 E.,  
Sec. 32, N½NW¼NE½.

**Mann Road Picnic Ground**

T. 4 S., R. 2 E.,  
Sec. 3, SW¼SW¼SE½.

**Reno Gulch Picnic Ground**

T. 2 S., R. 4 E.,  
Sec. 3, NW¼NW¼NW¼ part of lot 8;  
Sec. 4, NE½NE½NE½ part of lot 3.

**Rockerville Camp Ground**

T. 1 S., R. 6 E.,  
Sec. 14, SW¼SE½.

**Battle Creek Picnic Ground**

T. 2 S., R. 6 E.,  
Sec. 10, SE½SW¼NE½.

The above areas aggregate 140 acres, more or less, in Custer, Meade, Lawrence and Pennington Counties.

M 024510(SD)—Public Land Order No. 2265 dated February 28, 1961

**Norris Peak Lookout**

T. 2 N., R. 6 E.,  
Sec. 29, SW¼SE½SW¼.

**Parker Peak Lookout**

T. 7 S., R. 4 E.,  
Sec. 31, S½SE½NW¼, and N½NE½SW¼.

**Boulder Hill Lookout**

T. 1 S., R. 6 E.,  
Sec. 15, S½SW¼SW¼NW¼, NW¼NW¼ SW¼, and N½SW¼NW¼SW¼;  
Sec. 16, S½SE½SE½NE½, NE½NE½SE½, and N½SE½NE½SE½.

The above areas aggregate 90 acres, more or less, in Pennington and Fall River Counties.

M 024808(SD)—Public Land Order No. 1744 dated October 6, 1958

**Little Spearfish Ranger Station**

T. 4 N., R. 1 E.,  
Sec. 2, S½SW¼SW¼, and S½N½SW¼SW¼;  
Sec. 3, S½SE½SE½, S½N½SE½SE½, E½SE½S W¼SE½, and SE½NE½SW¼SE½.

The above area contains 67.50 acres located in Lawrence County.

M 025762(SD)—Public Land Order No. 1744 dated October 6, 1958

**Lone Grave Spring Picnic Ground**

T. 5 N., R. 1 E.,  
Sec. 31, lot 10.

**Moonshine Gulch Picnic Grounds**

T. 2 N., R. 3 E.,  
Sec. 24, lot 2.

Ex. A-5, Interstate Compact on Adoption and Medical Assistance

# **INTERSTATE COMPACT ON ADOPTION AND MEDICAL ASSISTANCE**

## **ARTICLE I. FINDINGS**

The states which are parties to this Compact find that:

- A. In order to obtain adoptive families for children with special needs, states must assure prospective adoptive parents of substantial assistance (usually on a continuing basis) in meeting the high costs of supporting and providing for the special needs and the services required by such children.
- B. The states have a fundamental interest in promoting adoption for children with special needs because the care, emotional stability, and general support and encouragement required by such children can be best, and often only, obtained in family homes with a normal parent-child relationship.
- C. The states obtain fiscal advantages from providing adoption assistance because the alternative is for the states to bear the higher cost of meeting all the needs of children while in foster care.
- D. The necessary assurances of adoption assistance for children with special needs, in those instances where children and adoptive parents live in states other than the one undertaking to provide the assistance, include the establishment and maintenance of suitable substantive guarantees and workable procedures for interstate cooperation and payments to assist with the necessary costs of child maintenance, the procurement of services, and the provision of medical assistance.

## **ARTICLE II. PURPOSES**

The purposes of this Compact are to:

- A. Strengthen protections for the interests of children with special needs on behalf of whom adoption assistance is committed to be paid, when such children are in or move to states other than the one committed to provide adoption assistance.
- B. Provide substantive assurances and operating procedures which will promote the delivery of medical and other services to children on an interstate basis through programs of adoption assistance established by the laws of the states which are parties to this Compact.

## **ARTICLE III. DEFINITIONS**

As used in this Compact, unless the context clearly requires a different construction:

- A. "Child with special needs" means a minor who has not yet attained the age at which the state normally discontinues children's services, or a child who has not yet reached the age of 21 where the state determines that the child's mental or physical handicaps warrant the continuation of assistance beyond the age of majority, for whom the state has determined the following:
  - 1. That the child cannot or should not be returned to the home of his or her parents;
  - 2. That there exists with respect to the child a specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical condition or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance;
  - 3. That, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in their care as a foster child, a reasonable but unsuccessful effort has been made to place the child with appropriate adoptive parents without providing adoption assistance.
- B. "Adoption assistance" means the payment or payments for the maintenance of a child which are made or committed to be made pursuant to the adoption assistance program established by the laws of a party state.
- C. "State" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, or a Territory or Possession of the United States.
- D. "Adoption assistance state" means the state that is signatory to an adoption assistance agreement in a particular case.
- E. "Residence state" means the state in which the child is a resident by virtue of the residence of the adoptive parents.
- F. "Parents" means either the singular or plural of the word "parent".

#### **ARTICLE IV. ADOPTION ASSISTANCE**

- A. Each state shall determine the amounts of adoption assistance and other aid which it will give to children with special needs and their adoptive parents in accordance with its own laws and programs. The adoption assistance and other aid may be made subject to periodic reevaluation of eligibility by the adoption assistance state in accordance with its laws.
- B. The adoption assistance, medical assistance, and other services and benefits to which this Compact applies are those provided to children with special needs and their adoptive parents from the effective date of the adoption assistance agreement.

- C. Every case of adoption assistance shall include a written adoption assistance agreement between the adoptive parents and the appropriate agency of the state undertaking to provide the adoption assistance. Every such agreement shall contain provisions for the fixing of actual or potential interstate aspects of the assistance so provided as follows:
1. An express commitment that the assistance so provided shall be payable without regard for the state of residence of the adoptive parents, both at the outset of the agreement period and at all times during its continuance;
  2. A provision setting forth with particularity the types of care and services toward which the adoption assistance state will make payments;
  3. A commitment to make medical assistance available to the child in accordance with Article V of this Compact;
  4. An express declaration that the agreement is for the benefit of the child, the adoptive parents and the state and that it is enforceable by any or all of them; and
  5. The date or dates upon which each payment or other benefit provided thereunder is to commence, but in no event prior to the effective date of the adoption assistance agreement.
- D. Any services or benefits provided for a child by the residence state and the adoption assistance state may be facilitated by the party states on each other's behalf. To this end, the personnel of the child welfare agencies of the party states will assist each other, as well as the beneficiaries of adoption assistance agreements, in assuring prompt and full access to all benefits expressly included in such agreements. It is further recognized and agreed that, in general, all children to whom adoption assistance agreements apply will be eligible for benefits under the child welfare, education, rehabilitation, mental health, and other programs of their state of residence on the same basis as other resident children.
- E. Adoption assistance payments on behalf of a child in another state shall be made on the same basis and in the same amounts as they would be made if the child were living in the state making the payments, except that the laws of the adoption assistance state may provide for the payment of higher amounts.

## **ARTICLE V. MEDICAL ASSISTANCE**

- A. Children, for whom a party state is committed, in accordance with the terms of an adoption assistance agreement to provide federally aided medical assistance under Title XIX of the Social Security Act, are eligible for such medical assistance during the entire period for which the agreement is in effect. Upon application therefore, the adoptive parents of a child who is the subject of such an adoption assistance agreement shall receive a medical assistance identification document made out in the

- child's name. The identification shall be issued by the medical assistance program of the residence state and shall entitle the child to the same benefits pursuant to the same procedures, as any other child who is covered by the medical assistance program in the state, whether or not the adoptive parents are themselves eligible for medical assistance.
- B. The identification document shall bear no indication that an adoption assistance agreement with another state is the basis for its issuance. However, if the identification is issued pursuant to such an adoption assistance agreement, the records of the issuing state and the adoption assistance state shall show the fact, and shall contain a copy of the adoption assistance agreement and any amendment or replacement thereof, as well as all other pertinent information. The adoption assistance and medical assistance programs of the adoption assistance state shall be notified of the issuance of such identification.
  - C. A state which has issued a medical assistance identification document pursuant to this Compact, which identification is valid and currently in force, shall accept, process and pay medical assistance claims thereon as it would with any other medical assistance claims by eligible residents.
  - D. The federally aided medical assistance provided by a party state pursuant to this Compact shall be in accordance with paragraphs (a) through (c) of this Article. In addition, when a child who is covered by an adoption assistance agreement is living in another party state, payment or reimbursement for any medical services and benefits specified under the terms of the adoption assistance agreement, which are not available to the child under the Title XIX medical assistance program of the residence state, shall be made by the adoption assistance state as required by its law. Any payments so provided shall be of the same kind and at the same rates as provided for children who are living in the adoption assistance state. However, where the payment rate authorized for a covered service under the medical assistance program of the adoption assistance state exceeds the rate authorized by the residence state for that service, the adoption assistance state shall not be required to pay the additional amounts for the services or benefits covered by the residence state.
  - E. A child referred to in paragraph (a) of this Article, whose residence is changed from one party state to another party state shall be eligible for federally aided medical assistance under the medical assistance program of the new state of residence.

## **ARTICLE VI. COMPACT ADMINISTRATION**

- A. In accordance with its own laws and procedures, each state which is a party to this Compact shall designate a Compact Administrator and such Deputy Compact Administrators as it deems necessary. The Compact Administrator shall coordinate all activities under this Compact within his or her state. The Compact Administrator shall also be the principal contact for officials and agencies within and without the state for the facilitation of

- interstate relations involving this Compact and the protection of benefits and services provided pursuant thereto. In this capacity, the Compact Administrator will be responsible for assisting child welfare agency personnel from other party states and adoptive families receiving adoption and medical assistance on an interstate basis.
- B. Acting jointly, the Compact Administrators shall develop uniform forms and administrative procedures for the interstate monitoring and delivery of adoption and medical assistance benefits and services pursuant to this Compact. The forms and procedures so developed may deal with such matters as:
1. Documentation of continuing adoption assistance eligibility;
  2. Interstate payments and reimbursements; and
  3. Any and all other matters arising pursuant to this Compact.
- C.
1. Some or all of the parties to this Compact may enter into supplementary agreements for the provision of or payment for additional medical benefits and services, as provided in Article V(d); for interstate service delivery, pursuant to Article IV(d); or for matters related thereto. Such agreements shall not be inconsistent with this Compact, nor shall they relieve the party states of any obligation to provide adoption and medical assistance in accordance with applicable state and federal law and the terms of this Compact.
  2. Administrative procedures or forms implementing the supplementary agreements referred to in paragraph (c) (1) of this Article may be developed by joint action of the Compact Administrators of those states which are party to such supplementary agreements.
- D. It shall be the responsibility of the Compact administrator to ascertain whether and to what extent additional legislation may be necessary in his or her own state to carry out the provisions of this Article IV or any supplementary agreements pursuant to this Compact.

## **ARTICLE VII. JOINDER AND WITHDRAWAL**

- A. This Compact shall be open to joinder by any state. It shall enter into force as to a state when its duly constituted and empowered authority has executed it.
- B. In order that the provisions of this Compact may be accessible to and known by the general public, and so that they may be implemented as law in each of the party states, the authority which has executed the Compact in each party state shall cause the full text of the Compact and notice of its execution to be published in his or her state. The executing authority in any party state shall also provide copies of the Compact upon request.
- C. Withdrawal from this Compact shall be by written notice, sent by the authority which executed it, to the appropriate officials of all other party

states, but no such notice shall take effect until one year after it is given in accordance with the requirements of this paragraph.

- D. All adoption assistance agreements outstanding and to which a party state is a signatory at the time when its withdrawal from this Compact takes effect shall continue to have the effects given to them pursuant to this Compact until they expire or are terminated in accordance with their provisions. Until such expiration or termination, all beneficiaries of the agreements involved shall continue to have all rights and obligations conferred or imposed by this Compact, and the withdrawing state shall continue to administer the Compact to the extent necessary to accord and implement fully the rights and protections preserved hereby.

#### **ARTICLE VIII. CONSTRUCTION AND SEVERABILITY**

The provisions of this Compact shall be liberally construed to effectuate the purposes thereof. The provisions of this Compact shall be severable, and if any phrase, clause, sentence, or provision of this Compact is declared to be contrary to the Constitution of the United States or of any party state, or where the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the Constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

**K&L GATES LLP**

**April 10, 2020 - 2:28 PM**

**Transmittal Information**

**Filed with Court:** Supreme Court  
**Appellate Court Case Number:** 97557-4  
**Appellate Court Case Title:** Peacehealth St. Joseph Medical Center, et al. v. State of WA, Dept. of Revenue  
**Superior Court Case Number:** 17-2-02434-9

**The following documents have been uploaded:**

- 975574\_Briefs\_20200410142441SC613599\_1201.pdf  
This File Contains:  
Briefs - Amicus Curiae  
*The Original File Name was Brief of the Washington State Hospital Association with exhibits.pdf*

**A copy of the uploaded files will be sent to:**

- EEarl@perkinscoie.com
- JFlesner@perkinscoie.com
- chris.wyant@klgates.com
- daniel.baker@atg.wa.gov
- davidmaas@dwt.com
- dirkgiseburt@dwt.com
- elainehuckabee@dwt.com
- ginachan@dwt.com
- micheleradosevich@dwt.com
- revolyef@atg.wa.gov
- rhonda.hinman@klgates.com
- rmahon@perkinscoie.com
- rosann.fitzpatrick@atg.wa.gov
- tera.heintz@atg.wa.gov

**Comments:**

---

Sender Name: Carla DewBerry - Email: carla.dewberry@klgates.com  
Address:  
925 4TH AVE STE 2900  
SEATTLE, WA, 98104-1158  
Phone: 206-370-8317

**Note: The Filing Id is 20200410142441SC613599**