Z-1172.1

SENATE BILL 6758

State of Washington 61st Legislature 2010 Regular Session

By Senators Keiser, Prentice, and Parlette; by request of Governor Gregoire

Read first time 01/25/10. Referred to Committee on Ways & Means.

AN ACT Relating to a hospital safety net assessment for increased hospital payments to improve health care access for the citizens of Washington; amending 2009 c 564 s 209 (uncodified); adding a new chapter to Title 74 RCW; providing an expiration date; and declaring an emergency.

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

NEW SECTION. **Sec. 1.** PURPOSE, FINDINGS, AND INTENT. (1) The purpose of this chapter is to provide for a safety net assessment on certain Washington hospitals, which will be used solely to augment funding from all other sources and thereby obtain additional funds to restore recent reductions and to support additional payments to hospitals for medicaid services.

(2) The legislature finds that:

(a) Washington hospitals, working with the department of social and health services, have proposed a hospital safety net assessment to generate additional state and federal funding for the medicaid program, which will be used to partially restore recent reductions in hospital reimbursement payments and provide for an increase in hospital reimbursement rates; and

(b) The hospital safety net assessment and hospital safety net assessment fund created in this chapter allows the state to generate additional federal financial participation for the medicaid program and provides for increased reimbursement to hospitals.

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

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

(b) That funds generated by the assessment shall be used solely to augment all other funding sources and not as a substitute for any other funds;

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

(d) To condition the assessment on receiving federal approval for receipt of additional federal financial participation and on continuation of other funding sufficient to maintain hospital reimbursement rates and small rural disproportionate share payments at least at the levels in effect on June 30, 2009.

NEW SECTION. **Sec. 2.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Certified public expenditure hospital" means a hospital participating in the department's certified public expenditure payment program as described in WAC 388-550-4650 or successor rule.

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

(3) "Date of expiration of section 5001 of P.L. No. 111-5" means December 31, 2010, or any subsequent date declared by congress to be the termination date of the temporary increase in the federal medical assistance percentage currently set forth in section 5001 of P.L. No. 111-5.

(4) "Department" means the department of social and health services.

(5) "Fund" means the hospital safety net assessment fund established under section 3 of this act.

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

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

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

(9) "Medicaid" means the medical assistance program as established in Title XIX of the social security act and as administered in the state of Washington by the department of social and health services.

(10) "Medicare cost report" means the medicare cost report, form 2552-96, or successor document.

(11) "Nonmedicare hospital inpatient day" means total hospital inpatient days less medicare inpatient days, including medicare days reported for medicare managed care plans, as reported on the medicare cost report, form 2552-96, or successor forms, excluding all skilled and nonskilled nursing facility days, skilled and nonskilled swing bed days, nursery days, observation bed days, hospice days, home health agency days, and other days not typically associated with an acute care inpatient hospital stay.

(12) "Prospective payment system hospital" means a hospital reimbursed for inpatient and outpatient services provided to medicaid beneficiaries under the inpatient prospective payment system and the outpatient prospective payment system as defined in WAC 388-550-1050. For purposes of this chapter, prospective payment system hospital does not include a hospital participating in the certified public expenditure program or a bordering city hospital located outside of the state of Washington and in one of the bordering cities listed in WAC 388-501-0175 or successor regulation.

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

(14) "Rehabilitation hospital" means a medicare-certified freestanding inpatient rehabilitation facility.

(15) "Secretary" means the secretary of the department of social and health services.

(16) "Small rural disproportionate share hospital payment" means a payment made in accordance with WAC 388-550-5200 or subsequently filed regulation.

NEW SECTION. **Sec. 3.** HOSPITAL SAFETY NET ASSESSMENT FUND. (1) A dedicated fund is hereby established within the state treasury to be known as the hospital safety net assessment fund. The purpose and use of the fund shall be to receive and disburse funds, together with accrued interest, in accordance with this chapter. Moneys in the fund, including interest earned, shall not be used or disbursed for any purposes other than those specified in this chapter. Any amounts expended from the fund that are later recouped by the department on audit or otherwise shall be returned to the fund.

(a) Any unexpended balance in the fund at the end of a fiscal biennium shall carry over into the following biennium and shall be applied to reduce the amount of the assessment under section 6(1)(c) of this act.

(b) Any amounts remaining in the fund on July 1, 2013, shall be used to make increased payments in accordance with sections 10 and 13 of this act for any outstanding claims with dates of service prior to July 1, 2013. Any amounts remaining in the fund after such increased payments are made shall be refunded to hospitals, pro rata according to the amount paid by the hospital, subject to the limitations of federal law.

(2) All assessments, interest, and penalties collected by the department under section 4 of this act shall be deposited into the fund. All interest earned on moneys in the fund shall be credited to the fund and used for purposes specified under this chapter.

(3) Disbursements from the fund may be made only as follows:

(a) Subject to appropriations and the continued availability of other funds in an amount sufficient to maintain the level of medicaid hospital rates in effect on July 1, 2009;

(b) Upon certification by the secretary that the conditions set forth in section 15(1) of this act have been met with respect to the assessments imposed under section 4(1) of this act, the payments provided under section 9 of this act, and any retroactive payment under sections 10, 11, 12, and 13 of this act, funds shall be disbursed in the amount necessary to make the payments specified in those sections;

(c) Upon certification by the secretary that the conditions set forth in section 15(1) of this act have been met with respect to the assessments imposed under section 4(2) of this act and the payments provided under sections 10, 11, 12, and 13 of this act, funds shall be disbursed periodically as necessary to make the payments as specified in those sections;

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

(e) The sum of thirty-two million dollars per biennium may be disbursed for the purpose of ensuring that no reductions in hospital payment rates take place from the effective date of this act until July 1, 2013;

(f) The sum of one million dollars per biennium may be disbursed for payment of administrative expenses incurred by the department in performing the activities authorized by this chapter;

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

NEW SECTION. **Sec. 4.** ASSESSMENTS. (1) An assessment in the amounts set forth in this section is imposed effective February 1, 2010, which is due and payable within thirty days after the department has transmitted a notice of assessment to hospitals. Such notice shall not be issued until the secretary has certified that the applicable conditions established by section 15(1) of this act have been met.

(a) Prospective payment system hospitals.

(i) Each prospective payment system hospital shall pay an assessment of thirty dollars for each annual nonmedicare hospital inpatient day up to sixty thousand per year, multiplied by 0.59.

(ii) Each prospective payment system hospital shall pay an

assessment of two dollars for each annual nonmedicare hospital inpatient day over and above sixty thousand per year, multiplied by 0.59.

(b) Each psychiatric hospital shall pay an assessment of six dollars for each annual nonmedicare hospital inpatient day, multiplied by 0.59.

(c) Each rehabilitation hospital shall pay an assessment of six dollars for each annual nonmedicare hospital inpatient day, multiplied by 0.59.

(d) Each critical access hospital shall pay an assessment of ten dollars for each annual nonmedicare hospital inpatient day, multiplied by 0.59.

(e) For purposes of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare inpatient days for each hospital that is not exempt from the assessment as described in section 5 of this act for the relevant state fiscal year 2008 portions included in the hospital's fiscal year end reports 2007 and/or 2008 cost reports. The department shall use nonmedicare hospital inpatient day data for each hospital taken from the centers for medicare and medicaid services' hospital 2552-96 cost report data file as of November 30, 2009, or equivalent data collected by the department.

(2) For the period February 1, 2010, through July 1, 2013, an assessment is imposed as follows, which shall be due and payable on the first day of each calendar quarter, provided that the department has sent notice of the assessment to each affected hospital at least thirty days prior to the due date for the assessment payment, and provided that the applicable conditions established by section 15(1) of this act have been satisfied. In the event that the applicable conditions in section 15(1) of this act have not been met, the department shall delay the initial due date for the assessment imposed under this subsection until such conditions have been met, at which time all amounts payable under this subsection to date are due.

(a) For the period February 1, 2010, through the day prior to the date of expiration of section 5001 of P.L. No. 111-5:

(i) Prospective payment system hospitals.

(A) Each prospective payment system hospital shall pay an assessment of one hundred thirty dollars for each annual nonmedicare

hospital inpatient day up to sixty thousand per year, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(B) Each prospective payment system hospital shall pay an assessment of nine dollars for each annual nonmedicare hospital inpatient day over and above sixty thousand per year, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(ii) Each psychiatric hospital shall pay an assessment of twenty-four dollars for each annual nonmedicare hospital inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(iii) Each rehabilitation hospital shall pay an assessment of twenty-four dollars for each annual nonmedicare hospital inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(iv) Each critical access hospital shall pay an assessment of ten dollars for each annual nonmedicare hospital inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(v) For purposes of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare inpatient days for each hospital that is not exempt from the assessment as described in section 5 of this act for the relevant state fiscal year 2008 portions included in the hospital's fiscal year end reports 2007 and/or 2008 cost reports. The department shall use nonmedicare hospital inpatient day data for each hospital taken from the centers for medicare and medicaid services' hospital 2552-96 cost report data file as of November 30, 2009, or equivalent data collected by the department.

(b) For the period beginning on the date of expiration of section 5001 of P.L. No. 111-5 through June 30, 2011:

(i) Prospective payment system hospitals.

(A) Each prospective payment system hospital shall pay an assessment of one hundred sixty-four dollars for each annual nonmedicare inpatient day up to sixty thousand per year, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(B) Each prospective payment system hospital shall pay an assessment of eleven dollars for each annual nonmedicare inpatient day over and above sixty thousand per year, multiplied by the number of days in the assessment period divided by three hundred sixty-five. The department may adjust the assessment downward if necessary to maintain compliance with federal regulations related to medicaid program health care-related taxes.

(ii) Each psychiatric hospital shall pay an assessment of thirty dollars for each annual nonmedicare hospital inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(iii) Each rehabilitation hospital shall pay an assessment of thirty dollars for each annual nonmedicare hospital inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(iv) Each critical access hospital shall pay an assessment of ten dollars for each annual nonmedicare hospital inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(v) For purposes of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare hospital inpatient days for each hospital that is not exempt from the assessment under section 5 of this act, taken from the most recent publicly available hospital 2552-96 cost report data file or successor data file available through the centers for medicare and medicaid services, as of a date to be determined by the department. If cost report data are unavailable from the foregoing source for any hospital subject to the assessment, the department shall collect such information directly from the hospital.

(c) For the period beginning July 1, 2011, through July 1, 2013:

(i) Prospective payment system hospitals.

(A) Each prospective payment system hospital shall pay an assessment of one hundred seventy-four dollars for each annual nonmedicare hospital inpatient day up to sixty thousand per year, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(B) Each prospective payment system hospital shall pay an assessment of twelve dollars for each annual nonmedicare inpatient day

over and above sixty thousand per year, multiplied by the number of days in the assessment period divided by three hundred sixty-five. The department may adjust the assessment downward if necessary to maintain compliance with federal regulations related to medicaid program health care-related taxes.

(ii) Each psychiatric hospital shall pay an assessment of thirty dollars for each annual nonmedicare inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(iii) Each rehabilitation hospital shall pay an assessment of thirty dollars for each annual nonmedicare inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(iv) Each critical access hospital shall pay an assessment of ten dollars for each annual nonmedicare inpatient day, multiplied by the number of days in the assessment period divided by three hundred sixty-five.

(v) For purposes of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare hospital inpatient days for each hospital that is not exempt from the assessment under section 5 of this act, taken from the most recent publicly available hospital 2552-96 cost report data file or successor data file available through the centers for medicare and medicaid services, as of a date to be determined by the department. If cost report data are unavailable from the foregoing source for any hospital subject to the assessment, the department shall collect such information directly from the hospital.

NEW SECTION. **Sec. 5.** EXEMPTIONS. The following hospitals are exempt from any assessment under this chapter provided that if and to the extent any exemption is held invalid, hospitals previously exempted shall be liable for assessments due after the date of final invalidation:

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

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

(3) Hospitals that do not charge directly or indirectly for hospital services; and

(4) Long-term acute care hospitals.

NEW SECTION. **Sec. 6.** ADMINISTRATION AND COLLECTION. (1) The department, in cooperation with the office of financial management, shall develop rules for determining the amount to be assessed to individual hospitals, notifying individual hospitals of the assessed amount, and collecting the amounts due. Such rule making shall specifically include provision for:

(a) Transmittal of quarterly notices of assessment by the department to each hospital informing the hospital of its nonmedicare hospital inpatient days and the assessment amount due and payable. Such quarterly notices shall be sent to each hospital at least thirty days prior to the due date for the quarterly assessment payment.

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

(c) Adjustment of the assessment amounts as follows:

(i) For each fiscal year beginning July 1, 2010, the assessment amounts under section 4(2) of this act may be adjusted as follows:

(A) If sufficient other funds, including any increase in federal financial participation in addition to what is provided under section 5001 of P.L. No. 111-5, are available to support the increased reimbursement rates and other payments under sections 10, 11, 12, and 13 of this act without utilizing the full assessment authorized under section 4(2) of this act, the department shall reduce the amount of the assessment for prospective payment system, psychiatric, and rehabilitation hospitals proportionately to the minimum level necessary to support those reimbursement rates and other payments.

(B) Provided that none of the conditions set forth in section 15(2) of this act have occurred, if the department's forecasts indicate that the assessment amounts under section 4(2) of this act, together with all other available funds, are not sufficient to support the increased reimbursement rates and other payments under sections 10, 11, 12, and 13 of this act, the department shall increase the assessment rates for prospective payment system, psychiatric, and rehabilitation hospitals

proportionately to the amount necessary to support those reimbursement rates and other payments, plus a contingency factor up to ten percent of the total assessment amount.

(C) Any positive balance remaining in the fund at the end of the fiscal year shall be applied to reduce the assessment amount for the subsequent fiscal year.

(ii) Any adjustment to the assessment amounts pursuant to this subsection, and the data supporting such adjustment, including but not limited to relevant data listed in subsection (2) of this section, must be submitted to the Washington state hospital association for review and comment at least sixty days prior to implementation of such adjusted assessment amounts. Any review and comment provided by the Washington state hospital association shall not limit the ability of the Washington state hospital association or its members to challenge an adjustment or other action by the department that is not made in accordance with this chapter.

(2) By November 30th of each year, the department shall provide the following data to the Washington state hospital association:

(a) The fund balance;

(b) The amount of assessment paid by each hospital;

(c) The annual medicaid fee-for-service payments for inpatient hospital services and outpatient hospital services; and

(d) The medicaid healthy options inpatient and outpatient payments as reported by all hospitals to the department on disproportionate share hospital applications. The department shall amend the disproportionate share hospital application and reporting instructions as needed to ensure that the foregoing data is reported by all hospitals as needed in order to comply with this subsection (2)(d).

(3) The department shall determine the number of nonmedicare hospital inpatient days for each hospital for each assessment period.

(4) To the extent necessary, the department shall amend the contracts between the managed care organizations and the department to incorporate the provisions of section 13 of this act. The department shall pursue amendments to the contracts as soon as possible after the effective date of this act. The amendments to the contracts shall, among other provisions, provide for increased payment rates to managed care organizations in accordance with section 13 of this act.

NEW SECTION. **Sec. 7.** LOCAL ASSESSMENTS OR TAXES NOT AUTHORIZED. Nothing in this chapter shall be construed to authorize any unit of local government to impose a tax or assessment on hospitals, including but not limited to a tax or assessment measured by a hospital's income, earnings, bed days, or other similar measures.

NEW SECTION. **Sec. 8.** ASSESSMENT PART OF OPERATING OVERHEAD. The incidence and burden of assessments imposed under this chapter shall be on hospitals and the expense associated with the assessments shall constitute a part of the operating overhead of hospitals. Hospitals shall not bill or otherwise pass on to patients the assessments provided for under this chapter.

NEW SECTION. **Sec. 9.** RESTORATION OF JUNE 30, 2009, REIMBURSEMENT RATES. Upon satisfaction of the applicable conditions set forth in section 15(1) of this act, the department shall:

(1) Reinstitute the medicaid inpatient rates and outpatient fee schedule for hospital reimbursement rates in effect on June 30, 2009; and

(2) Recalculate the amount payable to each hospital that submitted an otherwise allowable claim for inpatient and outpatient medicaid-covered services rendered from and after July 1, 2009, up to and including January 31, 2010, based on the inpatient and outpatient fee-for-service rates in effect on June 30, 2009, and, within sixty days after the date upon which the applicable conditions set forth in section 15(1) of this act have been satisfied, remit the difference to each hospital.

NEW SECTION. **Sec. 10.** INCREASED HOSPITAL PAYMENTS. (1) Upon satisfaction of the applicable conditions set forth in section 15(1) of this act and for services rendered on or after February 1, 2010, the department shall increase the medicaid inpatient and outpatient fee-for-service hospital reimbursement rates in effect on June 30, 2009, by the percentages specified below:

(a) Prospective payment system hospitals:

(i) Inpatient psychiatric services: Twelve percent;

(ii) Inpatient services: Twelve percent;

(iii) Outpatient services: Thirty-two percent.

(b) Harborview medical center and University of Washington medical center:

(i) Inpatient psychiatric services: Three percent;

(ii) Inpatient services: Three percent;

(iii) Outpatient services: Twenty-one percent.

(c) Rehabilitation hospitals:

(i) Inpatient services: Twelve percent;

(ii) Outpatient services: Thirty-two percent;

(d) Psychiatric hospitals:

(i) Inpatient psychiatric services: Twelve percent;

(ii) Inpatient services: Twelve percent.

(2) For claims processed for services rendered on or after February 1, 2010, but prior to satisfaction of the applicable conditions specified in section 15(1) of this act, the department shall, within sixty days after satisfaction of those conditions, calculate the amount payable to hospitals in accordance with this section and remit the difference to each hospital that has submitted an otherwise allowable claim for payment for such services.

NEW SECTION. **Sec. 11.** CRITICAL ACCESS HOSPITAL PAYMENTS. Upon satisfaction of the applicable conditions set forth in section 15(1) of this act, the department shall pay critical access hospitals that do not qualify for or receive a small rural disproportionate share payment in the subject state fiscal year an access payment of fifty dollars for each medicaid inpatient day, exclusive of days on which a swing bed is used for subacute care, from and after July 1, 2009. Initial payments to hospitals, covering the period from July 1, 2009, to the date when the applicable conditions under section 15(1) of this act are satisfied, shall be made within sixty days after such conditions are satisfied. Subsequent payments shall be made to critical access hospitals on an annual basis at the time that disproportionate share eligibility and payment for the state fiscal year are established. These payments shall be in addition to any other amount payable with respect to services provided by critical access hospitals and shall not reduce any other payments to critical access hospitals.

NEW SECTION. **Sec. 12.** DISPROPORTIONATE SHARE HOSPITAL PAYMENTS. Upon satisfaction of the applicable conditions set forth in section

15(1) of this act, small rural disproportionate share payments shall be increased to one hundred twenty percent of the level in effect as of June 30, 2009, for the period from and after July 1, 2009, until July 1, 2013. Initial payments, covering the period from July 1, 2009, to the date when the applicable conditions under section 15(1) of this act are satisfied, shall be made within sixty days after those conditions are satisfied. Subsequent payments shall be made directly to hospitals by the department on a periodic basis.

NEW SECTION. **Sec. 13.** INCREASED MANAGED CARE PAYMENTS AND CORRESPONDING PAYMENTS TO HOSPITALS. Subject to the applicable conditions set forth in section 15(1) of this act, the department shall:

(1) Amend medicaid-managed care contracts as necessary in order to ensure compliance with this chapter;

(2) Require managed care organizations to pay the full amount of payments received under this section to hospitals;

(3) With respect to the inpatient and outpatient rates established by section 9 of this act, within sixty days after satisfaction of the applicable conditions under section 15(1) of this act, calculate the additional amount due to each hospital to pay claims submitted for inpatient and outpatient medicaid-covered services rendered from and after July 1, 2009, through January 31, 2010, make payments to each managed care organization in amounts sufficient to pay the additional amounts due to each hospital, and require managed care organizations to make payments to hospitals on all previously submitted claims in accordance with section 9 of this act.

(4) Increase payments to managed care organizations as necessary to ensure that inpatient and outpatient medicaid reimbursement rates for hospital services, rendered from and after February 1, 2010, until July 1, 2013 and covered by such managed care organizations, are increased by the amounts specified in section 10 of this act. The increased payments made to hospitals pursuant to this subsection shall be in addition to any other amounts payable to hospitals by a managed care organization and shall not affect any other payments to hospitals;

(5) With respect to the inpatient and outpatient rates established by section 10 of this act, within ninety days after satisfaction of the applicable conditions under section 15(1) of this act, calculate the

additional amount due to each hospital to pay claims submitted for inpatient and outpatient medicaid-covered services rendered from and after February 1, 2010, through the date when the applicable conditions are met, make payments to each managed care organization in amounts sufficient to pay the additional amounts due to each hospital, and require managed care organizations to make payments to hospitals on all previously submitted claims in accordance with section 10 of this act.

(6) Require managed care organizations to demonstrate compliance with this section, including a requirement that payments due to hospitals under subsections (3) and (5) of this section be made within thirty days after the department disburses funds for those purposes.

NEW SECTION. **Sec. 14.** MULTIHOSPITAL LOCATIONS, NEW HOSPITALS, AND CHANGES IN OWNERSHIP. (1) If an entity owns or operates more than one hospital subject to assessment under this chapter, the entity shall pay the assessment for each hospital separately. However, if the entity operates multiple hospitals under a single medicaid provider number, it may pay the assessment for the hospitals in the aggregate.

(2) Notwithstanding any other provision of this chapter, if a hospital subject to the assessment imposed under this chapter ceases to conduct hospital operations throughout a state fiscal year, the assessment for the quarter in which the cessation occurs shall be adjusted by multiplying the assessment computed under section 4(2) of this act by a fraction, the numerator of which is the number of days during the year which the hospital conducts, operates, or maintains the hospital and the denominator of which is three hundred sixty-five. Immediately prior to ceasing to conduct, operate, or maintain a hospital, the hospital shall pay the adjusted assessment for the fiscal year to the extent not previously paid.

(3) Notwithstanding any other provision of this chapter, in the case of a hospital that commences conducting, operating, or maintaining a hospital that is not exempt from payment of the assessment under section 5 of this act and that did not conduct, operate, or maintain such hospital throughout the cost reporting year used to determine the assessment amount, the assessment for that hospital shall be computed on the basis of the actual number of nonmedicare inpatient days reported to the department by the hospital on a quarterly basis. The

hospital shall be eligible to receive increased payments under this chapter beginning on the date it commences hospital operations.

(4) Notwithstanding any other provision of this chapter, if a hospital previously subject to assessment is sold or transferred to another entity and remains subject to assessment, the assessment for that hospital shall be computed based upon the cost report data previously submitted by that hospital. The assessment shall be allocated between the transferor and transferee based on the number of days within the assessment period that each owned, operated, or maintained the hospital.

NEW SECTION. **Sec. 15.** CONDITIONS. (1) The assessment, collection, and disbursement of funds under this chapter shall be conditional upon:

(a) Withdrawal of those aspects of any pending state plan amendments previously submitted to the centers for medicare and medicaid services that are inconsistent with this chapter;

(b) Approval by the centers for medicare and medicaid services of any state plan amendments or waiver requests that are necessary in order to implement the applicable sections of this chapter; and

(c) To the extent necessary, amendment of contracts between the department and managed care organizations in order to implement this chapter.

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

(a) An appellate court or the centers for medicare and medicaid services makes a final determination that any element of this chapter, other than section 11 of this act, cannot be validly implemented;

(b) Medicaid inpatient or outpatient payment rates for hospitals are reduced below the aggregate reimbursement rates set forth in this chapter;

(c) Except for payments to the University of Washington medical center and harborview medical center payments to hospitals required under sections 9, 10, 12, and 13 of this act are not eligible for federal matching funds;

(d) The office of financial management certifies that appropriations have been adopted that fully support the rates established in this chapter for the upcoming fiscal year;

(e) If other funding available for the medicaid program is not sufficient to maintain medicaid inpatient and outpatient reimbursement rates for hospitals and small rural disproportionate share payments at one hundred percent of the levels in effect on July 1, 2009; or

(f) If the fund is used as a substitute for or to supplant other funds.

NEW SECTION. **Sec. 16.** SEVERABILITY. (1) The provisions of this chapter are not severable: If the conditions set forth in section 15(1) of this act are not satisfied or if any of the circumstances set forth in section 15(2) of this act should occur, this entire chapter shall have no effect from that point forward, except that if the payment under section 11 of this act, or the application thereof to any hospital or circumstances does not receive approval by the centers for medicare and medicaid services as described in section 15(1)(b) of this act or is determined to be unconstitutional or otherwise invalid, the other provisions of this chapter or its application to hospitals or circumstances other than those to which it is held invalid shall not be affected thereby.

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

(3) In the event that the payment under section 11 of this act, or the application thereof to any hospital or circumstances does not receive approval by the centers for medicare and medicaid services as described in section 15(1)(b) of this act or is determined to be unconstitutional or otherwise invalid, the amount of the assessment shall be adjusted under section 6(1)(c) of this act.

Sec. 17. 2009 c 564 s 209 (uncodified) is amended to read as follows:

FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES--MEDICAL ASSISTANCE PROGRAM

General Fund--State Appropriation (FY 2010) $1,597,387,000

General Fund--State Appropriation (FY 2011) $1,984,797,000
General Fund--Federal Appropriation $5,210,672,000
General Fund--Private/Local Appropriation $12,903,000
Emergency Medical Services and Trauma Care Systems
Trust Account--State Appropriation $15,076,000
Tobacco Prevention and Control Account--
State Appropriation $3,766,000
TOTAL APPROPRIATION $8,824,601,000

The appropriations in this section are subject to the following conditions and limitations:

(1) Based on quarterly expenditure reports and caseload forecasts, if the department estimates that expenditures for the medical assistance program will exceed the appropriations, the department shall take steps including but not limited to reduction of rates or elimination of optional services to reduce expenditures so that total program costs do not exceed the annual appropriation authority.

(2) In determining financial eligibility for medicaid-funded services, the department is authorized to disregard recoveries by Holocaust survivors of insurance proceeds or other assets, as defined in RCW 48.104.030.

(3) The legislature affirms that it is in the state's interest for Harborview medical center to remain an economically viable component of the state's health care system.

(4) When a person is ineligible for medicaid solely by reason of residence in an institution for mental diseases, the department shall provide the person with the same benefits as he or she would receive if eligible for medicaid, using state-only funds to the extent necessary.

(5) In accordance with RCW 74.46.625, $6,000,000 of the general fund--federal appropriation is provided solely for supplemental payments to nursing homes operated by public hospital districts. The public hospital district shall be responsible for providing the required nonfederal match for the supplemental payment, and the payments shall not exceed the maximum allowable under federal rules. It is the legislature's intent that the payments shall be supplemental to and shall not in any way offset or reduce the payments calculated and provided in accordance with part E of chapter 74.46 RCW. It is the legislature's further intent that costs otherwise allowable for rate-setting and settlement against payments under chapter 74.46 RCW shall

not be disallowed solely because such costs have been paid by revenues retained by the nursing home from these supplemental payments. The supplemental payments are subject to retrospective interim and final cost settlements based on the nursing homes' as-filed and final medicare cost reports. The timing of the interim and final cost settlements shall be at the department's discretion. During either the interim cost settlement or the final cost settlement, the department shall recoup from the public hospital districts the supplemental payments that exceed the medicaid cost limit and/or the medicare upper payment limit. The department shall apply federal rules for identifying the eligible incurred medicaid costs and the medicare upper payment limit.

(6) ((~~$1,110,000 of the general fund--federal appropriation and $1,105,000 of the general fund--state appropriation for fiscal year 2011 are provided solely for grants to rural hospitals. The department shall distribute the funds under a formula that provides a relatively larger share of the available funding to hospitals that (a) serve a disproportionate share of low-income and medically indigent patients, and (b) have relatively smaller net financial margins, to the extent allowed by the federal medicaid program.~~

~~(7)~~)) $9,818,000 of the general fund--state appropriation for fiscal year 2011, and $9,865,000 of the general fund--federal appropriation are provided solely for grants to nonrural hospitals. The department shall distribute the funds under a formula that provides a relatively larger share of the available funding to hospitals that (a) serve a disproportionate share of low-income and medically indigent patients, and (b) have relatively smaller net financial margins, to the extent allowed by the federal medicaid program.

((~~(8)~~)) (7) The department shall continue the inpatient hospital certified public expenditures program for the 2009-11 biennium. The program shall apply to all public hospitals, including those owned or operated by the state, except those classified as critical access hospitals or state psychiatric institutions. The department shall submit reports to the governor and legislature by November 1, 2009, and by November 1, 2010, that evaluate whether savings continue to exceed costs for this program. If the certified public expenditures (CPE) program in its current form is no longer cost-effective to maintain, the department shall submit a report to the governor and legislature

detailing cost-effective alternative uses of local, state, and federal resources as a replacement for this program. During fiscal year 2010 and fiscal year 2011, hospitals in the program shall be paid and shall retain one hundred percent of the federal portion of the allowable hospital cost for each medicaid inpatient fee-for-service claim payable by medical assistance and one hundred percent of the federal portion of the maximum disproportionate share hospital payment allowable under federal regulations. Inpatient medicaid payments shall be established using an allowable methodology that approximates the cost of claims submitted by the hospitals. Payments made to each hospital in the program in each fiscal year of the biennium shall be compared to a baseline amount. The baseline amount will be determined by the total of (a) the inpatient claim payment amounts that would have been paid during the fiscal year had the hospital not been in the CPE program, (b) one half of the indigent assistance disproportionate share hospital payment amounts paid to and retained by each hospital during fiscal year 2005, and (c) all of the other disproportionate share hospital payment amounts paid to and retained by each hospital during fiscal year 2005 to the extent the same disproportionate share hospital programs exist in the 2009-11 biennium. If payments during the fiscal year exceed the hospital's baseline amount, no additional payments will be made to the hospital except the federal portion of allowable disproportionate share hospital payments for which the hospital can certify allowable match. If payments during the fiscal year are less than the baseline amount, the hospital will be paid a state grant equal to the difference between payments during the fiscal year and the applicable baseline amount. Payment of the state grant shall be made in the applicable fiscal year and distributed in monthly payments. The grants will be recalculated and redistributed as the baseline is updated during the fiscal year. The grant payments are subject to an interim settlement within eleven months after the end of the fiscal year. A final settlement shall be performed. To the extent that either settlement determines that a hospital has received funds in excess of what it would have received as described in this subsection, the hospital must repay the excess amounts to the state when requested. $6,570,000 of the general fund-- state appropriation for fiscal year 2010, which is appropriated in section 204(1) of this act, and $1,500,000 of the general fund--state appropriation for fiscal year

2011, which is appropriated in section 204(1) of this act, are provided solely for state grants for the participating hospitals. Sufficient amounts are appropriated in this section for the remaining state grants for the participating hospitals.

((~~(9)~~)) (8) The department is authorized to use funds appropriated in this section to purchase goods and supplies through direct contracting with vendors when the department determines it is cost-effective to do so.

((~~(10)~~)) (9) Sufficient amounts are appropriated in this section for the department to continue podiatry services for medicaid-eligible adults.

((~~(11)~~)) (10) Sufficient amounts are appropriated in this section for the department to provide an adult dental benefit that is at least equivalent to the benefit provided in the 2003-05 biennium.

((~~(12)~~)) (11) $93,000 of the general fund--state appropriation for fiscal year 2010 and $93,000 of the general fund--federal appropriation are provided solely for the department to pursue a federal Medicaid waiver pursuant to Second Substitute Senate Bill No. 5945 (Washington health partnership plan). If the bill is not enacted by June 30, 2009, the amounts provided in this subsection shall lapse.

((~~(13)~~)) (12) The department shall require managed health care systems that have contracts with the department to serve medical assistance clients to limit any reimbursements or payments the systems make to providers not employed by or under contract with the systems to no more than the medical assistance rates paid by the department to providers for comparable services rendered to clients in the fee-for-service delivery system.

((~~(14)~~)) (13) Appropriations in this section are sufficient for the department to continue to fund family planning nurses in the community services offices.

((~~(15)~~)) (14) The department, in coordination with stakeholders, will conduct an analysis of potential savings in utilization of home dialysis. The department shall present its findings to the appropriate house of representatives and senate committees by December 2010.

((~~(16)~~)) (15) A maximum of $166,875,000 of the general fund--state appropriation and $38,389,000 of the general fund--federal appropriation may be expended in the fiscal biennium for the general assistance-unemployable medical program, and these amounts are provided

solely for this program. Of these amounts, $10,749,000 of the general fund--state appropriation for fiscal year 2010 and $10,892,000 of the general fund--federal appropriation are provided solely for payments to hospitals for providing outpatient services to low income patients who are recipients of general assistance-unemployable. Pursuant to RCW 74.09.035, the department shall not expend for the general assistance medical care services program any amounts in excess of the amounts provided in this subsection.

((~~(17)~~)) (16) If the department determines that it is feasible within the amounts provided in subsection ((~~(16)~~)) (15) of this section, and without the loss of federal disproportionate share hospital funds, the department shall contract with the carrier currently operating a managed care pilot project for the provision of medical care services to general assistance-unemployable clients. Mental health services shall be included in the services provided through the managed care system. If the department determines that it is feasible, effective October 1, 2009, in addition to serving clients in the pilot counties, the carrier shall expand managed care services to clients residing in at least the following counties: Spokane, Yakima, Chelan, Kitsap, and Cowlitz. If the department determines that it is feasible, the carrier shall complete implementation into the remaining counties. Total per person costs to the state, including outpatient and inpatient services and any additional costs due to stop loss agreements, shall not exceed the per capita payments projected for the general assistance-unemployable eligibility category, by fiscal year, in the February 2009 medical assistance expenditures forecast. The department, in collaboration with the carrier, shall seek to improve the transition rate of general assistance clients to the federal supplemental security income program.

((~~(18)~~)) (17) The department shall evaluate the impact of the use of a managed care delivery and financing system on state costs and outcomes for general assistance medical clients. Outcomes measured shall include state costs, utilization, changes in mental health status and symptoms, and involvement in the criminal justice system.

((~~(19)~~)) (18) The department shall report to the governor and the fiscal committees of the legislature by June 1, 2010, on its progress toward achieving a twenty percentage point increase in the generic prescription drug utilization rate.

((~~(20)~~)) (19) State funds shall not be used by hospitals for advertising purposes.

((~~(21)~~)) (20) The department shall seek a medicaid state plan amendment to create a professional services supplemental payment program for University of Washington medicine professional providers no later than July 1, 2009. The department shall apply federal rules for identifying the shortfall between current fee-for-service medicaid payments to participating providers and the applicable federal upper payment limit. Participating providers shall be solely responsible for providing the local funds required to obtain federal matching funds. Any incremental costs incurred by the department in the development, implementation, and maintenance of this program will be the responsibility of the participating providers. Participating providers will retain the full amount of supplemental payments provided under this program, net of any potential costs for any related audits or litigation brought against the state. The department shall report to the governor and the legislative fiscal committees on the prospects for expansion of the program to other qualifying providers as soon as feasibility is determined but no later than December 31, 2009. The report will outline estimated impacts on the participating providers, the procedures necessary to comply with federal guidelines, and the administrative resource requirements necessary to implement the program. The department will create a process for expansion of the program to other qualifying providers as soon as it is determined feasible by both the department and providers but no later than June 30, 2010.

((~~(22)~~)) (21) $9,350,000 of the general fund--state appropriation for fiscal year 2010, $8,313,000 of the general fund--state appropriation for fiscal year 2011, and $20,371,000 of the general fund--federal appropriation are provided solely for development and implementation of a replacement system for the existing medicaid management information system. The amounts provided in this subsection are conditioned on the department satisfying the requirements of section 902 of this act.

((~~(23)~~)) (22) $506,000 of the general fund--state appropriation for fiscal year 2011 and $657,000 of the general fund--federal appropriation are provided solely for the implementation of Second

Substitute House Bill No. 1373 (children's mental health). If the bill is not enacted by June 30, 2009, the amounts provided in this subsection shall lapse.

((~~(24)~~)) (23) Pursuant to 42 U.S.C. Sec. 1396(a)(25), the department shall pursue insurance claims on behalf of medicaid children served through its in-home medically intensive child program under WAC 388-551-3000. The department shall report to the Legislature by December 31, 2009, on the results of its efforts to recover such claims.

((~~(25)~~)) (24) The department may, on a case-by-case basis and in the best interests of the child, set payment rates for medically intensive home care services to promote access to home care as an alternative to hospitalization. Expenditures related to these increased payments shall not exceed the amount the department would otherwise pay for hospitalization for the child receiving medically intensive home care services.

((~~(26)~~)) (25) $425,000 of the general fund--state appropriation for fiscal year 2010, $425,000 of the general fund--state appropriation for fiscal year 2011, and $1,580,000 of the general fund--federal appropriation are provided solely to continue children's health coverage outreach and education efforts under RCW 74.09.470. These efforts shall rely on existing relationships and systems developed with local public health agencies, health care providers, public schools, the women, infants, and children program, the early childhood education and assistance program, child care providers, newborn visiting nurses, and other community-based organizations. The department shall seek public- private partnerships and federal funds that are or may become available to provide on-going support for outreach and education efforts under the federal children's health insurance program reauthorization act of 2009.

((~~(27) The department, in conjunction with the office of financial management, shall reduce outpatient and inpatient hospital rates and implement a prorated inpatient payment policy. In determining the level of reductions needed, the department shall include in its calculations services paid under fee-for-service, managed care, and certified public expenditure payment methods; but reductions shall not apply to payments for psychiatric inpatient services or payments to critical access hospitals.~~

((~~(28)~~)) (26) The department will pursue a competitive procurement process for antihemophilic products, emphasizing evidence-based medicine and protection of patient access without significant disruption in treatment.

((~~(29)~~)) (27) The department will pursue several strategies towards reducing pharmacy expenditures including but not limited to increasing generic prescription drug utilization by 20 percentage points and promoting increased utilization of the existing mail-order pharmacy program.

((~~(30)~~)) (28) The department shall reduce reimbursement for over-the-counter medications while maintaining reimbursement for those over-the-counter medications that can replace more costly prescription medications.

((~~(31)~~)) (29) The department shall seek public-private partnerships and federal funds that are or may become available to implement health information technology projects under the federal American recovery and reinvestment act of 2009.

((~~(32)~~)) (30) The department shall target funding for maternity support services towards pregnant women with factors that lead to higher rates of poor birth outcomes, including hypertension, a preterm or low birth weight birth in the most recent previous birth, a cognitive deficit or developmental disability, substance abuse, severe mental illness, unhealthy weight or failure to gain weight, tobacco use, or African American or Native American race.

((~~(33)~~)) (31) The department shall direct graduate medical education funds to programs that focus on primary care training.

((~~(34)~~)) (32) $79,000 of the general fund--state appropriation for fiscal year 2010 and $53,000 of the general fund--federal appropriation are provided solely to implement Substitute House Bill No. 1845 (medical support obligations).

((~~(35)~~)) (33) $63,000 of the general fund--state appropriation for fiscal year 2010, $583,000 of the general fund--state appropriation for fiscal year 2011, and $864,000 of the general fund--federal appropriation are provided solely to implement Engrossed House Bill No. 2194 (extraordinary medical placement for offenders). The department shall work in partnership with the department of corrections to identify services and find placements for offenders who are released through the extraordinary medical placement program. The department

shall collaborate with the department of corrections to identify and track cost savings to the department of corrections, including medical cost savings, and to identify and track expenditures incurred by the aging and disability services program for community services and by the medical assistance program for medical expenses. A joint report regarding the identified savings and expenditures shall be provided to the office of financial management and the appropriate fiscal committees of the legislature by November 30, 2010. If this bill is not enacted by June 30, 2009, the amounts provided in this subsection shall lapse.

((~~(36)~~)) (34) Sufficient amounts are provided in this section to provide full benefit dual eligible beneficiaries with medicare part D prescription drug copayment coverage in accordance with RCW 74.09.520.

NEW SECTION. **Sec. 18.** EXPIRATION. This act expires July 1, 2013.

NEW SECTION. **Sec. 19.** EMERGENCY. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

NEW SECTION. **Sec. 20.** NEW CHAPTER. Sections 1 through 16, 18, and 19 of this act constitute a new chapter in Title 74 RCW.

--- END ---