

SSB 5913 - S AMD 375
By Senator Hill

ADOPTED 06/26/2013

1 Strike everything after the enacting clause and insert the
2 following:

3 "Sec. 1. RCW 74.60.005 and 2010 1st sp.s. c 30 s 1 are each
4 amended to read as follows:

5 (1) The purpose of this chapter is to provide for a safety net
6 assessment on certain Washington hospitals, which will be used solely
7 to augment funding from all other sources and thereby (~~obtain~~
8 ~~additional funds to restore recent reductions and to~~) support
9 additional payments to hospitals for medicaid services as specified in
10 this chapter.

11 (2) The legislature finds that(~~+~~

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

18 ~~(b))~~ federal health care reform will result in an expansion of
19 medicaid enrollment in this state and an increase in federal financial
20 participation. As a result, the hospital safety net assessment and
21 hospital safety net assessment fund created in this chapter (~~allows~~
22 the state to generate additional federal financial participation for
23 the medicaid program and provides for increased reimbursement to
24 hospitals)) will begin phasing down over a four-year period beginning
25 in fiscal year 2016 as federal medicaid expansion is fully implemented.
26 The state will end its reliance on the assessment and the fund by the
27 end of fiscal year 2019.

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

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

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

4 ~~(e))~~ To generate approximately four hundred forty-six million
5 three hundred thirty-eight thousand dollars per state fiscal year in
6 fiscal years 2014 and 2015, and then phasing down in equal increments
7 to zero by the end of fiscal year 2019, in new state and federal funds
8 by disbursing all of that amount to pay for medicaid hospital services
9 and grants to certified public expenditure hospitals, except costs of
10 administration as specified in this chapter, in the form of additional
11 payments to hospitals and managed care plans, which may not be a
12 substitute for payments from other sources;

13 (c) To generate one hundred ninety-nine million eight hundred
14 thousand dollars in the 2013-2015 biennium, phasing down to zero by the
15 end of the 2017-2019 biennium, in new funds to be used in lieu of state
16 general fund payments for medicaid hospital services;

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

21 ~~((d))~~ (e) To condition the assessment on receiving federal
22 approval for receipt of additional federal financial participation and
23 on continuation of other funding sufficient to maintain ((hospital
24 inpatient and outpatient reimbursement rates and small rural
25 disproportionate share payments at least at the levels in effect on
26 July 1, 2009)) aggregate payment levels to hospitals for inpatient and
27 outpatient services covered by medicaid, including fee-for-service and
28 managed care, at least at the levels the state paid for those services
29 on July 1, 2009, as adjusted for current enrollment and utilization,
30 but without regard to payment increases resulting from chapter 30, Laws
31 of 2010 1st sp. sess.

32 **Sec. 2.** RCW 74.60.010 and 2010 1st sp.s. c 30 s 2 are each amended
33 to read as follows:

34 The definitions in this section apply throughout this chapter
35 unless the context clearly requires otherwise.

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

1 (2) "Base year" for medicaid payments for state fiscal year 2014 is
2 state fiscal year 2011. For each following year's calculations, the
3 base year must be updated to the next following year.

4 (3) "Bordering city hospital" means a hospital as defined in WAC
5 182-550-1050 and bordering cities as described in WAC 182-501-0175, or
6 successor rules.

7 (4) "Certified public expenditure hospital" means a hospital
8 participating in ((the department's)) or that at any point from the
9 effective date of this section to July 1, 2019, has participated in the
10 authority's certified public expenditure payment program as described
11 in WAC ((388-550-4650)) 182-550-4650 or successor rule. For purposes
12 of this chapter any such hospital shall continue to be treated as a
13 certified public expenditure hospital for assessment and payment
14 purposes through the date specified in RCW 74.60.901. The eligibility
15 of such hospitals to receive grants under RCW 74.60.090 solely from
16 funds generated under this chapter must not be affected by any
17 modification or termination of the federal certified public expenditure
18 program, or reduced by the amount of any federal funds no longer
19 available for that purpose.

20 ~~((+2))~~ (5) "Critical access hospital" means a hospital as
21 described in RCW 74.09.5225.

22 ~~((+3) "Department" means the department of social and health~~
23 ~~services.~~

24 ~~(+4))~~ (6) "Director" means the director of the health care
25 authority.

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

31 (8) "Fund" means the hospital safety net assessment fund
32 established under RCW 74.60.020.

33 ~~((+5))~~ (9) "Hospital" means a facility licensed under chapter
34 70.41 RCW.

35 ~~((+6))~~ (10) "Long-term acute care hospital" means a hospital which
36 has an average inpatient length of stay of greater than twenty-five
37 days as determined by the department of health.

1 ~~((7))~~ (11) "Managed care organization" means an organization
2 having a certificate of authority or certificate of registration from
3 the office of the insurance commissioner that contracts with the
4 ~~((department))~~ authority under a comprehensive risk contract to provide
5 prepaid health care services to eligible clients under the
6 ~~((department's))~~ authority's medicaid managed care programs, including
7 the healthy options program.

8 ~~((8))~~ (12) "Medicaid" means the medical assistance program as
9 established in Title XIX of the social security act and as administered
10 in the state of Washington by the ~~((department of social and health
11 services))~~ authority.

12 ~~((9))~~ (13) "Medicare cost report" means the medicare cost report,
13 form 2552~~((96))~~, or successor document.

14 ~~((10))~~ (14) "Nonmedicare hospital inpatient day" means total
15 hospital inpatient days less medicare inpatient days, including
16 medicare days reported for medicare managed care plans, as reported on
17 the medicare cost report, form 2552~~((96))~~, or successor forms,
18 excluding all skilled and nonskilled nursing facility days, skilled and
19 nonskilled swing bed days, nursery days, observation bed days, hospice
20 days, home health agency days, and other days not typically associated
21 with an acute care inpatient hospital stay.

22 ~~((11))~~ (15) "Outpatient" means services provided classified as
23 ambulatory payment classification services or successor payment
24 methodologies as defined in WAC 182-550-7050 or successor rule and
25 applies to fee-for-service payments and managed care encounter data.

26 (16) "Prospective payment system hospital" means a hospital
27 reimbursed for inpatient and outpatient services provided to medicaid
28 beneficiaries under the inpatient prospective payment system and the
29 outpatient prospective payment system as defined in WAC
30 ~~((388-550-1050))~~ 182-550-1050 or successor rule. For purposes of this
31 chapter, prospective payment system hospital does not include a
32 hospital participating in the certified public expenditure program or
33 a bordering city hospital located outside of the state of Washington
34 and in one of the bordering cities listed in WAC ~~((388-501-0175))~~ 182-
35 501-0175 or successor ~~((regulation))~~ rule.

36 ~~((12))~~ (17) "Psychiatric hospital" means a hospital facility
37 licensed as a psychiatric hospital under chapter 71.12 RCW.

1 ~~((13) "Regional support network" has the same meaning as provided~~
2 ~~in RCW 71.24.025.~~

3 ~~(14))~~ (18) "Rehabilitation hospital" means a medicare-certified
4 freestanding inpatient rehabilitation facility.

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

7 ~~(16))~~ (19) "Small rural disproportionate share hospital payment"
8 means a payment made in accordance with WAC ~~((388-550-5200))~~ 182-550-
9 5200 or ~~((subsequently filed regulation))~~ successor rule.

10 (20) "Upper payment limit" means the aggregate federal upper
11 payment limit on the amount of the medicaid payment for which federal
12 financial participation is available for a class of service and a class
13 of health care providers, as specified in 42 C.F.R. Part 47, as
14 separately determined for inpatient and outpatient hospital services.

15 **Sec. 3.** RCW 74.60.020 and 2011 1st sp.s. c 35 s 1 are each amended
16 to read as follows:

17 (1) A dedicated fund is hereby established within the state
18 treasury to be known as the hospital safety net assessment fund. The
19 purpose and use of the fund shall be to receive and disburse funds,
20 together with accrued interest, in accordance with this chapter.
21 Moneys in the fund, including interest earned, shall not be used or
22 disbursed for any purposes other than those specified in this chapter.
23 Any amounts expended from the fund that are later recouped by the
24 ~~((department))~~ authority on audit or otherwise shall be returned to the
25 fund.

26 (a) Any unexpended balance in the fund at the end of a fiscal
27 biennium shall carry over into the following biennium and shall be
28 applied to reduce the amount of the assessment under RCW
29 74.60.050(1)(c).

30 (b) Any amounts remaining in the fund ~~((on))~~ after July 1, ~~((2013))~~
31 2019, shall be ~~((used to make increased payments in accordance with RCW~~
32 ~~74.60.090 and 74.60.120 for any outstanding claims with dates of~~
33 ~~service prior to July 1, 2013. Any amounts remaining in the fund after~~
34 ~~such increased payments are made shall be refunded to hospitals, pro~~
35 ~~rata according to the amount paid by the hospital, subject to the~~
36 ~~limitations of federal law))~~ refunded to hospitals, pro rata according

1 to the amount paid by the hospital since July 1, 2013, subject to the
2 limitations of federal law.

3 (2) All assessments, interest, and penalties collected by the
4 ((department)) authority under RCW 74.60.030 and 74.60.050 shall be
5 deposited into the fund.

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

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

10 ~~(b) Upon certification by the secretary that the conditions set~~
11 ~~forth in RCW 74.60.150(1) have been met with respect to the assessments~~
12 ~~imposed under RCW 74.60.030 (1) and (2), the payments provided under~~
13 ~~RCW 74.60.080, payments provided under RCW 74.60.120(2), and any~~
14 ~~initial payments under RCW 74.60.100 and 74.60.110, funds shall be~~
15 ~~disbursed in the amount necessary to make the payments specified in~~
16 ~~those sections;~~

17 ~~(c) Upon certification by the secretary that the conditions set~~
18 ~~forth in RCW 74.60.150(1) have been met with respect to the assessments~~
19 ~~imposed under RCW 74.60.030(3) and the payments provided under RCW~~
20 ~~74.60.090 and 74.60.130, payments made subsequent to the initial~~
21 ~~payments under RCW 74.60.100 and 74.60.110, and payments under RCW~~
22 ~~74.60.120(3), funds shall be disbursed periodically as necessary to~~
23 ~~make the payments as specified in those sections;~~

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

26 ~~(e) The sum of forty nine million three hundred thousand dollars~~
27 ~~for the 2009-2011 fiscal biennium may be expended in lieu of state~~
28 ~~general fund payments to hospitals. An additional sum of seventeen~~
29 ~~million five hundred thousand dollars for the 2009-2011 fiscal biennium~~
30 ~~may be expended in lieu of state general fund payments to hospitals if~~
31 ~~additional federal financial participation under section 5001 of P.L.~~
32 ~~No. 111-5 is extended beyond December 31, 2010. The sum of one hundred~~
33 ~~ninety nine million eight hundred thousand dollars for the 2011-2013~~
34 ~~fiscal biennium may be expended in lieu of state general fund payments~~
35 ~~to hospitals;~~

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

1 ~~(g) To repay the federal government for any excess payments made to~~
2 ~~hospitals from the fund if the assessments or payment increases set~~
3 ~~forth in this chapter are deemed out of compliance with federal~~
4 ~~statutes and regulations and all appeals have been exhausted. In such~~
5 ~~a case, the department may require hospitals receiving excess payments~~
6 ~~to refund the payments in question to the fund. The state in turn~~
7 ~~shall return funds to the federal government in the same proportion as~~
8 ~~the original financing. If a hospital is unable to refund payments,~~
9 ~~the state shall develop a payment plan and/or deduct moneys from future~~
10 ~~medicaid payments))~~ are conditioned upon appropriation and the
11 continued availability of other funds sufficient to maintain aggregate
12 payment levels to hospitals for inpatient and outpatient services
13 covered by medicaid, including fee-for-service and managed care, at
14 least at the levels the state paid for those services on July 1, 2009,
15 as adjusted for current enrollment and utilization, but without regard
16 to payment increases resulting from chapter 30, Laws of 2010 1st sp.
17 sess.

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

19 (a) To make payments to hospitals and managed care plans as
20 specified in this chapter;

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

23 (c) For one million dollars per biennium for payment of
24 administrative expenses incurred by the authority in performing the
25 activities authorized by this chapter;

26 (d) For one hundred ninety-nine million eight hundred thousand
27 dollars in the 2013-2015 biennium, phasing down to zero by the end of
28 the 2017-2019 biennium to be used in lieu of state general fund
29 payments for medicaid hospital services, provided that if the full
30 amount of the payments required under RCW 74.60.120 and 74.60.130
31 cannot be distributed in a given fiscal year, this amount must be
32 reduced proportionately;

33 (e) To repay the federal government for any excess payments made to
34 hospitals from the fund if the assessments or payment increases set
35 forth in this chapter are deemed out of compliance with federal
36 statutes and regulations in a final determination by a court of
37 competent jurisdiction with all appeals exhausted. In such a case, the
38 authority may require hospitals receiving excess payments to refund the

1 payments in question to the fund. The state in turn shall return funds
2 to the federal government in the same proportion as the original
3 financing. If a hospital is unable to refund payments, the state shall
4 develop either a payment plan, or deduct moneys from future medicaid
5 payments, or both;

6 (f) Beginning in state fiscal year 2015, to pay an amount
7 sufficient, when combined with the maximum available amount of federal
8 funds necessary to provide a one percent increase in medicaid hospital
9 inpatient rates to hospitals eligible for quality improvement
10 incentives under section 18 of this act.

11 **Sec. 4.** RCW 74.60.030 and 2010 1st sp.s. c 30 s 4 are each amended
12 to read as follows:

13 ~~(1) ((An assessment is imposed as set forth in this subsection~~
14 ~~effective after the date when the applicable conditions under RCW~~
15 ~~74.60.150(1) have been satisfied through June 30, 2013, for the purpose~~
16 ~~of funding restoration of reimbursement rates under RCW 74.60.080(1)~~
17 ~~and 74.60.120(2)(a) and funding payments made subsequent to the initial~~
18 ~~payments under RCW 74.60.100 and 74.60.110. Payments under this~~
19 ~~subsection are due and payable on the first day of each calendar~~
20 ~~quarter after the department sends notice of assessment to affected~~
21 ~~hospitals. However, the initial assessment is not due and payable less~~
22 ~~than thirty calendar days after notice of the amount due has been~~
23 ~~provided to affected hospitals.~~

24 ~~(a) For the period beginning on the date the applicable conditions~~
25 ~~under RCW 74.60.150(1) are met through December 31, 2010:~~

26 ~~(i) Each prospective payment system hospital shall pay an~~
27 ~~assessment of thirty two dollars for each annual nonmedicare hospital~~
28 ~~inpatient day, multiplied by the number of days in the assessment~~
29 ~~period divided by three hundred sixty five.~~

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

34 ~~(b) For the period beginning on January 1, 2011, and ending on June~~
35 ~~30, 2011:~~

36 ~~(i) Each prospective payment system hospital shall pay an~~

1 ~~assessment of forty dollars for each annual nonmedicare hospital~~
2 ~~inpatient day, multiplied by the number of days in the assessment~~
3 ~~period divided by three hundred sixty-five.~~

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

8 ~~(c) For the period beginning July 1, 2011, through June 30, 2013:~~

9 ~~(i) Each prospective payment system hospital shall pay an~~
10 ~~assessment of forty-four dollars for each annual nonmedicare hospital~~
11 ~~inpatient day, multiplied by the number of days in the assessment~~
12 ~~period divided by three hundred sixty-five.~~

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

17 ~~(d)(i) For purposes of (a) and (b) of this subsection, the~~
18 ~~department shall determine each hospital's annual nonmedicare hospital~~
19 ~~inpatient days by summing the total reported nonmedicare inpatient days~~
20 ~~for each hospital that is not exempt from the assessment as described~~
21 ~~in RCW 74.60.040 for the relevant state fiscal year 2008 portions~~
22 ~~included in the hospital's fiscal year end reports 2007 and/or 2008~~
23 ~~cost reports. The department shall use nonmedicare hospital inpatient~~
24 ~~day data for each hospital taken from the centers for medicare and~~
25 ~~medicaid services' hospital 2552-96 cost report data file as of~~
26 ~~November 30, 2009, or equivalent data collected by the department.~~

27 ~~(ii) For purposes of (c) of this subsection, the department shall~~
28 ~~determine each hospital's annual nonmedicare hospital inpatient days by~~
29 ~~summing the total reported nonmedicare hospital inpatient days for each~~
30 ~~hospital that is not exempt from the assessment under RCW 74.60.040,~~
31 ~~taken from the most recent publicly available hospital 2552-96 cost~~
32 ~~report data file or successor data file available through the centers~~
33 ~~for medicare and medicaid services, as of a date to be determined by~~
34 ~~the department. If cost report data are unavailable from the foregoing~~
35 ~~source for any hospital subject to the assessment, the department shall~~
36 ~~collect such information directly from the hospital.~~

37 ~~(2) An assessment is imposed in the amounts set forth in this~~
38 ~~section for the purpose of funding the restoration of the rates under~~

1 ~~RCW 74.60.080(2) and 74.60.120(2)(b) and funding the initial payments~~
2 ~~under RCW 74.60.100 and 74.60.110, which shall be due and payable~~
3 ~~within thirty calendar days after the department has transmitted a~~
4 ~~notice of assessment to hospitals. Such notice shall be transmitted~~
5 ~~immediately upon determination by the secretary that the applicable~~
6 ~~conditions established by RCW 74.60.150(1) have been met.~~

7 ~~(a) Prospective payment system hospitals.~~

8 ~~(i) Each prospective payment system hospital shall pay an~~
9 ~~assessment of thirty dollars for each annual nonmedicare hospital~~
10 ~~inpatient day up to sixty thousand per year, multiplied by a ratio, the~~
11 ~~numerator of which is the number of days between June 30, 2009, and the~~
12 ~~day after the applicable conditions established by RCW 74.60.150(1)~~
13 ~~have been met and the denominator of which is three hundred sixty-five.~~

14 ~~(ii) Each prospective payment system hospital shall pay an~~
15 ~~assessment of one dollar for each annual nonmedicare hospital inpatient~~
16 ~~day over and above sixty thousand per year, multiplied by a ratio, the~~
17 ~~numerator of which is the number of days between June 30, 2009, and the~~
18 ~~day after the applicable conditions established by RCW 74.60.150(1)~~
19 ~~have been met and the denominator of which is three hundred sixty-five.~~

20 ~~(b) Each critical access hospital shall pay an assessment of ten~~
21 ~~dollars for each annual nonmedicare hospital inpatient day, multiplied~~
22 ~~by a ratio, the numerator of which is the number of days between June~~
23 ~~30, 2009, and the day after the applicable conditions established by~~
24 ~~RCW 74.60.150(1) have been met and the denominator of which is three~~
25 ~~hundred sixty-five.~~

26 ~~(c) For purposes of this subsection, the department shall determine~~
27 ~~each hospital's annual nonmedicare hospital inpatient days by summing~~
28 ~~the total reported nonmedicare inpatient days for each hospital that is~~
29 ~~not exempt from the assessment as described in RCW 74.60.040 for the~~
30 ~~relevant state fiscal year 2008 portions included in the hospital's~~
31 ~~fiscal year end reports 2007 and/or 2008 cost reports. The department~~
32 ~~shall use nonmedicare hospital inpatient day data for each hospital~~
33 ~~taken from the centers for medicare and medicaid services' hospital~~
34 ~~2552-96 cost report data file as of November 30, 2009, or equivalent~~
35 ~~data collected by the department.~~

36 ~~(3) An assessment is imposed as set forth in this subsection for~~
37 ~~the period February 1, 2010, through June 30, 2013, for the purpose of~~
38 ~~funding increased hospital payments under RCW 74.60.090 and~~

1 ~~74.60.120(3), which shall be due and payable on the first day of each~~
2 ~~calendar quarter after the department has sent notice of the assessment~~
3 ~~to each affected hospital, provided that the initial assessment shall~~
4 ~~be transmitted only after the secretary has determined that the~~
5 ~~applicable conditions established by RCW 74.60.150(1) have been~~
6 ~~satisfied and shall be payable no less than thirty calendar days after~~
7 ~~the department sends notice of the amount due to affected hospitals.~~
8 ~~The initial assessment shall include the full amount due from February~~
9 ~~1, 2010, through the date of the notice.~~

10 ~~(a) For the period February 1, 2010, through December 31, 2010:~~

11 ~~(i) Prospective payment system hospitals.~~

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

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

22 ~~(ii) Each psychiatric hospital and each rehabilitation hospital~~
23 ~~shall pay an assessment of thirty one dollars for each annual~~
24 ~~nonmedicare hospital inpatient day, multiplied by the number of days in~~
25 ~~the assessment period divided by three hundred sixty five.~~

26 ~~(b) For the period beginning on January 1, 2011, and ending on June~~
27 ~~30, 2011:~~

28 ~~(i) Prospective payment system hospitals.~~

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

33 ~~(B) Each prospective payment system hospital shall pay an~~
34 ~~assessment of six dollars for each annual nonmedicare inpatient day~~
35 ~~over and above sixty thousand per year, multiplied by the number of~~
36 ~~days in the assessment period divided by three hundred sixty five. The~~
37 ~~department may adjust the assessment or the number of nonmedicare~~

1 ~~hospital inpatient days used to calculate the assessment amount if~~
2 ~~necessary to maintain compliance with federal statutes and regulations~~
3 ~~related to medicaid program health care related taxes.~~

4 ~~(ii) Each psychiatric hospital and each rehabilitation hospital~~
5 ~~shall pay an assessment of thirty nine dollars for each annual~~
6 ~~nonmedicare hospital inpatient day, multiplied by the number of days in~~
7 ~~the assessment period divided by three hundred sixty five.~~

8 ~~(c) For the period beginning July 1, 2011, through June 30, 2013:~~

9 ~~(i) Prospective payment system hospitals.~~

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

15 ~~(B) Each prospective payment system hospital shall pay an~~
16 ~~assessment of six dollars for each annual nonmedicare inpatient day~~
17 ~~over and above sixty thousand per year, multiplied by the number of~~
18 ~~days in the assessment period divided by three hundred sixty five. The~~
19 ~~department may adjust the assessment or the number of nonmedicare~~
20 ~~hospital inpatient days if necessary to maintain compliance with~~
21 ~~federal statutes and regulations related to medicaid program health~~
22 ~~care related taxes.~~

23 ~~(ii) Each psychiatric hospital and each rehabilitation hospital~~
24 ~~shall pay an assessment of thirty nine dollars for each annual~~
25 ~~nonmedicare inpatient day, multiplied by the number of days in the~~
26 ~~assessment period divided by three hundred sixty five.~~

27 ~~(d)(i) For purposes of (a) and (b) of this subsection, the~~
28 ~~department shall determine each hospital's annual nonmedicare hospital~~
29 ~~inpatient days by summing the total reported nonmedicare inpatient days~~
30 ~~for each hospital that is not exempt from the assessment as described~~
31 ~~in RCW 74.60.040 for the relevant state fiscal year 2008 portions~~
32 ~~included in the hospital's fiscal year end reports 2007 and/or 2008~~
33 ~~cost reports. The department shall use nonmedicare hospital inpatient~~
34 ~~day data for each hospital taken from the centers for medicare and~~
35 ~~medicaid services' hospital 2552-96 cost report data file as of~~
36 ~~November 30, 2009, or equivalent data collected by the department.~~

37 ~~(ii) For purposes of (c) of this subsection, the department shall~~
38 ~~determine each hospital's annual nonmedicare hospital inpatient days by~~

1 ~~summing the total reported nonmedicare hospital inpatient days for each~~
2 ~~hospital that is not exempt from the assessment under RCW 74.60.040,~~
3 ~~taken from the most recent publicly available hospital 2552-96 cost~~
4 ~~report data file or successor data file available through the centers~~
5 ~~for medicare and medicaid services, as of a date to be determined by~~
6 ~~the department. If cost report data are unavailable from the foregoing~~
7 ~~source for any hospital subject to the assessment, the department shall~~
8 ~~collect such information directly from the hospital.~~

9 ~~(4) Notwithstanding the provisions of RCW 74.60.070, nothing in~~
10 ~~chapter 30, Laws of 2010 1st sp. sess. is intended to prohibit a~~
11 ~~hospital from including assessment amounts paid in accordance with this~~
12 ~~section on their medicare and medicaid cost reports)) (a) Upon~~
13 ~~satisfaction of the conditions in RCW 74.60.150(1), and so long as the~~
14 ~~conditions in RCW 74.60.150(2) have not occurred, an assessment is~~
15 ~~imposed as set forth in this subsection, effective July 1, 2013. The~~
16 ~~authority shall calculate the amount due annually and shall issue~~
17 ~~assessments quarterly for one-fourth of the annual amount due from each~~
18 ~~hospital. Initial assessment notices must be sent to each hospital not~~
19 ~~earlier than thirty days after satisfaction of the conditions in RCW~~
20 ~~74.60.150(1) and must include all amounts due from and after July 1,~~
21 ~~2013. Payment is due not sooner than thirty days thereafter.~~
22 ~~Subsequent notices must be sent on or about thirty days prior to the~~
23 ~~end of each subsequent quarter and payment is due thirty days~~
24 ~~thereafter.~~

25 ~~(b) Beginning July 1, 2013, and except as provided in RCW~~
26 ~~74.60.050:~~

27 ~~(i) Each prospective payment system hospital, except psychiatric~~
28 ~~and rehabilitation hospitals, shall pay a quarterly assessment. Each~~
29 ~~quarterly assessment shall be one quarter of three hundred forty-four~~
30 ~~dollars for each annual nonmedicare hospital inpatient day, up to a~~
31 ~~maximum of fifty-four thousand days per year. For each nonmedicare~~
32 ~~hospital inpatient day in excess of fifty-four thousand days, each~~
33 ~~prospective payment system hospital shall pay an assessment of one~~
34 ~~quarter of seven dollars for each such day;~~

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

1 (iii) Each psychiatric hospital shall pay a quarterly assessment of
2 one quarter of sixty-seven dollars for each annual nonmedicare hospital
3 inpatient day; and

4 (iv) Each rehabilitation hospital shall pay a quarterly assessment
5 of one quarter of sixty-seven dollars for each annual nonmedicare
6 hospital inpatient day.

7 (2) The authority shall determine each hospital's annual
8 nonmedicare hospital inpatient days by summing the total reported
9 nonmedicare hospital inpatient days for each hospital that is not
10 exempt from the assessment under RCW 74.60.040, taken from the
11 hospital's 2552 cost report data file or successor data file available
12 through the centers for medicare and medicaid services, as of a date to
13 be determined by the authority. For state fiscal year 2014, the
14 authority shall use cost report data for hospitals' fiscal years ending
15 in 2010. For subsequent years, the hospitals' next succeeding fiscal
16 year cost report data must be used.

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

23 (b) A prospective payment system hospital commencing operations
24 after January 1, 2009, must be assessed in accordance with this section
25 after becoming an eligible new prospective payment system hospital as
26 defined in RCW 74.60.010.

27 **Sec. 5.** RCW 74.60.050 and 2010 1st sp.s. c 30 s 6 are each amended
28 to read as follows:

29 (1) The (~~department~~) authority, in cooperation with the office of
30 financial management, shall develop rules for determining the amount to
31 be assessed to individual hospitals, notifying individual hospitals of
32 the assessed amount, and collecting the amounts due. Such rule making
33 shall specifically include provision for:

34 (a) Transmittal of (~~quarterly~~) notices of assessment by the
35 (~~department~~) authority to each hospital informing the hospital of its
36 nonmedicare hospital inpatient days and the assessment amount due and

1 payable(~~(. — Such quarterly notices shall be sent to each hospital at~~
2 ~~least thirty calendar days prior to the due date for the quarterly~~
3 ~~assessment payment.)~~);

4 (b) Interest on delinquent assessments at the rate specified in RCW
5 82.32.050(~~(-)~~); and

6 (c) Adjustment of the assessment amounts (~~as follows~~:

7 ~~(i) For each fiscal year beginning July 1, 2010, the assessment~~
8 ~~amounts under RCW 74.60.030 (1) and (3) may be adjusted as follows~~:

9 ~~(A) If sufficient other funds for hospitals, excluding any~~
10 ~~extension of section 5001 of P.L. No. 111-5, are available to support~~
11 ~~the reimbursement rates and other payments under RCW 74.60.080,~~
12 ~~74.60.090, 74.60.100, 74.60.110, or 74.60.120 without utilizing the~~
13 ~~full assessment authorized under RCW 74.60.030 (1) or (3), the~~
14 ~~department shall reduce the amount of the assessment for prospective~~
15 ~~payment system, psychiatric, and rehabilitation hospitals~~
16 ~~proportionately to the minimum level necessary to support those~~
17 ~~reimbursement rates and other payments.~~

18 ~~(B) Provided that none of the conditions set forth in RCW~~
19 ~~74.60.150(2) have occurred, if the department's forecasts indicate that~~
20 ~~the assessment amounts under RCW 74.60.030 (1) and (3), together with~~
21 ~~all other available funds, are not sufficient to support the~~
22 ~~reimbursement rates and other payments under RCW 74.60.080, 74.60.090,~~
23 ~~74.60.100, 74.60.110, or 74.60.120, the department shall increase the~~
24 ~~assessment rates for prospective payment system, psychiatric, and~~
25 ~~rehabilitation hospitals proportionately to the amount necessary to~~
26 ~~support those reimbursement rates and other payments, plus a~~
27 ~~contingency factor up to ten percent of the total assessment amount.~~

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

31 ~~(ii) Any adjustment to the assessment amounts pursuant to this~~
32 ~~subsection, and the data supporting such adjustment, including but not~~
33 ~~limited to relevant data listed in subsection (2) of this section, must~~
34 ~~be submitted to the Washington state hospital association for review~~
35 ~~and comment at least sixty calendar days prior to implementation of~~
36 ~~such adjusted assessment amounts. Any review and comment provided by~~
37 ~~the Washington state hospital association shall not limit the ability~~

1 of the Washington state hospital association or its members to
2 challenge an adjustment or other action by the department that is not
3 made in accordance with this chapter.

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

6 (a) The fund balance;

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

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

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

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

18 (4) To the extent necessary, the department shall amend the
19 contracts between the managed care organizations and the department and
20 between regional support networks and the department to incorporate the
21 provisions of RCW 74.60.120. The department shall pursue amendments to
22 the contracts as soon as possible after April 27, 2010. The amendments
23 to the contracts shall, among other provisions, provide for increased
24 payment rates to managed care organizations in accordance with RCW
25 74.60.120)) in accordance with subsections (2) and (3) of this section.

26 (2) For state fiscal year 2015, the assessment amounts established
27 under RCW 74.60.030 must be adjusted as follows:

28 (a) If sufficient other funds, including federal funds, are
29 available to make the payments required under this chapter and fund the
30 state portion of the quality incentive payments under section 18 of
31 this act and RCW 74.60.020(4)(f) without utilizing the full assessment
32 under RCW 74.60.030, the authority shall reduce the amount of the
33 assessment to the minimum levels necessary to support those payments;

34 (b) If the total amount of inpatient or outpatient supplemental
35 payments under RCW 74.60.120 is in excess of the upper payment limit
36 and the entire excess amount cannot be disbursed by additional payments
37 to managed care organizations under RCW 74.60.130, the authority shall
38 proportionately reduce future assessments on prospective payment

1 hospitals to the level necessary to generate additional payments to
2 hospitals that are consistent with the upper payment limit plus the
3 maximum permissible amount of additional payments to managed care
4 organizations under RCW 74.60.130;

5 (c) If the amount of payments to managed care organizations under
6 RCW 74.60.130 cannot be distributed because of failure to meet federal
7 actuarial soundness or utilization requirements or other federal
8 requirements, the authority shall apply the amount that cannot be
9 distributed to reduce future assessments to the level necessary to
10 generate additional payments to managed care organizations that are
11 consistent with federal actuarial soundness or utilization requirements
12 or other federal requirements;

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

17 (e) If the number of nonmedicare inpatient days applied to the
18 rates provided in RCW 74.60.030 will not produce sufficient funds to
19 support the payments required under this chapter and the state portion
20 of the quality incentive payments under section 18 of this act and RCW
21 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may be
22 increased proportionately by category of hospital to amounts no greater
23 than necessary in order to produce the required level of funds needed
24 to make the payments specified in this chapter and the state portion of
25 the quality incentive payments under section 18 of this act and RCW
26 74.60.020(4)(f); and

27 (f) Any actual or estimated surplus remaining in the fund at the
28 end of the fiscal year must be applied to reduce the assessment amount
29 for the subsequent fiscal year.

30 (3) For each fiscal year after June 30, 2015, the assessment
31 amounts established under RCW 74.60.030 must be adjusted as follows:

32 (a) In order to support the payments required in this chapter, the
33 assessment amounts must be reduced in approximately equal yearly
34 increments each fiscal year by category of hospital until the
35 assessment amount is zero by July 1, 2019;

36 (b) If sufficient other funds, including federal funds, are
37 available to make the payments required under this chapter and fund the
38 state portion of the quality incentive payments under section 18 of

1 this act and RCW 74.60.020(4)(f) without utilizing the full assessment
2 under RCW 74.60.030, the authority shall reduce the amount of the
3 assessment to the minimum levels necessary to support those payments;

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

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

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

25 (f) If the number of nonmedicare inpatient days applied to the
26 rates provided in RCW 74.60.030 will not produce sufficient funds to
27 support the payments required under this chapter and the state portion
28 of the quality incentive payments under section 18 of this act and RCW
29 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may be
30 increased proportionately by category of hospital to amounts no greater
31 than necessary in order to produce the required level of funds needed
32 to make the payments specified in this chapter and the state portion of
33 the quality incentive payments under section 18 of this act and RCW
34 74.60.020(4)(f); and

35 (g) Any actual or estimated surplus remaining in the fund at the
36 end of the fiscal year must be applied to reduce the assessment amount
37 for the subsequent fiscal year.

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

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

16 (i) The fund balance;

17 (ii) The amount of assessment paid by each hospital;

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

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

26 (v) The annual state share, federal share, and total payments made
27 to each hospital under each of the following programs: Grants to
28 certified public expenditure hospitals under RCW 74.60.090, for
29 critical access hospital payments under RCW 74.60.100; and
30 disproportionate share programs under RCW 74.60.110;

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

33 (vii) The amount of payments made to managed care plans under RCW
34 74.60.130, including the amount representing additional premium tax,
35 and the data used to calculate those payments.

36 **Sec. 6.** RCW 74.60.070 and 2010 1st sp.s. c 30 s 8 are each amended
37 to read as follows:

1 The incidence and burden of assessments imposed under this chapter
2 shall be on hospitals and the expense associated with the assessments
3 shall constitute a part of the operating overhead of hospitals.
4 Hospitals shall not increase charges or billings to patients or third-
5 party payers as a result of the assessments under this chapter. The
6 ((department)) authority may require hospitals to submit certified
7 statements by their chief financial officers or equivalent officials
8 attesting that they have not increased charges or billings as a result
9 of the assessments.

10 **Sec. 7.** RCW 74.60.080 and 2010 1st sp.s. c 30 s 9 are each amended
11 to read as follows:

12 ((Upon satisfaction of the applicable conditions set forth in RCW
13 74.60.150(1), the department shall:

14 (1) ~~Restore medicaid inpatient and outpatient reimbursement rates~~
15 ~~to levels as if the four percent medicaid inpatient and outpatient rate~~
16 ~~reductions did not occur on July 1, 2009; and~~

17 (2) ~~Recalculate the amount payable to each hospital that submitted~~
18 ~~an otherwise allowable claim for inpatient and outpatient~~
19 ~~medicaid covered services rendered from and after July 1, 2009, up to~~
20 ~~and including the date when the applicable conditions under RCW~~
21 ~~74.60.150(1) have been satisfied, as if the four percent medicaid~~
22 ~~inpatient and outpatient rate reductions did not occur effective July~~
23 ~~1, 2009, and, within sixty calendar days after the date upon which the~~
24 ~~applicable conditions set forth in RCW 74.60.150(1) have been~~
25 ~~satisfied, remit the difference to each hospital.)) In each fiscal year
26 and upon satisfaction of the conditions in RCW 74.60.150(1), after
27 deducting or reserving amounts authorized to be disbursed under RCW
28 74.60.020(4) (d), (e), and (f), disbursements from the fund must be
29 made as follows:~~

30 (1) For grants to certified public expenditure hospitals in
31 accordance with RCW 74.60.090;

32 (2) For payments to critical access hospitals in accordance with
33 RCW 74.60.100;

34 (3) For small rural disproportionate share payments in accordance
35 with RCW 74.60.110;

36 (4) For payments to hospitals under RCW 74.60.120; and

1 (5) For payments to managed care organizations under RCW 74.60.130
2 for the provision of hospital services.

3 **Sec. 8.** RCW 74.60.090 and 2011 1st sp.s. c 35 s 2 are each amended
4 to read as follows:

5 ~~(1) ((Upon satisfaction of the applicable conditions set forth in~~
6 ~~RCW 74.60.150(1) and for services rendered on or after February 1,~~
7 ~~2010, through June 30, 2011, the department shall increase the medicaid~~
8 ~~inpatient and outpatient fee for service hospital reimbursement rates~~
9 ~~in effect on June 30, 2009, by the percentages specified below:~~

10 ~~(a) Prospective payment system hospitals:~~

11 ~~(i) Inpatient psychiatric services: Thirteen percent;~~

12 ~~(ii) Inpatient services: Thirteen percent;~~

13 ~~(iii) Outpatient services: Thirty six and eighty three one~~
14 ~~hundredths percent.~~

15 ~~(b) Harborview medical center and University of Washington medical~~
16 ~~center:~~

17 ~~(i) Inpatient psychiatric services: Three percent;~~

18 ~~(ii) Inpatient services: Three percent;~~

19 ~~(iii) Outpatient services: Twenty one percent.~~

20 ~~(c) Rehabilitation hospitals:~~

21 ~~(i) Inpatient services: Thirteen percent;~~

22 ~~(ii) Outpatient services: Thirty six and eighty three one~~
23 ~~hundredths percent.~~

24 ~~(d) Psychiatric hospitals:~~

25 ~~(i) Inpatient psychiatric services: Thirteen percent;~~

26 ~~(ii) Inpatient services: Thirteen percent.~~

27 ~~(2) Upon satisfaction of the applicable conditions set forth in RCW~~
28 ~~74.60.150(1) and for services rendered on or after July 1, 2011, the~~
29 ~~department shall increase the medicaid inpatient and outpatient~~
30 ~~fee for service hospital reimbursement rates in effect on June 30,~~
31 ~~2009, by the percentages specified below:~~

32 ~~(a) Prospective payment system hospitals:~~

33 ~~(i) Inpatient psychiatric services: Thirteen percent;~~

34 ~~(ii) Inpatient services: Three and ninety six one hundredths~~
35 ~~percent;~~

36 ~~(iii) Outpatient services: Twenty seven and twenty five one~~
37 ~~hundredths percent.~~

1 ~~(b) Harborview medical center and University of Washington medical~~
2 ~~center:~~

3 ~~(i) Inpatient psychiatric services: Three percent;~~

4 ~~(ii) Inpatient services: Three percent;~~

5 ~~(iii) Outpatient services: Twenty one percent.~~

6 ~~(c) Rehabilitation hospitals:~~

7 ~~(i) Inpatient services: Thirteen percent;~~

8 ~~(ii) Outpatient services: Thirty six and eighty three one-~~
9 ~~hundredths percent.~~

10 ~~(d) Psychiatric hospitals:~~

11 ~~(i) Inpatient psychiatric services: Thirteen percent;~~

12 ~~(ii) Inpatient services: Thirteen percent.~~

13 ~~(3) For claims processed for services rendered on or after February~~
14 ~~1, 2010, but prior to satisfaction of the applicable conditions~~
15 ~~specified in RCW 74.60.150(1), the department shall, within sixty~~
16 ~~calendar days after satisfaction of those conditions, calculate the~~
17 ~~amount payable to hospitals in accordance with this section and remit~~
18 ~~the difference to each hospital that has submitted an otherwise~~
19 ~~allowable claim for payment for such services.~~

20 ~~(4) By December 1, 2012, the department will submit a study to the~~
21 ~~legislature with recommendations on the amount of the assessments~~
22 ~~necessary to continue to support hospital payments for the 2013-2015~~
23 ~~biennium. The evaluation will assess medicaid hospital payments~~
24 ~~relative to medicaid hospital costs. The study should address current~~
25 ~~federal law, including any changes on scope of medicaid coverage,~~
26 ~~provisions related to provider taxes, and impacts of federal health~~
27 ~~care reform legislation. The study should also address the state's~~
28 ~~economic forecast. Based on the forecast, the department should~~
29 ~~recommend the amount of assessment needed to support future hospital~~
30 ~~payments and the departmental administrative expenses. Recommendations~~
31 ~~should be developed with the fiscal committees of the legislature,~~
32 ~~office of financial management, and the Washington state hospital~~
33 ~~association.) In each fiscal year commencing upon satisfaction of the~~
34 ~~applicable conditions in RCW 74.60.150(1), funds must be disbursed from~~
35 ~~the fund and the authority shall make grants to certified public~~
36 ~~expenditure hospitals, which shall not be considered payments for~~
37 ~~hospital services, as follows:~~

1 (a) University of Washington medical center: Three million three
2 hundred thousand dollars per state fiscal year in fiscal years 2014 and
3 2015, and then reduced in approximately equal increments per fiscal
4 year until the grant amount is zero by July 1, 2019;

5 (b) Harborview medical center: Seven million six hundred thousand
6 dollars per state fiscal year in fiscal years 2014 and 2015, and then
7 reduced in approximately equal increments per fiscal year until the
8 grant amount is zero by July 1, 2019;

9 (c) All other certified public expenditure hospitals: Four million
10 seven hundred thousand dollars per state fiscal year in fiscal years
11 2014 and 2015, and then reduced in approximately equal increments per
12 fiscal year until the grant amount is zero by July 1, 2019. The amount
13 of payments to individual hospitals under this subsection must be
14 determined using a methodology that provides each hospital with a
15 proportional allocation of the group's total amount of medicaid and
16 state children's health insurance program payments determined from
17 claims and encounter data using the same general methodology set forth
18 in RCW 74.60.120 (3) and (4).

19 (2) Payments must be made quarterly, taking the total disbursement
20 amount and dividing by four to calculate the quarterly amount. The
21 initial payment, which must include all amounts due from and after July
22 1, 2013, to the date of the initial payment, must be made within thirty
23 days after satisfaction of the conditions in RCW 74.60.150(1). The
24 authority shall provide a quarterly report of such payments to the
25 Washington state hospital association.

26 **Sec. 9.** RCW 74.60.100 and 2010 1st sp.s. c 30 s 11 are each
27 amended to read as follows:

28 ~~((Upon satisfaction of the applicable conditions set forth in RCW~~
29 ~~74.60.150(1), the department shall pay critical access hospitals that~~
30 ~~do not qualify for or receive a small rural disproportionate share~~
31 ~~payment in the subject state fiscal year an access payment of fifty~~
32 ~~dollars for each medicaid inpatient day, exclusive of days on which a~~
33 ~~swing bed is used for subacute care, from and after July 1, 2009.~~
34 ~~Initial payments to hospitals, covering the period from July 1, 2009,~~
35 ~~to the date when the applicable conditions under RCW 74.60.150(1) are~~
36 ~~satisfied, shall be made within sixty calendar days after such~~
37 ~~conditions are satisfied. Subsequent payments shall be made to~~

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

23 **Sec. 10.** RCW 74.60.110 and 2010 1st sp.s. c 30 s 12 are each
24 amended to read as follows:

25 ~~((Upon satisfaction of the applicable conditions set forth in RCW~~
26 ~~74.60.150(1), small rural disproportionate share payments shall be~~
27 ~~increased to one hundred twenty percent of the level in effect as of~~
28 ~~June 30, 2009, for the period from and after July 1, 2009, until July~~
29 ~~1, 2013. Initial payments, covering the period from July 1, 2009, to~~
30 ~~the date when the applicable conditions under RCW 74.60.150(1) are~~
31 ~~satisfied, shall be made within sixty calendar days after those~~
32 ~~conditions are satisfied. Subsequent payments shall be made directly~~
33 ~~to hospitals by the department on a periodic basis.)) In each fiscal~~
34 ~~year commencing upon satisfaction of the applicable conditions in RCW~~
35 ~~74.60.150(1), one million nine hundred nine thousand dollars must be~~
36 ~~distributed from the fund and, with available federal matching funds,~~
37 ~~paid to hospitals eligible for small rural disproportionate share~~

1 payments under WAC 182-550-4900 or successor rule. Payments must be
2 made directly to hospitals by the authority in accordance with that
3 regulation. The authority shall provide a report of such payments to
4 the Washington state hospital association within thirty days after
5 payments are made.

6 **Sec. 11.** RCW 74.60.120 and 2010 1st sp.s. c 30 s 13 are each
7 amended to read as follows:

8 ~~((Subject to the applicable conditions set forth in RCW~~
9 ~~74.60.150(1), the department shall:~~

10 ~~(1) Amend medicaid managed care and regional support network~~
11 ~~contracts as necessary in order to ensure compliance with this chapter;~~

12 ~~(2) With respect to the inpatient and outpatient rates established~~
13 ~~by RCW 74.60.080:~~

14 ~~(a) Upon satisfaction of the applicable conditions under RCW~~
15 ~~74.60.150(1), increase payments to managed care organizations and~~
16 ~~regional support networks as necessary to ensure that hospitals are~~
17 ~~reimbursed in accordance with RCW 74.60.080(1) for services rendered~~
18 ~~from and after the date when applicable conditions under RCW~~
19 ~~74.60.150(1) have been satisfied, and pay an additional amount equal to~~
20 ~~the estimated amount of additional state taxes on managed care~~
21 ~~organizations or regional support networks due as a result of the~~
22 ~~payments under this section, and require managed care organizations and~~
23 ~~regional support networks to make payments to each hospital in~~
24 ~~accordance with RCW 74.60.080. The increased payments made to~~
25 ~~hospitals pursuant to this subsection shall be in addition to any other~~
26 ~~amounts payable to hospitals by managed care organizations or regional~~
27 ~~support networks and shall not affect any other payments to hospitals;~~

28 ~~(b) Within sixty calendar days after satisfaction of the applicable~~
29 ~~conditions under RCW 74.60.150(1), calculate the additional amount due~~
30 ~~to each hospital to pay claims submitted for inpatient and outpatient~~
31 ~~medicaid-covered services rendered from and after July 1, 2009, through~~
32 ~~the date when the applicable conditions under RCW 74.60.150(1) have~~
33 ~~been satisfied, based on the rates required by RCW 74.60.080(2), make~~
34 ~~payments to managed care organizations and regional support networks in~~
35 ~~amounts sufficient to pay the additional amounts due to each hospital~~
36 ~~plus an additional amount equal to the estimated amount of additional~~
37 ~~state taxes on managed care organizations or regional support networks~~

1 due as a result of the payments under this subsection, and require
2 managed care organizations and regional support networks to make
3 payments to each hospital in accordance with the department's
4 calculations within forty five calendar days after the department
5 disburses funds for those purposes;

6 (3) With respect to the inpatient and outpatient hospital rates
7 established by RCW 74.60.090:

8 (a) Upon satisfaction of the applicable conditions under RCW
9 74.60.150(1), increase payments to managed care organizations and
10 regional support networks as necessary to ensure that hospitals are
11 reimbursed in accordance with RCW 74.60.090, and pay an additional
12 amount equal to the estimated amount of additional state taxes on
13 managed care organizations or regional support networks due as a result
14 of the payments under this section;

15 (b) Require managed care organizations and regional support
16 networks to reimburse hospitals for hospital inpatient and outpatient
17 services rendered after the date that the applicable conditions under
18 RCW 74.60.150(1) are satisfied at rates no lower than the combined
19 rates established by RCW 74.60.080 and 74.60.090;

20 (c) Within sixty calendar days after satisfaction of the applicable
21 conditions under RCW 74.60.150(1), calculate the additional amount due
22 to each hospital to pay claims submitted for inpatient and outpatient
23 medicaid-covered services rendered from and after February 1, 2010,
24 through the date when the applicable conditions under RCW 74.60.150(1)
25 are satisfied based on the rates required by RCW 74.60.090, make
26 payments to managed care organizations and regional support networks in
27 amounts sufficient to pay the additional amounts due to each hospital
28 plus an additional amount equal to the estimated amount of additional
29 state taxes on managed care organizations or regional support networks,
30 and require managed care organizations and regional support networks to
31 make payments to each hospital in accordance with the department's
32 calculations within forty five calendar days after the department
33 disburses funds for those purposes;

34 (d) Require managed care organizations that contract with health
35 care organizations that provide, directly or by contract, health care
36 services on a prepaid or capitated basis to make payments to health
37 care organizations for any of the hospital payments that the managed
38 care organizations would have been required to pay to hospitals under

1 ~~this section if the managed care organizations did not contract with~~
2 ~~those health care organizations, and require the managed care~~
3 ~~organizations to require those health care organizations to make~~
4 ~~equivalent payments to the hospitals that would have received payments~~
5 ~~under this section if the managed care organizations did not contract~~
6 ~~with the health care organizations;~~

7 ~~(4) The department shall ensure that the increases to the medicaid~~
8 ~~fee schedules as described in RCW 74.60.090 are included in the~~
9 ~~development of healthy options premiums.~~

10 ~~(5) The department may require managed care organizations and~~
11 ~~regional support networks to demonstrate compliance with this~~
12 ~~section.)~~ (1) Beginning in state fiscal year 2014, commencing thirty
13 days after satisfaction of the applicable conditions in RCW
14 74.60.150(1), and for the period of state fiscal years 2014 through
15 2019, the authority shall make supplemental payments directly to
16 Washington hospitals, separately for inpatient and outpatient fee-for-
17 service medicaid services, as follows:

18 (a) For inpatient fee-for-service payments for prospective payment
19 hospitals other than psychiatric or rehabilitation hospitals, twenty-
20 nine million two hundred twenty-five thousand dollars per state fiscal
21 year in fiscal years 2014 and 2015, and then amounts reduced in equal
22 increments per fiscal year until the supplemental payment amount is
23 zero by July 1, 2019, from the fund, plus federal matching funds;

24 (b) For outpatient fee-for-service payments for prospective payment
25 hospitals other than psychiatric or rehabilitation hospitals, thirty
26 million dollars per state fiscal year in fiscal years 2014 and 2015,
27 and then amounts reduced in equal increments per fiscal year until the
28 supplemental payment amount is zero by July 1, 2019, from the fund,
29 plus federal matching funds;

30 (c) For inpatient fee-for-service payments for psychiatric
31 hospitals, six hundred twenty-five thousand dollars per state fiscal
32 year in fiscal years 2014 and 2015, and then amounts reduced in equal
33 increments per fiscal year until the supplemental payment amount is
34 zero by July 1, 2019, from the fund, plus federal matching funds;

35 (d) For inpatient fee-for-service payments for rehabilitation
36 hospitals, one hundred fifty thousand dollars per state fiscal year in
37 fiscal years 2014 and 2015, and then amounts reduced in equal

1 increments per fiscal year until the supplemental payment amount is
2 zero by July 1, 2019, from the fund, plus federal matching funds;

3 (e) For inpatient fee-for-service payments for border hospitals,
4 two hundred fifty thousand dollars per state fiscal year in fiscal
5 years 2014 and 2015, and then amounts reduced in equal increments per
6 fiscal year until the supplemental payment amount is zero by July 1,
7 2019, from the fund, plus federal matching funds; and

8 (f) For outpatient fee-for-service payments for border hospitals,
9 two hundred fifty thousand dollars per state fiscal year in fiscal
10 years 2014 and 2015, and then amounts reduced in equal increments per
11 fiscal year until the supplemental payment amount is zero by July 1,
12 2019, from the fund, plus federal matching funds.

13 (2) If the amount of inpatient or outpatient payments under
14 subsection (1) of this section, when combined with federal matching
15 funds, exceeds the upper payment limit, payments to each category of
16 hospital must be reduced proportionately to a level where the total
17 payment amount is consistent with the upper payment limit. Funds under
18 this chapter unable to be paid to hospitals under this section because
19 of the upper payment limit must be paid to managed care organizations
20 under RCW 74.60.130, subject to the limitations in this chapter.

21 (3) The amount of such fee-for-service inpatient payments to
22 individual hospitals within each of the categories identified in
23 subsection (1)(a), (c), (d), and (e) of this section must be determined
24 by:

25 (a) Applying the medicaid fee-for-service rates in effect on July
26 1, 2009, without regard to the increases required by chapter 30, Laws
27 of 2010 1st sp. sess. to each hospital's inpatient fee-for-services
28 claims and medicaid managed care encounter data for the base year;

29 (b) Applying the medicaid fee-for-service rates in effect on July
30 1, 2009, without regard to the increases required by chapter 30, Laws
31 of 2010 1st sp. sess. to all hospitals' inpatient fee-for-services
32 claims and medicaid managed care encounter data for the base year; and

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

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

1 (a) Applying the medicaid fee-for-service rates in effect on July
2 1, 2009, without regard to the increases required by chapter 30, Laws
3 of 2010 1st sp. sess. to each hospital's outpatient fee-for-services
4 claims and medicaid managed care encounter data for the base year;

5 (b) Applying the medicaid fee-for-service rates in effect on July
6 1, 2009, without regard to the increases required by chapter 30, Laws
7 of 2010 1st sp. sess. to all hospitals' outpatient fee-for-services
8 claims and medicaid managed care encounter data for the base year; and

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

12 (5) Thirty days before the initial payments and sixty days before
13 the first payment in each subsequent fiscal year, the authority shall
14 provide each hospital and the Washington state hospital association
15 with an explanation of how the amounts due to each hospital under this
16 section were calculated.

17 (6) Payments must be made in quarterly installments on or about the
18 last day of every quarter, except that the initial payment must be made
19 within thirty days after satisfaction of the conditions in RCW
20 74.60.150(1) and must include all amounts due from July 1, 2013, to the
21 date of the initial payment.

22 (7) A prospective payment system hospital commencing operations
23 after January 1, 2009, is eligible to receive payments in accordance
24 with this section after becoming an eligible new prospective payment
25 system hospital as defined in RCW 74.60.010.

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

28 **Sec. 12.** RCW 74.60.130 and 2010 1st sp.s. c 30 s 14 are each
29 amended to read as follows:

30 ~~(1) ((The department, in collaboration with the health care~~
31 ~~authority, the department of health, the department of labor and~~
32 ~~industries, the Washington state hospital association, the Puget Sound~~
33 ~~health alliance, and the forum, a collaboration of health carriers,~~
34 ~~physicians, and hospitals in Washington state, shall design a system of~~
35 ~~hospital quality incentive payments. The design of the system shall be~~
36 ~~submitted to the relevant policy and fiscal committees of the~~

1 legislature by December 15, 2010. The system shall be based upon the
2 following principles:

3 (a) Evidence-based treatment and processes shall be used to improve
4 health care outcomes for hospital patients;

5 (b) Effective purchasing strategies to improve the quality of
6 health care services should involve the use of common quality
7 improvement measures by public and private health care purchasers,
8 while recognizing that some measures may not be appropriate for
9 application to specialty pediatric, psychiatric, or rehabilitation
10 hospitals;

11 (c) Quality measures chosen for the system should be consistent
12 with the standards that have been developed by national quality
13 improvement organizations, such as the national quality forum, the
14 federal centers for medicare and medicaid services, or the federal
15 agency for healthcare research and quality. New reporting burdens to
16 hospitals should be minimized by giving priority to measures hospitals
17 are currently required to report to governmental agencies, such as the
18 hospital compare measures collected by the federal centers for medicare
19 and medicaid services;

20 (d) Benchmarks for each quality improvement measure should be set
21 at levels that are feasible for hospitals to achieve, yet represent
22 real improvements in quality and performance for a majority of
23 hospitals in Washington state; and

24 (e) Hospital performance and incentive payments should be designed
25 in a manner such that all noncritical access hospitals in Washington
26 are able to receive the incentive payments if performance is at or
27 above the benchmark score set in the system established under this
28 section.

29 (2) Upon satisfaction of the applicable conditions set forth in RCW
30 74.60.150(1), and for state fiscal year 2013 and each fiscal year
31 thereafter, assessments may be increased to support an additional one
32 percent increase in inpatient hospital rates for noncritical access
33 hospitals that meet the quality incentive benchmarks established under
34 this section.) For state fiscal year 2014, commencing within thirty
35 days after satisfaction of the conditions in RCW 74.60.150(1) and
36 subsection (6) of this section, and for the period of state fiscal
37 years 2014 through 2019, the authority shall increase capitation
38 payments to managed care organizations by an amount at least equal to

1 the amount available from the fund after deducting disbursements
2 authorized by RCW 74.60.020(4) (c) through (f) and payments required by
3 RCW 74.60.080 through 74.60.120. The capitation payment under this
4 subsection must be no less than one hundred fifty-three million one
5 hundred thirty-one thousand six hundred dollars per state fiscal year
6 in fiscal years 2014 and 2015, and then the increased capitation
7 payment amounts are reduced in equal increments per fiscal year until
8 the increased capitation payment amount is zero by July 1, 2019, plus
9 the maximum available amount of federal matching funds. The initial
10 payment following satisfaction of the conditions in RCW 74.60.150(1)
11 must include all amounts due from July 1, 2013. Subsequent payments
12 shall be made quarterly.

13 (2) In fiscal years 2015, 2016, and 2017, the authority shall use
14 any additional federal matching funds for the increased managed care
15 capitation payments under subsection (1) of this section available from
16 medicaid expansion under the federal patient protection and affordable
17 care act to substitute for assessment funds which otherwise would have
18 been used to pay managed care plans under this section.

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

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

37 (5) Payments under this section do not reduce the amounts that

1 otherwise would be paid to managed care organizations: PROVIDED, That
2 such payments are consistent with actuarial soundness certification and
3 enrollment.

4 (6) Before making such payments, the authority shall require
5 medicaid managed care organizations to comply with the following
6 requirements:

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

17 (b) Before the end of the quarter in which funds are paid to them,
18 managed care organizations shall expend the increased capitation
19 payments under this section in a manner consistent with the purposes of
20 this chapter;

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

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

27 (8) No hospital has a claim or cause of action against a managed
28 care organization for monetary compensation based on the amount of
29 payments under subsection (6) of this section.

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

34 **Sec. 13.** RCW 74.09.522 and 2013 c 261 s 2 are each amended to read
35 as follows:

36 (1) For the purposes of this section:

1 (a) "Managed health care system" means any health care
2 organization, including health care providers, insurers, health care
3 service contractors, health maintenance organizations, health insuring
4 organizations, or any combination thereof, that provides directly or by
5 contract health care services covered under this chapter and rendered
6 by licensed providers, on a prepaid capitated basis and that meets the
7 requirements of section 1903(m)(1)(A) of Title XIX of the federal
8 social security act or federal demonstration waivers granted under
9 section 1115(a) of Title XI of the federal social security act;

10 (b) "Nonparticipating provider" means a person, health care
11 provider, practitioner, facility, or entity, acting within their scope
12 of practice, that does not have a written contract to participate in a
13 managed health care system's provider network, but provides health care
14 services to enrollees of programs authorized under this chapter whose
15 health care services are provided by the managed health care system.

16 (2) The authority shall enter into agreements with managed health
17 care systems to provide health care services to recipients of temporary
18 assistance for needy families under the following conditions:

19 (a) Agreements shall be made for at least thirty thousand
20 recipients statewide;

21 (b) Agreements in at least one county shall include enrollment of
22 all recipients of temporary assistance for needy families;

23 (c) To the extent that this provision is consistent with section
24 1903(m) of Title XIX of the federal social security act or federal
25 demonstration waivers granted under section 1115(a) of Title XI of the
26 federal social security act, recipients shall have a choice of systems
27 in which to enroll and shall have the right to terminate their
28 enrollment in a system: PROVIDED, That the authority may limit
29 recipient termination of enrollment without cause to the first month of
30 a period of enrollment, which period shall not exceed twelve months:
31 AND PROVIDED FURTHER, That the authority shall not restrict a
32 recipient's right to terminate enrollment in a system for good cause as
33 established by the authority by rule;

34 (d) To the extent that this provision is consistent with section
35 1903(m) of Title XIX of the federal social security act, participating
36 managed health care systems shall not enroll a disproportionate number
37 of medical assistance recipients within the total numbers of persons

1 served by the managed health care systems, except as authorized by the
2 authority under federal demonstration waivers granted under section
3 1115(a) of Title XI of the federal social security act;

4 (e)(i) In negotiating with managed health care systems the
5 authority shall adopt a uniform procedure to enter into contractual
6 arrangements, to be included in contracts issued or renewed on or after
7 January 1, 2015, including:

8 (A) Standards regarding the quality of services to be provided;

9 (B) The financial integrity of the responding system;

10 (C) Provider reimbursement methods that incentivize chronic care
11 management within health homes, including comprehensive medication
12 management services for patients with multiple chronic conditions
13 consistent with the findings and goals established in section 1 of this
14 act;

15 (D) Provider reimbursement methods that reward health homes that,
16 by using chronic care management, reduce emergency department and
17 inpatient use;

18 (E) Promoting provider participation in the program of training and
19 technical assistance regarding care of people with chronic conditions
20 described in RCW 43.70.533, including allocation of funds to support
21 provider participation in the training, unless the managed care system
22 is an integrated health delivery system that has programs in place for
23 chronic care management;

24 (F) Provider reimbursement methods within the medical billing
25 processes that incentivize pharmacists or other qualified providers
26 licensed in Washington state to provide comprehensive medication
27 management services consistent with the findings and goals established
28 in section 1 of this act; and

29 (G) Evaluation and reporting on the impact of comprehensive
30 medication management services on patient clinical outcomes and total
31 health care costs, including reductions in emergency department
32 utilization, hospitalization, and drug costs.

33 (ii)(A) Health home services contracted for under this subsection
34 may be prioritized to enrollees with complex, high cost, or multiple
35 chronic conditions.

36 (B) Contracts that include the items in (e)(i)(C) through (G) of
37 this subsection must not exceed the rates that would be paid in the
38 absence of these provisions;

1 (f) The authority shall seek waivers from federal requirements as
2 necessary to implement this chapter;

3 (g) The authority shall, wherever possible, enter into prepaid
4 capitation contracts that include inpatient care. However, if this is
5 not possible or feasible, the authority may enter into prepaid
6 capitation contracts that do not include inpatient care;

7 (h) The authority shall define those circumstances under which a
8 managed health care system is responsible for out-of-plan services and
9 assure that recipients shall not be charged for such services;

10 (i) Nothing in this section prevents the authority from entering
11 into similar agreements for other groups of people eligible to receive
12 services under this chapter; and

13 (j) The authority must consult with the federal center for medicare
14 and medicaid innovation and seek funding opportunities to support
15 health homes.

16 (3) The authority shall ensure that publicly supported community
17 health centers and providers in rural areas, who show serious intent
18 and apparent capability to participate as managed health care systems
19 are seriously considered as contractors. The authority shall
20 coordinate its managed care activities with activities under chapter
21 70.47 RCW.

22 (4) The authority shall work jointly with the state of Oregon and
23 other states in this geographical region in order to develop
24 recommendations to be presented to the appropriate federal agencies and
25 the United States congress for improving health care of the poor, while
26 controlling related costs.

27 (5) The legislature finds that competition in the managed health
28 care marketplace is enhanced, in the long term, by the existence of a
29 large number of managed health care system options for medicaid
30 clients. In a managed care delivery system, whose goal is to focus on
31 prevention, primary care, and improved enrollee health status,
32 continuity in care relationships is of substantial importance, and
33 disruption to clients and health care providers should be minimized.
34 To help ensure these goals are met, the following principles shall
35 guide the authority in its healthy options managed health care
36 purchasing efforts:

37 (a) All managed health care systems should have an opportunity to
38 contract with the authority to the extent that minimum contracting

1 requirements defined by the authority are met, at payment rates that
2 enable the authority to operate as far below appropriated spending
3 levels as possible, consistent with the principles established in this
4 section.

5 (b) Managed health care systems should compete for the award of
6 contracts and assignment of medicaid beneficiaries who do not
7 voluntarily select a contracting system, based upon:

8 (i) Demonstrated commitment to or experience in serving low-income
9 populations;

10 (ii) Quality of services provided to enrollees;

11 (iii) Accessibility, including appropriate utilization, of services
12 offered to enrollees;

13 (iv) Demonstrated capability to perform contracted services,
14 including ability to supply an adequate provider network;

15 (v) Payment rates; and

16 (vi) The ability to meet other specifically defined contract
17 requirements established by the authority, including consideration of
18 past and current performance and participation in other state or
19 federal health programs as a contractor.

20 (c) Consideration should be given to using multiple year
21 contracting periods.

22 (d) Quality, accessibility, and demonstrated commitment to serving
23 low-income populations shall be given significant weight in the
24 contracting, evaluation, and assignment process.

25 (e) All contractors that are regulated health carriers must meet
26 state minimum net worth requirements as defined in applicable state
27 laws. The authority shall adopt rules establishing the minimum net
28 worth requirements for contractors that are not regulated health
29 carriers. This subsection does not limit the authority of the
30 Washington state health care authority to take action under a contract
31 upon finding that a contractor's financial status seriously jeopardizes
32 the contractor's ability to meet its contract obligations.

33 (f) Procedures for resolution of disputes between the authority and
34 contract bidders or the authority and contracting carriers related to
35 the award of, or failure to award, a managed care contract must be
36 clearly set out in the procurement document.

37 (6) The authority may apply the principles set forth in subsection

1 (5) of this section to its managed health care purchasing efforts on
2 behalf of clients receiving supplemental security income benefits to
3 the extent appropriate.

4 (7) A managed health care system shall pay a nonparticipating
5 provider that provides a service covered under this chapter to the
6 system's enrollee no more than the lowest amount paid for that service
7 under the managed health care system's contracts with similar providers
8 in the state.

9 (8) For services covered under this chapter to medical assistance
10 or medical care services enrollees and provided on or after August 24,
11 2011, nonparticipating providers must accept as payment in full the
12 amount paid by the managed health care system under subsection (7) of
13 this section in addition to any deductible, coinsurance, or copayment
14 that is due from the enrollee for the service provided. An enrollee is
15 not liable to any nonparticipating provider for covered services,
16 except for amounts due for any deductible, coinsurance, or copayment
17 under the terms and conditions set forth in the managed health care
18 system contract to provide services under this section.

19 (9) Pursuant to federal managed care access standards, 42 C.F.R.
20 Sec. 438, managed health care systems must maintain a network of
21 appropriate providers that is supported by written agreements
22 sufficient to provide adequate access to all services covered under the
23 contract with the ((department)) authority, including hospital-based
24 physician services. The ((department)) authority will monitor and
25 periodically report on the proportion of services provided by
26 contracted providers and nonparticipating providers, by county, for
27 each managed health care system to ensure that managed health care
28 systems are meeting network adequacy requirements. No later than
29 January 1st of each year, the ((department)) authority will review and
30 report its findings to the appropriate policy and fiscal committees of
31 the legislature for the preceding state fiscal year.

32 (10) Payments under RCW 74.60.130 are exempt from this section.

33 (11) Subsections (7) through (9) of this section expire July 1,
34 2016.

35 **Sec. 14.** RCW 74.60.140 and 2010 1st sp.s. c 30 s 16 are each
36 amended to read as follows:

37 (1) If an entity owns or operates more than one hospital subject to

1 assessment under this chapter, the entity shall pay the assessment for
2 each hospital separately. However, if the entity operates multiple
3 hospitals under a single medicaid provider number, it may pay the
4 assessment for the hospitals in the aggregate.

5 (2) Notwithstanding any other provision of this chapter, if a
6 hospital subject to the assessment imposed under this chapter ceases to
7 conduct hospital operations throughout a state fiscal year, the
8 assessment for the quarter in which the cessation occurs shall be
9 adjusted by multiplying the assessment computed under RCW 74.60.030
10 (~~((1) and (3))~~) by a fraction, the numerator of which is the number of
11 days during the year which the hospital conducts, operates, or
12 maintains the hospital and the denominator of which is three hundred
13 sixty-five. Immediately prior to ceasing to conduct, operate, or
14 maintain a hospital, the hospital shall pay the adjusted assessment for
15 the fiscal year to the extent not previously paid.

16 ~~(3) ((Notwithstanding any other provision of this chapter, in the
17 case of a hospital that commences conducting, operating, or maintaining
18 a hospital that is not exempt from payment of the assessment under RCW
19 74.60.040 and that did not conduct, operate, or maintain such hospital
20 throughout the cost reporting year used to determine the assessment
21 amount, the assessment for that hospital shall be computed on the basis
22 of the actual number of nonmedicare inpatient days reported to the
23 department by the hospital on a quarterly basis. The hospital shall be
24 eligible to receive increased payments under this chapter beginning on
25 the date it commences hospital operations.~~

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

34 **Sec. 15.** RCW 74.60.150 and 2010 1st sp.s. c 30 s 17 are each
35 amended to read as follows:

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

1 ~~(a) ((Withdrawal of those aspects of any pending state plan~~
2 ~~amendments previously submitted to the centers for medicare and~~
3 ~~medicaid services that are inconsistent with this chapter, specifically~~
4 ~~any pending state plan amendment related to the four percent rate~~
5 ~~reductions for inpatient and outpatient hospital rates and elimination~~
6 ~~of the small rural disproportionate share hospital payment program as~~
7 ~~implemented July 1, 2009;~~

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

11 ~~(c))~~ Final approval by the centers for medicare and medicaid
12 services of any state plan amendments or waiver requests that are
13 necessary in order to implement the applicable sections of this chapter
14 including, if necessary, waiver of the broad-based or uniformity
15 requirements as specified under section 1903(w)(3)(E) of the federal
16 social security act and 42 C.F.R. 433.68(e);

17 (b) To the extent necessary, amendment of contracts between the
18 ~~((department))~~ authority and managed care organizations in order to
19 implement this chapter; and

20 ~~((d))~~ (c) Certification by the office of financial management
21 that appropriations have been adopted that fully support the rates
22 established in this chapter for the upcoming fiscal year.

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

27 ~~(a) ((An appellate court or the centers for medicare and medicaid~~
28 ~~services))~~ The federal department of health and human services and a
29 court of competent jurisdiction makes a final determination, with all
30 appeals exhausted, that any element of this chapter, other than RCW
31 74.60.100, cannot be validly implemented;

32 ~~(b) ((Medicaid inpatient or outpatient reimbursement rates for~~
33 ~~hospitals are reduced below the combined rates established by RCW~~
34 ~~74.60.080 and 74.60.090;~~

35 ~~(c) Except for payments to the University of Washington medical~~
36 ~~center and harborview medical center, payments to hospitals required~~
37 ~~under RCW 74.60.080, 74.60.090, 74.60.110, and 74.60.120 are not~~
38 ~~eligible for federal matching funds;~~

1 ~~(d) Other funding available for the medicaid program is not~~
2 ~~sufficient to maintain medicaid inpatient and outpatient reimbursement~~
3 ~~rates at the levels set in RCW 74.60.080, 74.60.090, and 74.60.110))~~
4 Funds generated by the assessment for payments to prospective payment
5 hospitals or managed care organizations are determined to be not
6 eligible for federal match;

7 (c) Other funding sufficient to maintain aggregate payment levels
8 to hospitals for inpatient and outpatient services covered by medicaid,
9 including fee-for-service and managed care, at least at the levels the
10 state paid for those services on July 1, 2009, as adjusted for current
11 enrollment and utilization, but without regard to payment increases
12 resulting from chapter 30, Laws of 2010 1st sp. sess., is not
13 appropriated or available;

14 (d) Payments required by this chapter are reduced, except as
15 specifically authorized in this chapter, or payments are not made in
16 substantial compliance with the time frames set forth in this chapter;
17 or

18 (e) The fund is used as a substitute for or to supplant other
19 funds, except as authorized by RCW 74.60.020(~~(+3)(e)~~)).

20 **Sec. 16.** RCW 74.60.900 and 2010 1st sp.s. c 30 s 18 are each
21 amended to read as follows:

22 (1) The provisions of this chapter are not severable: If the
23 conditions (~~set forth~~) in RCW 74.60.150(1) are not satisfied or if
24 any of the circumstances (~~set forth~~) in RCW 74.60.150(2) should
25 occur, this entire chapter shall have no effect from that point
26 forward(~~, except that if the payment under RCW 74.60.100, or the~~
27 ~~application thereof to any hospital or circumstances does not receive~~
28 ~~approval by the centers for medicare and medicaid services as described~~
29 ~~in RCW 74.60.150(1)(b) or is determined to be unconstitutional or~~
30 ~~otherwise invalid, the other provisions of this chapter or its~~
31 ~~application to hospitals or circumstances other than those to which it~~
32 ~~is held invalid shall not be affected thereby)).~~

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

1 ~~((3) In the event that the payment under RCW 74.60.100, or the~~
2 ~~application thereof to any hospital or circumstances does not receive~~
3 ~~approval by the centers for medicare and medicaid services as described~~
4 ~~in RCW 74.60.150(1)(b) or is determined to be unconstitutional or~~
5 ~~otherwise invalid, the amount of the assessment shall be adjusted under~~
6 ~~RCW 74.60.050(1)(c).))~~

7 NEW SECTION. **Sec. 17.** A new section is added to chapter 74.60 RCW
8 to read as follows:

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

17 (2) Each odd-numbered year after enactment of the biennial omnibus
18 operating appropriations act, the authority shall offer to enter into
19 a contract for the period of the fiscal biennium beginning July 1st
20 with a hospital that is required to pay the assessment under this
21 chapter. The contract must include the following terms:

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

23 (i) Increase the assessment from the level set by the authority
24 pursuant to this chapter on the first day of the contract period for
25 reasons other than those allowed under RCW 74.60.050(3);

26 (ii) Reduce aggregate payment levels to hospitals for inpatient and
27 outpatient services covered by medicaid, including fee-for-service and
28 managed care, allowing for variations due to budget-neutral rebasing
29 and adjusting for changes in enrollment and utilization, from the
30 levels the state paid for those services on the first day of the
31 contract period;

32 (iii) For critical access hospitals only, reduce the levels of
33 disproportionate share hospital payments under RCW 74.60.110 or access
34 payments under RCW 74.60.100 for all critical access hospitals below
35 the levels specified in those sections on the first day of the contract
36 period;

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

7 (v) For prospective payment system, psychiatric, and rehabilitation
8 hospitals only, reduce the increased capitation payments to managed
9 care organizations under RCW 74.60.130 below the levels specified in
10 that section on the first day of the contract period unless the managed
11 care payments are reduced under RCW 74.60.130(4); or

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

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

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

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

26 (b) May discontinue supplemental payments, increased managed care
27 payments, disproportionate share hospital payments, and access payments
28 made subsequent to the breach for the hospital that are required under
29 this chapter.

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

33 NEW SECTION. **Sec. 18.** A new section is added to chapter 74.09 RCW
34 to read as follows:

35 (1) If sufficient funds are made available as provided in
36 subsection (2) of this section the authority, in collaboration with the

1 Washington state hospital association, shall design a system of
2 hospital quality incentive payments for noncritical access hospitals.
3 The system must be based upon the following principles:

4 (a) Evidence-based treatment and processes must be used to improve
5 health care outcomes for hospital patients;

6 (b) Effective purchasing strategies to improve the quality of
7 health care services should involve the use of common quality
8 improvement measures by public and private health care purchasers,
9 while recognizing that some measures may not be appropriate for
10 application to specialty pediatric, psychiatric, or rehabilitation
11 hospitals;

12 (c) Quality measures chosen for the system should be consistent
13 with the standards that have been developed by national quality
14 improvement organizations, such as the national quality forum, the
15 federal centers for medicare and medicaid services, or the federal
16 agency for healthcare research and quality. New reporting burdens to
17 hospitals should be minimized by giving priority to measures hospitals
18 are currently required to report to governmental agencies, such as the
19 hospital compare measures collected by the federal centers for medicare
20 and medicaid services;

21 (d) Benchmarks for each quality improvement measure should be set
22 at levels that are feasible for hospitals to achieve, yet represent
23 real improvements in quality and performance for a majority of
24 hospitals in Washington state; and

25 (e) Hospital performance and incentive payments should be designed
26 in a manner such that all noncritical access hospitals are able to
27 receive the incentive payments if performance is at or above the
28 benchmark score set in the system established under this section.

29 (2) If hospital safety net assessment funds under RCW 74.60.020 are
30 made available, such funds must be used to support an additional one
31 percent increase in inpatient hospital rates for noncritical access
32 hospitals that:

33 (a) Meet the quality incentive benchmarks established under this
34 section; and

35 (b) Participate in Washington state hospital association
36 collaboratives related to the benchmarks in order to improve care and
37 promote sharing of best practices with other hospitals.

1 (3) Funds directed from any other lawful source may also be used to
2 support the purposes of this section.

3 **Sec. 19.** RCW 74.60.901 and 2010 1st sp.s. c 30 s 21 are each
4 amended to read as follows:

5 This chapter expires July 1, (~~2013~~) 2017.

6 NEW SECTION. **Sec. 20.** This act is necessary for the immediate
7 preservation of the public peace, health, or safety, or support of the
8 state government and its existing public institutions, and takes effect
9 immediately."

SSB 5913 - S AMD
By Senator Hill

ADOPTED 06/26/2013

10 On page 1, line 3 of the title, after "Washington;" strike the
11 remainder of the title and insert "amending RCW 74.60.005, 74.60.010,
12 74.60.020, 74.60.030, 74.60.050, 74.60.070, 74.60.080, 74.60.090,
13 74.60.100, 74.60.110, 74.60.120, 74.60.130, 74.09.522, 74.60.140,
14 74.60.150, 74.60.900, and 74.60.901; adding a new section to chapter
15 74.60 RCW; adding a new section to chapter 74.09 RCW; providing an
16 expiration date; and declaring an emergency."

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