
HOUSE BILL 2790

State of Washington

63rd Legislature

2014 Regular Session

By Representatives Hunter, Chandler, and Cody; by request of Health Care Authority

Read first time 02/19/14. Referred to Committee on Appropriations.

1 AN ACT Relating to adjusting timelines regarding the hospital
2 safety net assessment; and amending RCW 74.60.030, 74.60.120, and
3 74.60.130.

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

5 **Sec. 1.** RCW 74.60.030 and 2013 2nd sp.s. c 17 s 4 are each amended
6 to read as follows:

7 (1)(a) Upon satisfaction of the conditions in RCW 74.60.150(1), and
8 so long as the conditions in RCW 74.60.150(2) have not occurred, an
9 assessment is imposed as set forth in this subsection, effective ((July
10 1, 2013. ~~The authority shall calculate the amount due annually and~~
11 ~~shall issue assessments quarterly for one fourth)) October 1, 2013.
12 Initial assessment notices must be sent to each hospital not earlier
13 than thirty days after satisfaction of the conditions in RCW
14 74.60.150(1). Payment is due not sooner than thirty days thereafter.
15 Except for the initial assessment, notices must be sent on or about
16 thirty days prior to the end of each quarter and payment is due thirty
17 days thereafter.~~

18 (b) Effective October 1, 2013, and except as provided in RCW
19 74.60.050:

1 (i) For fiscal year 2014, an annual assessment for amounts
2 determined as described in (b)(ii) through (iv) of this subsection is
3 imposed for the time period of October 1, 2013, through June 30, 2014.
4 The initial assessment notice must cover amounts due from October 1,
5 2013, through either: (A) The end of the calendar quarter prior to the
6 satisfaction of the conditions in RCW 74.60.150(1) if federal approval
7 is received more than forty-five days prior to the end of a quarter; or
8 (B) the end of the calendar quarter after the satisfaction of the
9 conditions in RCW 74.60.150(1) if federal approval is received within
10 forty-five days of the end of a quarter. For subsequent assessments
11 during fiscal year 2014, the authority shall calculate the amount due
12 annually and shall issue assessments for the appropriate proportion of
13 the annual amount due from each hospital((. Initial assessment notices
14 must be sent to each hospital not earlier than thirty days after
15 satisfaction of the conditions in RCW 74.60.150(1) and must include all
16 amounts due from and after July 1, 2013. Payment is due not sooner
17 than thirty days thereafter. Subsequent notices must be sent on or
18 about thirty days prior to the end of each subsequent quarter and
19 payment is due thirty days thereafter.

20 ~~(b) Beginning July 1, 2013, and except as provided in RCW~~
21 ~~74.60.050:~~

22 ~~(i))~~;

23 (ii) After the assessments described in (b)(i) of this subsection,
24 each prospective payment system hospital, except psychiatric and
25 rehabilitation hospitals, shall pay a quarterly assessment. Each
26 quarterly assessment shall be one quarter of three hundred forty-four
27 dollars for each annual nonmedicare hospital inpatient day, up to a
28 maximum of fifty-four thousand days per year. For each nonmedicare
29 hospital inpatient day in excess of fifty-four thousand days, each
30 prospective payment system hospital shall pay an assessment of one
31 quarter of seven dollars for each such day;

32 ~~((+ii))~~ (iii) After the assessments described in (b)(i) of this
33 subsection, each critical access hospital shall pay a quarterly
34 assessment of one quarter of ten dollars for each annual nonmedicare
35 hospital inpatient day;

36 ~~((+iii))~~ (iv) After the assessments described in (b)(i) of this
37 subsection, each psychiatric hospital shall pay a quarterly assessment

1 of one quarter of sixty-seven dollars for each annual nonmedicare
2 hospital inpatient day; and

3 ~~((iv))~~ (v) After the assessments described in (b)(i) of this
4 subsection, each rehabilitation hospital shall pay a quarterly
5 assessment of one quarter of sixty-seven dollars for each annual
6 nonmedicare 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. 2.** RCW 74.60.120 and 2013 2nd sp.s. c 17 s 11 are each
28 amended to read as follows:

29 (1) Beginning in state fiscal year 2014, commencing thirty days
30 after satisfaction of the applicable conditions in RCW 74.60.150(1),
31 and for the period of state fiscal years 2014 through 2019, the
32 authority shall make supplemental payments directly to Washington
33 hospitals, separately for inpatient and outpatient fee-for-service
34 medicaid services, as follows:

35 (a) For inpatient fee-for-service payments for prospective payment
36 hospitals other than psychiatric or rehabilitation hospitals, twenty-
37 nine million two hundred twenty-five thousand dollars per state fiscal

1 year in fiscal years 2014 and 2015, and then amounts reduced in equal
2 increments per fiscal year until the supplemental payment amount is
3 zero by July 1, 2019, from the fund, plus federal matching funds;

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

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

15 (d) For inpatient fee-for-service payments for rehabilitation
16 hospitals, one hundred fifty thousand dollars per state fiscal year in
17 fiscal years 2014 and 2015, and then amounts reduced in equal
18 increments per fiscal year until the supplemental payment amount is
19 zero by July 1, 2019, from the fund, plus federal matching funds;

20 (e) For inpatient fee-for-service payments for border hospitals,
21 two hundred fifty thousand dollars per state fiscal year in fiscal
22 years 2014 and 2015, and then amounts reduced in equal increments per
23 fiscal year until the supplemental payment amount is zero by July 1,
24 2019, from the fund, plus federal matching funds; and

25 (f) For outpatient fee-for-service payments for border hospitals,
26 two hundred fifty thousand dollars per state fiscal year in fiscal
27 years 2014 and 2015, and then amounts reduced in equal increments per
28 fiscal year until the supplemental payment amount is zero by July 1,
29 2019, from the fund, plus federal matching funds.

30 (2) If the amount of inpatient or outpatient payments under
31 subsection (1) of this section, when combined with federal matching
32 funds, exceeds the upper payment limit, payments to each category of
33 hospital must be reduced proportionately to a level where the total
34 payment amount is consistent with the upper payment limit. Funds under
35 this chapter unable to be paid to hospitals under this section because
36 of the upper payment limit must be paid to managed care organizations
37 under RCW 74.60.130, subject to the limitations in this chapter.

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

5 (a) 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 each hospital's inpatient fee-for-services
8 claims and medicaid managed care encounter data for the base year;

9 (b) Applying the medicaid fee-for-service rates in effect on July
10 1, 2009, without regard to the increases required by chapter 30, Laws
11 of 2010 1st sp. sess. to all hospitals' inpatient fee-for-services
12 claims and medicaid managed care encounter data for the base year; and

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

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

19 (a) Applying the medicaid fee-for-service rates in effect on July
20 1, 2009, without regard to the increases required by chapter 30, Laws
21 of 2010 1st sp. sess. to each hospital's outpatient fee-for-services
22 claims and medicaid managed care encounter data for the base year;

23 (b) Applying the medicaid fee-for-service rates in effect on July
24 1, 2009, without regard to the increases required by chapter 30, Laws
25 of 2010 1st sp. sess. to all hospitals' outpatient fee-for-services
26 claims and medicaid managed care encounter data for the base year; and

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

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

35 (6) Payments must be made in quarterly installments on or about the
36 last day of every quarter(~~(, except that)~~). The initial payment must
37 be made within thirty days after satisfaction of the conditions in RCW
38 74.60.150(1) and must include all amounts due from July 1, 2013, to

1 ~~((the date of the initial payment))~~ either: (a) The end of the
2 calendar quarter prior to when the conditions in RCW 70.60.150(1) are
3 satisfied if approval is received more than forty-five days prior to
4 the end of a quarter; or (b) the end of the calendar quarter after the
5 satisfaction of the conditions in RCW 74.60.150(1) if approval is
6 received within forty-five days of the end of a quarter.

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

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

13 **Sec. 3.** RCW 74.60.130 and 2013 2nd sp.s. c 17 s 12 are each
14 amended to read as follows:

15 (1) For state fiscal year 2014, commencing within thirty days after
16 satisfaction of the conditions in RCW 74.60.150(1) and subsection (6)
17 of this section, and for the period of state fiscal years 2014 through
18 2019, the authority shall increase capitation payments to managed care
19 organizations by an amount at least equal to the amount available from
20 the fund after deducting disbursements authorized by RCW 74.60.020(4)
21 (c) through (f) and payments required by RCW 74.60.080 through
22 74.60.120. The capitation payment under this subsection must be no
23 less than one hundred fifty-three million one hundred thirty-one
24 thousand six hundred dollars per state fiscal year in fiscal years 2014
25 and 2015, and then the increased capitation payment amounts are reduced
26 in equal increments per fiscal year until the increased capitation
27 payment amount is zero by July 1, 2019, plus the maximum available
28 amount of federal matching funds. The initial payment following
29 satisfaction of the conditions in RCW 74.60.150(1) must include all
30 amounts due from July 1, 2013, to the end of the calendar month during
31 which the conditions in RCW 74.60.150(1) are satisfied. Subsequent
32 payments shall be made (~~quarterly~~) monthly.

33 (2) In fiscal years 2015, 2016, and 2017, the authority shall use
34 any additional federal matching funds for the increased managed care
35 capitation payments under subsection (1) of this section available from
36 medicaid expansion under the federal patient protection and affordable

1 care act to substitute for assessment funds which otherwise would have
2 been used to pay managed care plans under this section.

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

10 (4) If the federal government determines that total payments to
11 managed care organizations under this section exceed what is permitted
12 under applicable medicaid laws and regulations, payments must be
13 reduced to levels that meet such requirements, and the balance
14 remaining must be applied as provided in RCW 74.60.050. Further, in
15 the event a managed care organization is legally obligated to repay
16 amounts distributed to hospitals under this section to the state or
17 federal government, a managed care organization may recoup the amount
18 it is obligated to repay under the medicaid program from individual
19 hospitals by not more than the amount of overpayment each hospital
20 received from that managed care organization.

21 (5) Payments under this section do not reduce the amounts that
22 otherwise would be paid to managed care organizations: PROVIDED, That
23 such payments are consistent with actuarial soundness certification and
24 enrollment.

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

28 (a) All payments to managed care organizations under this chapter
29 must be expended for hospital services provided by Washington
30 hospitals, which for purposes of this section includes psychiatric and
31 rehabilitation hospitals, in a manner consistent with the purposes and
32 provisions of this chapter, and must be equal to all increased
33 capitation payments under this section received by the organization or
34 network, consistent with actuarial certification and enrollment, less
35 an allowance for any estimated premium taxes the organization is
36 required to pay under Title 48 RCW associated with the payments under
37 this chapter;

1 (b) (~~Before the end of the quarter in which funds are paid to~~
2 ~~them,~~) Managed care organizations shall expend the increased
3 capitation payments under this section in a manner consistent with the
4 purposes of this chapter, with the initial expenditures to hospitals to
5 be made within thirty days of receipt of payment from the authority.
6 Subsequent expenditures by the managed care plans are to be made before
7 the end of the quarter in which funds are received from the authority;

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

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

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

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

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