
ENGROSSED SUBSTITUTE SENATE BILL 5913

State of Washington 63rd Legislature 2013 2nd Special Session

By Senate Ways & Means (originally sponsored by Senator Becker)

READ FIRST TIME 04/23/13.

1 AN ACT Relating to a hospital safety net assessment and quality
2 incentive program for increased hospital payments to improve health
3 care access for the citizens of Washington; amending RCW 74.60.005,
4 74.60.010, 74.60.020, 74.60.030, 74.60.050, 74.60.070, 74.60.080,
5 74.60.090, 74.60.100, 74.60.110, 74.60.120, 74.60.130, 74.09.522,
6 74.60.140, 74.60.150, 74.60.900, and 74.60.901; adding a new section to
7 chapter 74.60 RCW; adding a new section to chapter 74.09 RCW; providing
8 an expiration date; and declaring an emergency.

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

10 **Sec. 1.** RCW 74.60.005 and 2010 1st sp.s. c 30 s 1 are each amended
11 to read as follows:

12 (1) The purpose of this chapter is to provide for a safety net
13 assessment on certain Washington hospitals, which will be used solely
14 to augment funding from all other sources and thereby (~~obtain~~
15 ~~additional—funds—to—restore—recent—reductions—and—to~~) support
16 additional payments to hospitals for medicaid services as specified in
17 this chapter.

18 (2) The legislature finds that((+)

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

7 (b)) federal health care reform will result in an expansion of
8 medicaid enrollment in this state and an increase in federal financial
9 participation. As a result, the hospital safety net assessment and
10 hospital safety net assessment fund created in this chapter ((allows
11 the state to generate additional federal financial participation for
12 the medicaid program and provides for increased reimbursement to
13 hospitals)) will begin phasing down over a four-year period beginning
14 in fiscal year 2016 as federal medicaid expansion is fully implemented.
15 The state will end its reliance on the assessment and the fund by the
16 end of fiscal year 2019.

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

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

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

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

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

36 (d) That the total amount assessed not exceed the amount needed, in
37 combination with all other available funds, to support the

1 (~~reimbursement rates and other~~) payments authorized by this chapter;
2 and

3 ~~((d))~~ (e) To condition the assessment on receiving federal
4 approval for receipt of additional federal financial participation and
5 on continuation of other funding sufficient to maintain ~~((hospital~~
6 ~~inpatient — and — outpatient — reimbursement — rates — and — small — rural~~
7 ~~disproportionate share payments at least at the levels in effect on~~
8 ~~July 1, 2009))~~ aggregate payment levels to hospitals for inpatient and
9 outpatient services covered by medicaid, including fee-for-service and
10 managed care, at least at the levels the state paid for those services
11 on July 1, 2009, as adjusted for current enrollment and utilization,
12 but without regard to payment increases resulting from chapter 30, Laws
13 of 2010 1st sp. sess.

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

16 The definitions in this section apply throughout this chapter
17 unless the context clearly requires otherwise.

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

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

22 (3) "Bordering city hospital" means a hospital as defined in WAC
23 182-550-1050 and bordering cities as described in WAC 182-501-0175, or
24 successor rules.

25 (4) "Certified public expenditure hospital" means a hospital
26 participating in ~~((the department's))~~ or that at any point from the
27 effective date of this section to July 1, 2019, has participated in the
28 authority's certified public expenditure payment program as described
29 in WAC ~~((388-550-4650))~~ 182-550-4650 or successor rule. For purposes
30 of this chapter any such hospital shall continue to be treated as a
31 certified public expenditure hospital for assessment and payment
32 purposes through the date specified in RCW 74.60.901. The eligibility
33 of such hospitals to receive grants under RCW 74.60.090 solely from
34 funds generated under this chapter must not be affected by any
35 modification or termination of the federal certified public expenditure
36 program, or reduced by the amount of any federal funds no longer
37 available for that purpose.

1 ~~((2))~~ (5) "Critical access hospital" means a hospital as
2 described in RCW 74.09.5225.

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

5 ~~((4))~~ (6) "Director" means the director of the health care
6 authority.

7 (7) "Eligible new prospective payment hospital" means a prospective
8 payment hospital opened after January 1, 2009, for which a full year of
9 cost report data as described in RCW 74.60.030(2) and a full year of
10 medicaid base year data required for the calculations in RCW
11 74.60.120(3) are available.

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

14 ~~((5))~~ (9) "Hospital" means a facility licensed under chapter
15 70.41 RCW.

16 ~~((6))~~ (10) "Long-term acute care hospital" means a hospital which
17 has an average inpatient length of stay of greater than twenty-five
18 days as determined by the department of health.

19 ~~((7))~~ (11) "Managed care organization" means an organization
20 having a certificate of authority or certificate of registration from
21 the office of the insurance commissioner that contracts with the
22 ~~((department))~~ authority under a comprehensive risk contract to provide
23 prepaid health care services to eligible clients under the
24 ~~((department's))~~ authority's medicaid managed care programs, including
25 the healthy options program.

26 ~~((8))~~ (12) "Medicaid" means the medical assistance program as
27 established in Title XIX of the social security act and as administered
28 in the state of Washington by the ~~((department of social and health~~
29 ~~services))~~ authority.

30 ~~((9))~~ (13) "Medicare cost report" means the medicare cost report,
31 form 2552~~((96))~~, or successor document.

32 ~~((10))~~ (14) "Nonmedicare hospital inpatient day" means total
33 hospital inpatient days less medicare inpatient days, including
34 medicare days reported for medicare managed care plans, as reported on
35 the medicare cost report, form 2552~~((96))~~, or successor forms,
36 excluding all skilled and nonskilled nursing facility days, skilled and
37 nonskilled swing bed days, nursery days, observation bed days, hospice

1 days, home health agency days, and other days not typically associated
2 with an acute care inpatient hospital stay.

3 ~~((11))~~ (15) "Outpatient" means services provided classified as
4 ambulatory payment classification services or successor payment
5 methodologies as defined in WAC 182-550-7050 or successor rule and
6 applies to fee-for-service payments and managed care encounter data.

7 (16) "Prospective payment system hospital" means a hospital
8 reimbursed for inpatient and outpatient services provided to medicaid
9 beneficiaries under the inpatient prospective payment system and the
10 outpatient prospective payment system as defined in WAC
11 ~~(388-550-1050)~~ 182-550-1050 or successor rule. For purposes of this
12 chapter, prospective payment system hospital does not include a
13 hospital participating in the certified public expenditure program or
14 a bordering city hospital located outside of the state of Washington
15 and in one of the bordering cities listed in WAC ~~(388-501-0175)~~ 182-
16 501-0175 or successor ~~(regulation)~~ rule.

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

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

21 ~~(14))~~ (18) "Rehabilitation hospital" means a medicare-certified
22 freestanding inpatient rehabilitation facility.

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

25 ~~(16))~~ (19) "Small rural disproportionate share hospital payment"
26 means a payment made in accordance with WAC ~~(388-550-5200)~~ 182-550-
27 5200 or ~~(subsequently filed regulation)~~ successor rule.

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

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

35 (1) A dedicated fund is hereby established within the state
36 treasury to be known as the hospital safety net assessment fund. The
37 purpose and use of the fund shall be to receive and disburse funds,

1 together with accrued interest, in accordance with this chapter.
2 Moneys in the fund, including interest earned, shall not be used or
3 disbursed for any purposes other than those specified in this chapter.
4 Any amounts expended from the fund that are later recouped by the
5 ((department)) authority on audit or otherwise shall be returned to the
6 fund.

7 (a) Any unexpended balance in the fund at the end of a fiscal
8 biennium shall carry over into the following biennium and shall be
9 applied to reduce the amount of the assessment under RCW
10 74.60.050(1)(c).

11 (b) Any amounts remaining in the fund ((~~on~~)) after July 1, ((2013))
12 2019, shall be ((~~used to make increased payments in accordance with RCW~~
13 ~~74.60.090 and 74.60.120 for any outstanding claims with dates of~~
14 ~~service prior to July 1, 2013. Any amounts remaining in the fund after~~
15 ~~such increased payments are made shall be refunded to hospitals, pro~~
16 ~~rata according to the amount paid by the hospital, subject to the~~
17 ~~limitations of federal law~~)) refunded to hospitals, pro rata according
18 to the amount paid by the hospital since July 1, 2013, subject to the
19 limitations of federal law.

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

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

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

27 ~~(b) Upon certification by the secretary that the conditions set~~
28 ~~forth in RCW 74.60.150(1) have been met with respect to the assessments~~
29 ~~imposed under RCW 74.60.030 (1) and (2), the payments provided under~~
30 ~~RCW 74.60.080, payments provided under RCW 74.60.120(2), and any~~
31 ~~initial payments under RCW 74.60.100 and 74.60.110, funds shall be~~
32 ~~disbursed in the amount necessary to make the payments specified in~~
33 ~~those sections;~~

34 ~~(c) Upon certification by the secretary that the conditions set~~
35 ~~forth in RCW 74.60.150(1) have been met with respect to the assessments~~
36 ~~imposed under RCW 74.60.030(3) and the payments provided under RCW~~
37 ~~74.60.090 and 74.60.130, payments made subsequent to the initial~~

1 ~~payments under RCW 74.60.100 and 74.60.110, and payments under RCW~~
2 ~~74.60.120(3), funds shall be disbursed periodically as necessary to~~
3 ~~make the payments as specified in those sections;~~

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

6 ~~(e) The sum of forty nine million three hundred thousand dollars~~
7 ~~for the 2009-2011 fiscal biennium may be expended in lieu of state~~
8 ~~general fund payments to hospitals. An additional sum of seventeen~~
9 ~~million five hundred thousand dollars for the 2009-2011 fiscal biennium~~
10 ~~may be expended in lieu of state general fund payments to hospitals if~~
11 ~~additional federal financial participation under section 5001 of P.L.~~
12 ~~No. 111-5 is extended beyond December 31, 2010. The sum of one hundred~~
13 ~~ninety nine million eight hundred thousand dollars for the 2011-2013~~
14 ~~fiscal biennium may be expended in lieu of state general fund payments~~
15 ~~to hospitals;~~

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

19 ~~(g) To repay the federal government for any excess payments made to~~
20 ~~hospitals from the fund if the assessments or payment increases set~~
21 ~~forth in this chapter are deemed out of compliance with federal~~
22 ~~statutes and regulations and all appeals have been exhausted. In such~~
23 ~~a case, the department may require hospitals receiving excess payments~~
24 ~~to refund the payments in question to the fund. The state in turn~~
25 ~~shall return funds to the federal government in the same proportion as~~
26 ~~the original financing. If a hospital is unable to refund payments,~~
27 ~~the state shall develop a payment plan and/or deduct moneys from future~~
28 ~~medicaid payments)) are conditioned upon appropriation and the~~
29 ~~continued availability of other funds sufficient to maintain aggregate~~
30 ~~payment levels to hospitals for inpatient and outpatient services~~
31 ~~covered by medicaid, including fee-for-service and managed care, at~~
32 ~~least at the levels the state paid for those services on July 1, 2009,~~
33 ~~as adjusted for current enrollment and utilization, but without regard~~
34 ~~to payment increases resulting from chapter 30, Laws of 2010 1st sp.~~
35 ~~sess.~~

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

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

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

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

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

13 (e) To repay the federal government for any excess payments made to
14 hospitals from the fund if the assessments or payment increases set
15 forth in this chapter are deemed out of compliance with federal
16 statutes and regulations in a final determination by a court of
17 competent jurisdiction with all appeals exhausted. In such a case, the
18 authority may require hospitals receiving excess payments to refund the
19 payments in question to the fund. The state in turn shall return funds
20 to the federal government in the same proportion as the original
21 financing. If a hospital is unable to refund payments, the state shall
22 develop either a payment plan, or deduct moneys from future medicaid
23 payments, or both;

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

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

31 ~~(1) ((An assessment is imposed as set forth in this subsection~~
32 ~~effective after the date when the applicable conditions under RCW~~
33 ~~74.60.150(1) have been satisfied through June 30, 2013, for the purpose~~
34 ~~of funding restoration of reimbursement rates under RCW 74.60.080(1)~~
35 ~~and 74.60.120(2)(a) and funding payments made subsequent to the initial~~
36 ~~payments under RCW 74.60.100 and 74.60.110. Payments under this~~
37 ~~subsection are due and payable on the first day of each calendar~~

1 ~~quarter after the department sends notice of assessment to affected~~
2 ~~hospitals. However, the initial assessment is not due and payable less~~
3 ~~than thirty calendar days after notice of the amount due has been~~
4 ~~provided to affected hospitals.~~

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

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

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

15 ~~(b) For the period beginning on January 1, 2011, and ending on June~~
16 ~~30, 2011:~~

17 ~~(i) Each prospective payment system hospital shall pay an~~
18 ~~assessment of forty dollars for each annual nonmedicare hospital~~
19 ~~inpatient day, multiplied by the number of days in the assessment~~
20 ~~period divided by three hundred sixty five.~~

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

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

26 ~~(i) Each prospective payment system hospital shall pay an~~
27 ~~assessment of forty four 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 ~~(d)(i) For purposes of (a) and (b) of this subsection, the~~
35 ~~department shall determine each hospital's annual nonmedicare hospital~~
36 ~~inpatient days by summing the total reported nonmedicare inpatient days~~
37 ~~for each hospital that is not exempt from the assessment as described~~
38 ~~in RCW 74.60.040 for the relevant state fiscal year 2008 portions~~

1 included in the hospital's fiscal year end reports 2007 and/or 2008
2 cost reports. The department shall use nonmedicare hospital inpatient
3 day data for each hospital taken from the centers for medicare and
4 medicaid services' hospital 2552-96 cost report data file as of
5 November 30, 2009, or equivalent data collected by the department.

6 (ii) For purposes of (c) of this subsection, the department shall
7 determine each hospital's annual nonmedicare hospital inpatient days by
8 summing the total reported nonmedicare hospital inpatient days for each
9 hospital that is not exempt from the assessment under RCW 74.60.040,
10 taken from the most recent publicly available hospital 2552-96 cost
11 report data file or successor data file available through the centers
12 for medicare and medicaid services, as of a date to be determined by
13 the department. If cost report data are unavailable from the foregoing
14 source for any hospital subject to the assessment, the department shall
15 collect such information directly from the hospital.

16 (2) An assessment is imposed in the amounts set forth in this
17 section for the purpose of funding the restoration of the rates under
18 RCW 74.60.080(2) and 74.60.120(2)(b) and funding the initial payments
19 under RCW 74.60.100 and 74.60.110, which shall be due and payable
20 within thirty calendar days after the department has transmitted a
21 notice of assessment to hospitals. Such notice shall be transmitted
22 immediately upon determination by the secretary that the applicable
23 conditions established by RCW 74.60.150(1) have been met.

24 (a) Prospective payment system hospitals.

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

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

37 (b) Each critical access hospital shall pay an assessment of ten
38 dollars for each annual nonmedicare hospital inpatient day, multiplied

1 by a ratio, the numerator of which is the number of days between June
2 30, 2009, and the day after the applicable conditions established by
3 RCW 74.60.150(1) have been met and the denominator of which is three
4 hundred sixty five.

5 (c) For purposes of this subsection, the department shall determine
6 each hospital's annual nonmedicare hospital inpatient days by summing
7 the total reported nonmedicare inpatient days for each hospital that is
8 not exempt from the assessment as described in RCW 74.60.040 for the
9 relevant state fiscal year 2008 portions included in the hospital's
10 fiscal year end reports 2007 and/or 2008 cost reports. The department
11 shall use nonmedicare hospital inpatient day data for each hospital
12 taken from the centers for medicare and medicaid services' hospital
13 2552-96 cost report data file as of November 30, 2009, or equivalent
14 data collected by the department.

15 (3) An assessment is imposed as set forth in this subsection for
16 the period February 1, 2010, through June 30, 2013, for the purpose of
17 funding increased hospital payments under RCW 74.60.090 and
18 74.60.120(3), which shall be due and payable on the first day of each
19 calendar quarter after the department has sent notice of the assessment
20 to each affected hospital, provided that the initial assessment shall
21 be transmitted only after the secretary has determined that the
22 applicable conditions established by RCW 74.60.150(1) have been
23 satisfied and shall be payable no less than thirty calendar days after
24 the department sends notice of the amount due to affected hospitals.
25 The initial assessment shall include the full amount due from February
26 1, 2010, through the date of the notice.

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

28 (i) Prospective payment system hospitals.

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

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

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

5 ~~(b) For the period beginning on January 1, 2011, and ending on June~~
6 ~~30, 2011:~~

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

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

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

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

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

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

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

31 ~~(B) Each prospective payment system hospital shall pay an~~
32 ~~assessment of six dollars for each annual nonmedicare inpatient day~~
33 ~~over and above sixty thousand per year, multiplied by the number of~~
34 ~~days in the assessment period divided by three hundred sixty five. The~~
35 ~~department may adjust the assessment or the number of nonmedicare~~
36 ~~hospital inpatient days if necessary to maintain compliance with~~
37 ~~federal statutes and regulations related to medicaid program health~~
38 ~~care related taxes.~~

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

5 ~~(d)(i) For purposes of (a) and (b) of this subsection, the~~
6 ~~department shall determine each hospital's annual nonmedicare hospital~~
7 ~~inpatient days by summing the total reported nonmedicare inpatient days~~
8 ~~for each hospital that is not exempt from the assessment as described~~
9 ~~in RCW 74.60.040 for the relevant state fiscal year 2008 portions~~
10 ~~included in the hospital's fiscal year end reports 2007 and/or 2008~~
11 ~~cost reports. The department shall use nonmedicare hospital inpatient~~
12 ~~day data for each hospital taken from the centers for medicare and~~
13 ~~medicaid services' hospital 2552-96 cost report data file as of~~
14 ~~November 30, 2009, or equivalent data collected by the department.~~

15 ~~(ii) For purposes of (c) of this subsection, the department shall~~
16 ~~determine each hospital's annual nonmedicare hospital inpatient days by~~
17 ~~summing the total reported nonmedicare hospital inpatient days for each~~
18 ~~hospital that is not exempt from the assessment under RCW 74.60.040,~~
19 ~~taken from the most recent publicly available hospital 2552-96 cost~~
20 ~~report data file or successor data file available through the centers~~
21 ~~for medicare and medicaid services, as of a date to be determined by~~
22 ~~the department. If cost report data are unavailable from the foregoing~~
23 ~~source for any hospital subject to the assessment, the department shall~~
24 ~~collect such information directly from the hospital.~~

25 ~~(4) Notwithstanding the provisions of RCW 74.60.070, nothing in~~
26 ~~chapter 30, Laws of 2010 1st sp. sess. is intended to prohibit a~~
27 ~~hospital from including assessment amounts paid in accordance with this~~
28 ~~section on their medicare and medicaid cost reports)) (a) Upon~~
29 ~~satisfaction of the conditions in RCW 74.60.150(1), and so long as the~~
30 ~~conditions in RCW 74.60.150(2) have not occurred, an assessment is~~
31 ~~imposed as set forth in this subsection, effective July 1, 2013. The~~
32 ~~authority shall calculate the amount due annually and shall issue~~
33 ~~assessments quarterly for one-fourth of the annual amount due from each~~
34 ~~hospital. Initial assessment notices must be sent to each hospital not~~
35 ~~earlier than thirty days after satisfaction of the conditions in RCW~~
36 ~~74.60.150(1) and must include all amounts due from and after July 1,~~
37 ~~2013. Payment is due not sooner than thirty days thereafter.~~

1 Subsequent notices must be sent on or about thirty days prior to the
2 end of each subsequent quarter and payment is due thirty days
3 thereafter.

4 (b) Beginning July 1, 2013, and except as provided in RCW
5 74.60.050:

6 (i) Each prospective payment system hospital, except psychiatric
7 and rehabilitation hospitals, shall pay a quarterly assessment. Each
8 quarterly assessment shall be one quarter of three hundred forty-four
9 dollars for each annual nonmedicare hospital inpatient day, up to a
10 maximum of fifty-four thousand days per year. For each nonmedicare
11 hospital inpatient day in excess of fifty-four thousand days, each
12 prospective payment system hospital shall pay an assessment of one
13 quarter of seven dollars for each such day;

14 (ii) Each critical access hospital shall pay a quarterly assessment
15 of one quarter of ten dollars for each annual nonmedicare hospital
16 inpatient day;

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

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

23 (2) The authority shall determine each hospital's annual
24 nonmedicare hospital inpatient days by summing the total reported
25 nonmedicare hospital inpatient days for each hospital that is not
26 exempt from the assessment under RCW 74.60.040, taken from the
27 hospital's 2552 cost report data file or successor data file available
28 through the centers for medicare and medicaid services, as of a date to
29 be determined by the authority. For state fiscal year 2014, the
30 authority shall use cost report data for hospitals' fiscal years ending
31 in 2010. For subsequent years, the hospitals' next succeeding fiscal
32 year cost report data must be used.

33 (a) With the exception of a prospective payment system hospital
34 commencing operations after January 1, 2009, for any hospital without
35 a cost report for the relevant fiscal year, the authority shall work
36 with the affected hospital to identify appropriate supplemental
37 information that may be used to determine annual nonmedicare hospital
38 inpatient days.

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

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

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

12 (a) Transmittal of ~~((quarterly))~~ notices of assessment by the
13 ~~((department))~~ authority to each hospital informing the hospital of its
14 nonmedicare hospital inpatient days and the assessment amount due and
15 payable~~((. — Such quarterly notices shall be sent to each hospital at~~
16 ~~least thirty calendar days prior to the due date for the quarterly~~
17 ~~assessment payment.))~~;

18 (b) Interest on delinquent assessments at the rate specified in RCW
19 82.32.050~~((—))~~; and

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

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

23 ~~((A) — If sufficient other funds for hospitals, excluding any~~
24 ~~extension of section 5001 of P.L. No. 111-5, are available to support~~
25 ~~the reimbursement rates and other payments under RCW 74.60.080,~~
26 ~~74.60.090, 74.60.100, 74.60.110, or 74.60.120 without utilizing the~~
27 ~~full assessment authorized under RCW 74.60.030 (1) or (3), the~~
28 ~~department shall reduce the amount of the assessment for prospective~~
29 ~~payment — system, — psychiatric, — and — rehabilitation — hospitals~~
30 ~~proportionately to the minimum level necessary to support those~~
31 ~~reimbursement rates and other payments.~~

32 ~~((B) — Provided that none of the conditions set forth in RCW~~
33 ~~74.60.150(2) have occurred, if the department's forecasts indicate that~~
34 ~~the assessment amounts under RCW 74.60.030 (1) and (3), together with~~
35 ~~all other available funds, are not sufficient to support the~~
36 ~~reimbursement rates and other payments under RCW 74.60.080, 74.60.090,~~
37 ~~74.60.100, 74.60.110, or 74.60.120, the department shall increase the~~

1 ~~assessment – rates – for – prospective – payment – system, – psychiatric, – and~~
2 ~~rehabilitation – hospitals – proportionately – to – the – amount – necessary – to~~
3 ~~support – those – reimbursement – rates – and – other – payments, – plus – a~~
4 ~~contingency factor up to ten percent of the total assessment amount.~~

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

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

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

20 ~~(a) The fund balance;~~

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

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

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

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

32 ~~(4) To the extent necessary, the department shall amend the~~
33 ~~contracts between the managed care organizations and the department and~~
34 ~~between regional support networks and the department to incorporate the~~
35 ~~provisions of RCW 74.60.120. The department shall pursue amendments to~~
36 ~~the contracts as soon as possible after April 27, 2010. The amendments~~
37 ~~to the contracts shall, among other provisions, provide for increased~~

1 ~~payment rates to managed care organizations in accordance with RCW~~
2 ~~74.60.120~~) in accordance with subsections (2) and (3) of this section.

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

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

11 (b) If the total amount of inpatient or outpatient supplemental
12 payments under RCW 74.60.120 is in excess of the upper payment limit
13 and the entire excess amount cannot be disbursed by additional payments
14 to managed care organizations under RCW 74.60.130, the authority shall
15 proportionately reduce future assessments on prospective payment
16 hospitals to the level necessary to generate additional payments to
17 hospitals that are consistent with the upper payment limit plus the
18 maximum permissible amount of additional payments to managed care
19 organizations under RCW 74.60.130;

20 (c) If the amount of payments to managed care organizations under
21 RCW 74.60.130 cannot be distributed because of failure to meet federal
22 actuarial soundness or utilization requirements or other federal
23 requirements, the authority shall apply the amount that cannot be
24 distributed to reduce future assessments to the level necessary to
25 generate additional payments to managed care organizations that are
26 consistent with federal actuarial soundness or utilization requirements
27 or other federal requirements;

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

32 (e) If the number of nonmedicare inpatient days applied to the
33 rates provided in RCW 74.60.030 will not produce sufficient funds to
34 support the payments required under this chapter and the state portion
35 of the quality incentive payments under section 18 of this act and RCW
36 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may be
37 increased proportionately by category of hospital to amounts no greater
38 than necessary in order to produce the required level of funds needed

1 to make the payments specified in this chapter and the state portion of
2 the quality incentive payments under section 18 of this act and RCW
3 74.60.020(4)(f); and

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

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

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

13 (b) If sufficient other funds, including federal funds, are
14 available to make the payments required under this chapter and fund the
15 state portion of the quality incentive payments under section 18 of
16 this act and RCW 74.60.020(4)(f) without utilizing the full assessment
17 under RCW 74.60.030, the authority shall reduce the amount of the
18 assessment to the minimum levels necessary to support those payments;

19 (c) If in any fiscal year the total amount of inpatient or
20 outpatient supplemental payments under RCW 74.60.120 is in excess of
21 the upper payment limit and the entire excess amount cannot be
22 disbursed by additional payments to managed care organizations under
23 RCW 74.60.130, the authority shall proportionately reduce future
24 assessments on prospective payment hospitals to the level necessary to
25 generate additional payments to hospitals that are consistent with the
26 upper payment limit plus the maximum permissible amount of additional
27 payments to managed care organizations under RCW 74.60.130;

28 (d) If the amount of payments to managed care organizations under
29 RCW 74.60.130 cannot be distributed because of failure to meet federal
30 actuarial soundness or utilization requirements or other federal
31 requirements, the authority shall apply the amount that cannot be
32 distributed to reduce future assessments to the level necessary to
33 generate additional payments to managed care organizations that are
34 consistent with federal actuarial soundness or utilization requirements
35 or other federal requirements;

36 (e) If required in order to obtain federal matching funds, the
37 maximum number of nonmedicare inpatient days at the higher rate

1 provided under RCW 74.60.030(1)(b)(i) may be adjusted in order to
2 comply with federal requirements;

3 (f) If the number of nonmedicare inpatient days applied to the
4 rates provided in RCW 74.60.030 will not produce sufficient funds to
5 support the payments required under this chapter and the state portion
6 of the quality incentive payments under section 18 of this act and RCW
7 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may be
8 increased proportionately by category of hospital to amounts no greater
9 than necessary in order to produce the required level of funds needed
10 to make the payments specified in this chapter and the state portion of
11 the quality incentive payments under section 18 of this act and RCW
12 74.60.020(4)(f); and

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

16 (4)(a) Any adjustment to the assessment amounts pursuant to this
17 section, and the data supporting such adjustment, including, but not
18 limited to, relevant data listed in (b) of this subsection, must be
19 submitted to the Washington state hospital association for review and
20 comment at least sixty calendar days prior to implementation of such
21 adjusted assessment amounts. Any review and comment provided by the
22 Washington state hospital association does not limit the ability of the
23 Washington state hospital association or its members to challenge an
24 adjustment or other action by the authority that is not made in
25 accordance with this chapter.

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

31 (i) The fund balance;

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

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

37 (iv) The state share, federal share, and total annual medicaid fee-

1 for-service payments for outpatient hospital services made to each
2 hospital under RCW 74.60.120, and the data used to calculate annual
3 payments to individual hospitals under that section;

4 (v) The annual state share, federal share, and total payments made
5 to each hospital under each of the following programs: Grants to
6 certified public expenditure hospitals under RCW 74.60.090, for
7 critical access hospital payments under RCW 74.60.100; and
8 disproportionate share programs under RCW 74.60.110;

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

11 (vii) The amount of payments made to managed care plans under RCW
12 74.60.130, including the amount representing additional premium tax,
13 and the data used to calculate those payments.

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

16 The incidence and burden of assessments imposed under this chapter
17 shall be on hospitals and the expense associated with the assessments
18 shall constitute a part of the operating overhead of hospitals.
19 Hospitals shall not increase charges or billings to patients or third-
20 party payers as a result of the assessments under this chapter. The
21 ((department)) authority may require hospitals to submit certified
22 statements by their chief financial officers or equivalent officials
23 attesting that they have not increased charges or billings as a result
24 of the assessments.

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

27 ~~((Upon satisfaction of the applicable conditions set forth in RCW~~
28 ~~74.60.150(1), the department shall:~~

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

32 ~~(2) Recalculate the amount payable to each hospital that submitted~~
33 ~~an otherwise allowable claim for inpatient and outpatient~~
34 ~~medicaid covered services rendered from and after July 1, 2009, up to~~
35 ~~and including the date when the applicable conditions under RCW~~
36 ~~74.60.150(1) have been satisfied, as if the four percent medicaid~~

1 ~~inpatient and outpatient rate reductions did not occur effective July~~
2 ~~1, 2009, and, within sixty calendar days after the date upon which the~~
3 ~~applicable conditions set forth in RCW 74.60.150(1) have been~~
4 ~~satisfied, remit the difference to each hospital.)~~ In each fiscal year
5 and upon satisfaction of the conditions in RCW 74.60.150(1), after
6 deducting or reserving amounts authorized to be disbursed under RCW
7 74.60.020(4) (d), (e), and (f), disbursements from the fund must be
8 made as follows:

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

11 (2) For payments to critical access hospitals in accordance with
12 RCW 74.60.100;

13 (3) For small rural disproportionate share payments in accordance
14 with RCW 74.60.110;

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

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

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

20 ~~(1) ((Upon satisfaction of the applicable conditions set forth in~~
21 ~~RCW 74.60.150(1) and for services rendered on or after February 1,~~
22 ~~2010, through June 30, 2011, the department shall increase the medicaid~~
23 ~~inpatient and outpatient fee for service hospital reimbursement rates~~
24 ~~in effect on June 30, 2009, by the percentages specified below:~~

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

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

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

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

30 ~~(b) Harborview medical center and University of Washington medical~~
31 ~~center:~~

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

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

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

35 ~~(c) Rehabilitation hospitals:~~

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

1 ~~(ii) – Outpatient – services:—Thirty six – and – eighty three – one –~~
2 ~~hundredths percent.~~

3 ~~(d) Psychiatric hospitals:~~

4 ~~(i) Inpatient psychiatric services:—Thirteen percent;~~

5 ~~(ii) Inpatient services:—Thirteen percent.~~

6 ~~(2) Upon satisfaction of the applicable conditions set forth in RCW~~
7 ~~74.60.150(1) and for services rendered on or after July 1, 2011, the~~
8 ~~department – shall – increase – the – medicaid – inpatient – and – outpatient~~
9 ~~fee for service hospital reimbursement rates in effect on June 30,~~
10 ~~2009, by the percentages specified below:~~

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

12 ~~(i) Inpatient psychiatric services:—Thirteen percent;~~

13 ~~(ii) – Inpatient – services:—Three – and – ninety six – one hundredths~~
14 ~~percent;~~

15 ~~(iii) – Outpatient – services:—Twenty seven – and – twenty five – one –~~
16 ~~hundredths percent.~~

17 ~~(b) Harborview medical center and University of Washington medical~~
18 ~~center:~~

19 ~~(i) Inpatient psychiatric services:—Three percent;~~

20 ~~(ii) Inpatient services:—Three percent;~~

21 ~~(iii) Outpatient services:—Twenty one percent.~~

22 ~~(c) Rehabilitation hospitals:~~

23 ~~(i) Inpatient services:—Thirteen percent;~~

24 ~~(ii) – Outpatient – services:—Thirty six – and – eighty three – one –~~
25 ~~hundredths percent.~~

26 ~~(d) Psychiatric hospitals:~~

27 ~~(i) Inpatient psychiatric services:—Thirteen percent;~~

28 ~~(ii) Inpatient services:—Thirteen percent.~~

29 ~~(3) For claims processed for services rendered on or after February~~
30 ~~1, 2010, – but – prior – to – satisfaction – of – the – applicable – conditions~~
31 ~~specified in RCW 74.60.150(1), – the – department – shall, – within – sixty~~
32 ~~calendar days after satisfaction of those conditions, – calculate – the~~
33 ~~amount payable to hospitals in accordance with this section and remit~~
34 ~~the – difference – to – each – hospital – that – has – submitted – an – otherwise~~
35 ~~allowable claim for payment for such services.~~

36 ~~(4) By December 1, 2012, the department will submit a study to the~~
37 ~~legislature – with – recommendations – on – the – amount – of – the – assessments~~
38 ~~necessary to continue to support hospital payments for the 2013–2015~~

1 biennium. — The — evaluation — will — assess — medicaid — hospital — payments
2 relative to medicaid hospital costs. The study should address current
3 federal law, — including — any — changes — on — scope — of — medicaid — coverage,
4 provisions related to provider taxes, — and — impacts — of — federal — health
5 care reform legislation. — The — study — should — also — address — the — state's
6 economic — forecast. — Based — on — the — forecast, — the — department — should
7 recommend the amount of assessment needed to support future hospital
8 payments and the departmental administrative expenses. Recommendations
9 should be developed with the fiscal committees of the legislature,
10 office of financial management, — and — the — Washington — state — hospital
11 association.)

12 In each fiscal year commencing upon satisfaction of the
13 applicable conditions in RCW 74.60.150(1), funds must be disbursed from
14 the fund and the authority shall make grants to certified public
15 expenditure hospitals, which shall not be considered payments for
16 hospital services, as follows:

17 (a) University of Washington medical center: Three million three
18 hundred thousand dollars per state fiscal year in fiscal years 2014 and
19 2015, and then reduced in approximately equal increments per fiscal
20 year until the grant amount is zero by July 1, 2019;

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

25 (c) All other certified public expenditure hospitals: Four million
26 seven hundred thousand dollars per state fiscal year in fiscal years
27 2014 and 2015, and then reduced in approximately equal increments per
28 fiscal year until the grant amount is zero by July 1, 2019. The amount
29 of payments to individual hospitals under this subsection must be
30 determined using a methodology that provides each hospital with a
31 proportional allocation of the group's total amount of medicaid and
32 state children's health insurance program payments determined from
33 claims and encounter data using the same general methodology set forth
34 in RCW 74.60.120 (3) and (4).

35 (2) Payments must be made quarterly, taking the total disbursement
36 amount and dividing by four to calculate the quarterly amount. The
37 initial payment, which must include all amounts due from and after July
1, 2013, to the date of the initial payment, must be made within thirty

1 days after satisfaction of the conditions in RCW 74.60.150(1). The
2 authority shall provide a quarterly report of such payments to the
3 Washington state hospital association.

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

6 ~~((Upon satisfaction of the applicable conditions set forth in RCW~~
7 ~~74.60.150(1), the department shall pay critical access hospitals that~~
8 ~~do not qualify for or receive a small rural disproportionate share~~
9 ~~payment in the subject state fiscal year an access payment of fifty~~
10 ~~dollars for each medicaid inpatient day, exclusive of days on which a~~
11 ~~swing bed is used for subacute care, from and after July 1, 2009.~~
12 ~~Initial payments to hospitals, covering the period from July 1, 2009,~~
13 ~~to the date when the applicable conditions under RCW 74.60.150(1) are~~
14 ~~satisfied, shall be made within sixty calendar days after such~~
15 ~~conditions are satisfied. Subsequent payments shall be made to~~
16 ~~critical access hospitals on an annual basis at the time that~~
17 ~~disproportionate share eligibility and payment for the state fiscal~~
18 ~~year are established. These payments shall be in addition to any other~~
19 ~~amount payable with respect to services provided by critical access~~
20 ~~hospitals and shall not reduce any other payments to critical access~~
21 ~~hospitals.)) In each fiscal year commencing upon satisfaction of the~~
22 ~~conditions in RCW 74.60.150(1), the authority shall make access~~
23 ~~payments to critical access hospitals that do not qualify for or~~
24 ~~receive a small rural disproportionate share hospital payment in a~~
25 ~~given fiscal year in the total amount of five hundred twenty thousand~~
26 ~~dollars from the fund. The amount of payments to individual hospitals~~
27 ~~under this section must be determined using a methodology that provides~~
28 ~~each hospital with a proportional allocation of the group's total~~
29 ~~amount of medicaid and state children's health insurance program~~
30 ~~payments determined from claims and encounter data using the same~~
31 ~~general methodology set forth in RCW 74.60.120 (3) and (4). Payments~~
32 ~~must be made after the authority determines a hospital's payments under~~
33 ~~RCW 74.60.110. These payments shall be in addition to any other amount~~
34 ~~payable with respect to services provided by critical access hospitals~~
35 ~~and shall not reduce any other payments to critical access hospitals.~~
36 ~~The authority shall provide a report of such payments to the Washington~~
37 ~~state hospital association within thirty days after payments are made.~~

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

3 (~~Upon satisfaction of the applicable conditions set forth in RCW~~
4 ~~74.60.150(1), small rural disproportionate share payments shall be~~
5 ~~increased to one hundred twenty percent of the level in effect as of~~
6 ~~June 30, 2009, for the period from and after July 1, 2009, until July~~
7 ~~1, 2013. Initial payments, covering the period from July 1, 2009, to~~
8 ~~the date when the applicable conditions under RCW 74.60.150(1) are~~
9 ~~satisfied, shall be made within sixty calendar days after those~~
10 ~~conditions are satisfied. Subsequent payments shall be made directly~~
11 ~~to hospitals by the department on a periodic basis.)) In each fiscal
12 year commencing upon satisfaction of the applicable conditions in RCW
13 74.60.150(1), one million nine hundred nine thousand dollars must be
14 distributed from the fund and, with available federal matching funds,
15 paid to hospitals eligible for small rural disproportionate share
16 payments under WAC 182-550-4900 or successor rule. Payments must be
17 made directly to hospitals by the authority in accordance with that
18 regulation. The authority shall provide a report of such payments to
19 the Washington state hospital association within thirty days after
20 payments are made.~~

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

23 (~~Subject to the applicable conditions set forth in RCW~~
24 ~~74.60.150(1), the department shall:~~

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

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

29 ~~(a) Upon satisfaction of the applicable conditions under RCW~~
30 ~~74.60.150(1), increase payments to managed care organizations and~~
31 ~~regional support networks as necessary to ensure that hospitals are~~
32 ~~reimbursed in accordance with RCW 74.60.080(1) for services rendered~~
33 ~~from and after the date when applicable conditions under RCW~~
34 ~~74.60.150(1) have been satisfied, and pay an additional amount equal to~~
35 ~~the estimated amount of additional state taxes on managed care~~
36 ~~organizations or regional support networks due as a result of the~~
37 ~~payments under this section, and require managed care organizations and~~

1 regional support networks to make payments to each hospital in
2 accordance with RCW 74.60.080. The increased payments made to
3 hospitals pursuant to this subsection shall be in addition to any other
4 amounts payable to hospitals by managed care organizations or regional
5 support networks and shall not affect any other payments to hospitals;

6 (b) Within sixty calendar days after satisfaction of the applicable
7 conditions under RCW 74.60.150(1), calculate the additional amount due
8 to each hospital to pay claims submitted for inpatient and outpatient
9 medicaid covered services rendered from and after July 1, 2009, through
10 the date when the applicable conditions under RCW 74.60.150(1) have
11 been satisfied, based on the rates required by RCW 74.60.080(2), make
12 payments to managed care organizations and regional support networks in
13 amounts sufficient to pay the additional amounts due to each hospital
14 plus an additional amount equal to the estimated amount of additional
15 state taxes on managed care organizations or regional support networks
16 due as a result of the payments under this subsection, and require
17 managed care organizations and regional support networks to make
18 payments to each hospital in accordance with the department's
19 calculations within forty five calendar days after the department
20 disburses funds for those purposes;

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

23 (a) Upon satisfaction of the applicable conditions under RCW
24 74.60.150(1), increase payments to managed care organizations and
25 regional support networks as necessary to ensure that hospitals are
26 reimbursed in accordance with RCW 74.60.090, and pay an additional
27 amount equal to the estimated amount of additional state taxes on
28 managed care organizations or regional support networks due as a result
29 of the payments under this section;

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

35 (c) Within sixty calendar days after satisfaction of the applicable
36 conditions under RCW 74.60.150(1), calculate the additional amount due
37 to each hospital to pay claims submitted for inpatient and outpatient
38 medicaid covered services rendered from and after February 1, 2010,

1 through the date when the applicable conditions under RCW 74.60.150(1)
2 are satisfied based on the rates required by RCW 74.60.090, make
3 payments to managed care organizations and regional support networks in
4 amounts sufficient to pay the additional amounts due to each hospital
5 plus an additional amount equal to the estimated amount of additional
6 state taxes on managed care organizations or regional support networks,
7 and require managed care organizations and regional support networks to
8 make payments to each hospital in accordance with the department's
9 calculations within forty-five calendar days after the department
10 disburses funds for those purposes;

11 (d) Require managed care organizations that contract with health
12 care organizations that provide, directly or by contract, health care
13 services on a prepaid or capitated basis to make payments to health
14 care organizations for any of the hospital payments that the managed
15 care organizations would have been required to pay to hospitals under
16 this section if the managed care organizations did not contract with
17 those health care organizations, and require the managed care
18 organizations to require those health care organizations to make
19 equivalent payments to the hospitals that would have received payments
20 under this section if the managed care organizations did not contract
21 with the health care organizations;

22 (4) The department shall ensure that the increases to the medicaid
23 fee schedules as described in RCW 74.60.090 are included in the
24 development of healthy options premiums.

25 (5) The department may require managed care organizations and
26 regional support networks to demonstrate compliance with this
27 section.) (1) Beginning in state fiscal year 2014, commencing thirty
28 days after satisfaction of the applicable conditions in RCW
29 74.60.150(1), and for the period of state fiscal years 2014 through
30 2019, the authority shall make supplemental payments directly to
31 Washington hospitals, separately for inpatient and outpatient fee-for-
32 service medicaid services, as follows:

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

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

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

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

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

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

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

35 (3) The amount of such fee-for-service inpatient payments to
36 individual hospitals within each of the categories identified in
37 subsection (1)(a), (c), (d), and (e) of this section must be determined
38 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 inpatient 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' inpatient 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 (4) The amount of such fee-for-service outpatient payments to
13 individual hospitals within each of the categories identified in
14 subsection (1)(b) and (f) of this section must be determined by:

15 (a) Applying the medicaid fee-for-service rates in effect on July
16 1, 2009, without regard to the increases required by chapter 30, Laws
17 of 2010 1st sp. sess. to each hospital's outpatient fee-for-services
18 claims and medicaid managed care encounter data for the base year;

19 (b) 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 all hospitals' outpatient fee-for-services
22 claims and medicaid managed care encounter data for the base year; and

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

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

31 (6) Payments must be made in quarterly installments on or about the
32 last day of every quarter, except that the initial payment must be made
33 within thirty days after satisfaction of the conditions in RCW
34 74.60.150(1) and must include all amounts due from July 1, 2013, to the
35 date of the initial payment.

36 (7) A prospective payment system hospital commencing operations
37 after January 1, 2009, is eligible to receive payments in accordance

1 with this section after becoming an eligible new prospective payment
2 system hospital as defined in RCW 74.60.010.

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

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

7 ~~(1) ((The department, in collaboration with the health care~~
8 ~~authority, the department of health, the department of labor and~~
9 ~~industries, the Washington state hospital association, the Puget Sound~~
10 ~~health alliance, and the forum, a collaboration of health carriers,~~
11 ~~physicians, and hospitals in Washington state, shall design a system of~~
12 ~~hospital quality incentive payments. The design of the system shall be~~
13 ~~submitted to the relevant policy and fiscal committees of the~~
14 ~~legislature by December 15, 2010. The system shall be based upon the~~
15 ~~following principles:~~

16 ~~(a) Evidence based treatment and processes shall be used to improve~~
17 ~~health care outcomes for hospital patients;~~

18 ~~(b) Effective purchasing strategies to improve the quality of~~
19 ~~health care services should involve the use of common quality~~
20 ~~improvement measures by public and private health care purchasers,~~
21 ~~while recognizing that some measures may not be appropriate for~~
22 ~~application to specialty pediatric, psychiatric, or rehabilitation~~
23 ~~hospitals;~~

24 ~~(c) Quality measures chosen for the system should be consistent~~
25 ~~with the standards that have been developed by national quality~~
26 ~~improvement organizations, such as the national quality forum, the~~
27 ~~federal centers for medicare and medicaid services, or the federal~~
28 ~~agency for healthcare research and quality. New reporting burdens to~~
29 ~~hospitals should be minimized by giving priority to measures hospitals~~
30 ~~are currently required to report to governmental agencies, such as the~~
31 ~~hospital compare measures collected by the federal centers for medicare~~
32 ~~and medicaid services;~~

33 ~~(d) Benchmarks for each quality improvement measure should be set~~
34 ~~at levels that are feasible for hospitals to achieve, yet represent~~
35 ~~real improvements in quality and performance for a majority of~~
36 ~~hospitals in Washington state; and~~

1 ~~(e) Hospital performance and incentive payments should be designed~~
2 ~~in a manner such that all noncritical access hospitals in Washington~~
3 ~~are able to receive the incentive payments if performance is at or~~
4 ~~above the benchmark score set in the system established under this~~
5 ~~section.~~

6 ~~(2) Upon satisfaction of the applicable conditions set forth in RCW~~
7 ~~74.60.150(1), and for state fiscal year 2013 and each fiscal year~~
8 ~~thereafter, assessments may be increased to support an additional one~~
9 ~~percent increase in inpatient hospital rates for noncritical access~~
10 ~~hospitals that meet the quality incentive benchmarks established under~~
11 ~~this section.)) For state fiscal year 2014, commencing within thirty~~
12 ~~days after satisfaction of the conditions in RCW 74.60.150(1) and~~
13 ~~subsection (6) of this section, and for the period of state fiscal~~
14 ~~years 2014 through 2019, the authority shall increase capitation~~
15 ~~payments to managed care organizations by an amount at least equal to~~
16 ~~the amount available from the fund after deducting disbursements~~
17 ~~authorized by RCW 74.60.020(4) (c) through (f) and payments required by~~
18 ~~RCW 74.60.080 through 74.60.120. The capitation payment under this~~
19 ~~subsection must be no less than one hundred fifty-three million one~~
20 ~~hundred thirty-one thousand six hundred dollars per state fiscal year~~
21 ~~in fiscal years 2014 and 2015, and then the increased capitation~~
22 ~~payment amounts are reduced in equal increments per fiscal year until~~
23 ~~the increased capitation payment amount is zero by July 1, 2019, plus~~
24 ~~the maximum available amount of federal matching funds. The initial~~
25 ~~payment following satisfaction of the conditions in RCW 74.60.150(1)~~
26 ~~must include all amounts due from July 1, 2013. Subsequent payments~~
27 ~~shall be made quarterly.~~

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

34 (3) Payments to individual managed care organizations shall be
35 determined by the authority based on each organization's or network's
36 enrollment relative to the anticipated total enrollment in each program
37 for the fiscal year in question, the anticipated utilization of

1 hospital services by an organization's or network's medicaid enrollees,
2 and such other factors as are reasonable and appropriate to ensure that
3 purposes of this chapter are met.

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

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

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

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

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

36 (c) Providing that any delegation or attempted delegation of an
37 organization's or network's obligations under agreements with the

1 authority do not relieve the organization or network of its obligations
2 under this section and related contract provisions.

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

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

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

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

14 (1) For the purposes of this section:

15 (a) "Managed health care system" means any health care
16 organization, including health care providers, insurers, health care
17 service contractors, health maintenance organizations, health insuring
18 organizations, or any combination thereof, that provides directly or by
19 contract health care services covered under this chapter and rendered
20 by licensed providers, on a prepaid capitated basis and that meets the
21 requirements of section 1903(m)(1)(A) of Title XIX of the federal
22 social security act or federal demonstration waivers granted under
23 section 1115(a) of Title XI of the federal social security act;

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

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

33 (a) Agreements shall be made for at least thirty thousand
34 recipients statewide;

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

1 (c) To the extent that this provision is consistent with section
2 1903(m) of Title XIX of the federal social security act or federal
3 demonstration waivers granted under section 1115(a) of Title XI of the
4 federal social security act, recipients shall have a choice of systems
5 in which to enroll and shall have the right to terminate their
6 enrollment in a system: PROVIDED, That the authority may limit
7 recipient termination of enrollment without cause to the first month of
8 a period of enrollment, which period shall not exceed twelve months:
9 AND PROVIDED FURTHER, That the authority shall not restrict a
10 recipient's right to terminate enrollment in a system for good cause as
11 established by the authority by rule;

12 (d) To the extent that this provision is consistent with section
13 1903(m) of Title XIX of the federal social security act, participating
14 managed health care systems shall not enroll a disproportionate number
15 of medical assistance recipients within the total numbers of persons
16 served by the managed health care systems, except as authorized by the
17 authority under federal demonstration waivers granted under section
18 1115(a) of Title XI of the federal social security act;

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

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

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

25 (C) Provider reimbursement methods that incentivize chronic care
26 management within health homes, including comprehensive medication
27 management services for patients with multiple chronic conditions
28 consistent with the findings and goals established in section 1 of this
29 act;

30 (D) Provider reimbursement methods that reward health homes that,
31 by using chronic care management, reduce emergency department and
32 inpatient use;

33 (E) Promoting provider participation in the program of training and
34 technical assistance regarding care of people with chronic conditions
35 described in RCW 43.70.533, including allocation of funds to support
36 provider participation in the training, unless the managed care system
37 is an integrated health delivery system that has programs in place for
38 chronic care management;

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

6 (G) Evaluation and reporting on the impact of comprehensive
7 medication management services on patient clinical outcomes and total
8 health care costs, including reductions in emergency department
9 utilization, hospitalization, and drug costs.

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

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

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

18 (g) The authority shall, wherever possible, enter into prepaid
19 capitation contracts that include inpatient care. However, if this is
20 not possible or feasible, the authority may enter into prepaid
21 capitation contracts that do not include inpatient care;

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

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

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

31 (3) The authority shall ensure that publicly supported community
32 health centers and providers in rural areas, who show serious intent
33 and apparent capability to participate as managed health care systems
34 are seriously considered as contractors. The authority shall
35 coordinate its managed care activities with activities under chapter
36 70.47 RCW.

37 (4) The authority shall work jointly with the state of Oregon and
38 other states in this geographical region in order to develop

1 recommendations to be presented to the appropriate federal agencies and
2 the United States congress for improving health care of the poor, while
3 controlling related costs.

4 (5) The legislature finds that competition in the managed health
5 care marketplace is enhanced, in the long term, by the existence of a
6 large number of managed health care system options for medicaid
7 clients. In a managed care delivery system, whose goal is to focus on
8 prevention, primary care, and improved enrollee health status,
9 continuity in care relationships is of substantial importance, and
10 disruption to clients and health care providers should be minimized.
11 To help ensure these goals are met, the following principles shall
12 guide the authority in its healthy options managed health care
13 purchasing efforts:

14 (a) All managed health care systems should have an opportunity to
15 contract with the authority to the extent that minimum contracting
16 requirements defined by the authority are met, at payment rates that
17 enable the authority to operate as far below appropriated spending
18 levels as possible, consistent with the principles established in this
19 section.

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

23 (i) Demonstrated commitment to or experience in serving low-income
24 populations;

25 (ii) Quality of services provided to enrollees;

26 (iii) Accessibility, including appropriate utilization, of services
27 offered to enrollees;

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

30 (v) Payment rates; and

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

35 (c) Consideration should be given to using multiple year
36 contracting periods.

37 (d) Quality, accessibility, and demonstrated commitment to serving

1 low-income populations shall be given significant weight in the
2 contracting, evaluation, and assignment process.

3 (e) All contractors that are regulated health carriers must meet
4 state minimum net worth requirements as defined in applicable state
5 laws. The authority shall adopt rules establishing the minimum net
6 worth requirements for contractors that are not regulated health
7 carriers. This subsection does not limit the authority of the
8 Washington state health care authority to take action under a contract
9 upon finding that a contractor's financial status seriously jeopardizes
10 the contractor's ability to meet its contract obligations.

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

15 (6) The authority may apply the principles set forth in subsection
16 (5) of this section to its managed health care purchasing efforts on
17 behalf of clients receiving supplemental security income benefits to
18 the extent appropriate.

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

24 (8) For services covered under this chapter to medical assistance
25 or medical care services enrollees and provided on or after August 24,
26 2011, nonparticipating providers must accept as payment in full the
27 amount paid by the managed health care system under subsection (7) of
28 this section in addition to any deductible, coinsurance, or copayment
29 that is due from the enrollee for the service provided. An enrollee is
30 not liable to any nonparticipating provider for covered services,
31 except for amounts due for any deductible, coinsurance, or copayment
32 under the terms and conditions set forth in the managed health care
33 system contract to provide services under this section.

34 (9) Pursuant to federal managed care access standards, 42 C.F.R.
35 Sec. 438, managed health care systems must maintain a network of
36 appropriate providers that is supported by written agreements
37 sufficient to provide adequate access to all services covered under the
38 contract with the ((department)) authority, including hospital-based

1 physician services. The ((department)) authority will monitor and
2 periodically report on the proportion of services provided by
3 contracted providers and nonparticipating providers, by county, for
4 each managed health care system to ensure that managed health care
5 systems are meeting network adequacy requirements. No later than
6 January 1st of each year, the ((department)) authority will review and
7 report its findings to the appropriate policy and fiscal committees of
8 the legislature for the preceding state fiscal year.

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

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

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

14 (1) If an entity owns or operates more than one hospital subject to
15 assessment under this chapter, the entity shall pay the assessment for
16 each hospital separately. However, if the entity operates multiple
17 hospitals under a single medicaid provider number, it may pay the
18 assessment for the hospitals in the aggregate.

19 (2) Notwithstanding any other provision of this chapter, if a
20 hospital subject to the assessment imposed under this chapter ceases to
21 conduct hospital operations throughout a state fiscal year, the
22 assessment for the quarter in which the cessation occurs shall be
23 adjusted by multiplying the assessment computed under RCW 74.60.030
24 ((~~(1) and (3)~~)) by a fraction, the numerator of which is the number of
25 days during the year which the hospital conducts, operates, or
26 maintains the hospital and the denominator of which is three hundred
27 sixty-five. Immediately prior to ceasing to conduct, operate, or
28 maintain a hospital, the hospital shall pay the adjusted assessment for
29 the fiscal year to the extent not previously paid.

30 ~~(3) ((Notwithstanding any other provision of this chapter, in the
31 case of a hospital that commences conducting, operating, or maintaining
32 a hospital that is not exempt from payment of the assessment under RCW
33 74.60.040 and that did not conduct, operate, or maintain such hospital
34 throughout the cost reporting year used to determine the assessment
35 amount, the assessment for that hospital shall be computed on the basis
36 of the actual number of nonmedicare inpatient days reported to the~~

1 ~~department by the hospital on a quarterly basis. The hospital shall be~~
2 ~~eligible to receive increased payments under this chapter beginning on~~
3 ~~the date it commences hospital operations.~~

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

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

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

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

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

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

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

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

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

5 ~~((An appellate court or the centers for medicare and medicaid
6 services))~~ The federal department of health and human services and a
7 court of competent jurisdiction makes a final determination, with all
8 appeals exhausted, that any element of this chapter, other than RCW
9 74.60.100, cannot be validly implemented;

10 (b) ~~((Medicaid inpatient or outpatient reimbursement rates for
11 hospitals are reduced below the combined rates established by RCW
12 74.60.080 and 74.60.090;~~

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

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

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

30 (d) Payments required by this chapter are reduced, except as
31 specifically authorized in this chapter, or payments are not made in
32 substantial compliance with the time frames set forth in this chapter;
33 or

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

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

1 (1) The provisions of this chapter are not severable: If the
2 conditions (~~(set forth)~~) in RCW 74.60.150(1) are not satisfied or if
3 any of the circumstances (~~(set forth)~~) in RCW 74.60.150(2) should
4 occur, this entire chapter shall have no effect from that point
5 forward(~~(, except that if the payment under RCW 74.60.100, or the~~
6 ~~application thereof to any hospital or circumstances does not receive~~
7 ~~approval by the centers for medicare and medicaid services as described~~
8 ~~in RCW 74.60.150(1)(b) or is determined to be unconstitutional or~~
9 ~~otherwise invalid, the other provisions of this chapter or its~~
10 ~~application to hospitals or circumstances other than those to which it~~
11 ~~is held invalid shall not be affected thereby)).~~

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

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

22 NEW SECTION. Sec. 17. A new section is added to chapter 74.60 RCW
23 to read as follows:

24 (1) The legislature intends to provide the hospitals with an
25 opportunity to contract with the authority each fiscal biennium to
26 protect the hospitals from future legislative action during the
27 biennium that could result in hospitals receiving less from
28 supplemental payments, increased managed care payments,
29 disproportionate share hospital payments, or access payments than the
30 hospitals expected to receive in return for the assessment based on the
31 biennial appropriations and assessment legislation.

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

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

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

4 (ii) Reduce aggregate payment levels to hospitals for inpatient and
5 outpatient services covered by medicaid, including fee-for-service and
6 managed care, allowing for variations due to budget-neutral rebasing
7 and adjusting for changes in enrollment and utilization, from the
8 levels the state paid for those services on the first day of the
9 contract period;

10 (iii) For critical access hospitals only, reduce the levels of
11 disproportionate share hospital payments under RCW 74.60.110 or access
12 payments under RCW 74.60.100 for all critical access hospitals below
13 the levels specified in those sections on the first day of the contract
14 period;

15 (iv) For prospective payment system, psychiatric, and
16 rehabilitation hospitals only, reduce the levels of supplemental
17 payments under RCW 74.60.120 for all prospective payment system
18 hospitals below the levels specified in that section on the first day
19 of the contract period unless the supplemental payments are reduced
20 under RCW 74.60.120(2);

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

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

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

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

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

3 (b) May discontinue supplemental payments, increased managed care
4 payments, disproportionate share hospital payments, and access payments
5 made subsequent to the breach for the hospital that are required under
6 this chapter.

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

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

12 (1) If sufficient funds are made available as provided in
13 subsection (2) of this section the authority, in collaboration with the
14 Washington state hospital association, shall design a system of
15 hospital quality incentive payments for noncritical access hospitals.
16 The system must be based upon the following principles:

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

19 (b) Effective purchasing strategies to improve the quality of
20 health care services should involve the use of common quality
21 improvement measures by public and private health care purchasers,
22 while recognizing that some measures may not be appropriate for
23 application to specialty pediatric, psychiatric, or rehabilitation
24 hospitals;

25 (c) Quality measures chosen for the system should be consistent
26 with the standards that have been developed by national quality
27 improvement organizations, such as the national quality forum, the
28 federal centers for medicare and medicaid services, or the federal
29 agency for healthcare research and quality. New reporting burdens to
30 hospitals should be minimized by giving priority to measures hospitals
31 are currently required to report to governmental agencies, such as the
32 hospital compare measures collected by the federal centers for medicare
33 and medicaid services;

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

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

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

9 (a) Meet the quality incentive benchmarks established under this
10 section; and

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

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

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

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

19 NEW SECTION. **Sec. 20.** This act is necessary for the immediate
20 preservation of the public peace, health, or safety, or support of the
21 state government and its existing public institutions, and takes effect
22 immediately.

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