S-2487.2

SENATE BILL 5913

State of Washington 63rd Legislature 2013 Regular Session

By Senator Becker

Read first time 04/15/13. Referred to Committee on Ways & Means.

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

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

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

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

(2) The legislature finds that((~~:~~

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

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

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

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

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

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

(c) To generate one hundred eighty-three million sixty-seven thousand dollars in the 2013-2015 biennium, phasing down to zero by the end of the 2017-2019 biennium, in new funds to be used in lieu of state general fund payments for medicaid hospital services;

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

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

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

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

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

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

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

(4) "Certified public expenditure hospital" means a hospital participating in ((~~the department's~~)), or that at any point from the effective date of this section to July 1, 2019, participates in the authority's certified public expenditure payment program as described in WAC ((~~388-550-4650~~)) 182-550-4650 or successor rule. The eligibility of such hospitals to receive grants under RCW 74.60.090 solely from funds generated under this chapter must not be affected by any modification or termination of the federal certified public expenditure program, or reduced by the amount of any federal funds no longer available for that purpose.

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

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

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

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

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

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

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

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

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

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

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

((~~(11)~~)) (15) "Prospective payment system hospital" means a hospital reimbursed for inpatient and outpatient services provided to medicaid beneficiaries under the inpatient prospective payment system

and the outpatient prospective payment system as defined in WAC ((~~388-550-1050~~)) 182-550-1050 or successor rule. For purposes of this chapter, prospective payment system hospital does not include a hospital participating in the certified public expenditure program or a bordering city hospital located outside of the state of Washington and in one of the bordering cities listed in WAC ((~~388-501-0175~~)) 182-501-0175 or successor ((~~regulation~~)) rule.

((~~(12)~~)) (16) "Psychiatric hospital" means a hospital facility licensed as a psychiatric hospital under chapter 71.12 RCW.

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

~~(14)~~)) (17) "Rehabilitation hospital" means a medicare-certified freestanding inpatient rehabilitation facility.

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

~~(16)~~)) (18) "Small rural disproportionate share hospital payment" means a payment made in accordance with WAC ((~~388-550-5200~~)) 182-550-5200 or ((~~subsequently filed regulation~~)) successor rule.

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

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

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

(a) Any unexpended balance in the fund at the end of a fiscal biennium shall carry over into the following biennium and shall be

applied to reduce the amount of the assessment under RCW 74.60.050(1)(c).

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

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

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

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

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

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

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

~~(e) The sum of forty-nine million three hundred thousand dollars for the 2009-2011 fiscal biennium may be expended in lieu of state general fund payments to hospitals. An additional sum of seventeen million five hundred thousand dollars for the 2009-2011 fiscal biennium~~

~~may be expended in lieu of state general fund payments to hospitals if additional federal financial participation under section 5001 of P.L. No. 111-5 is extended beyond December 31, 2010. The sum of one hundred ninety-nine million eight hundred thousand dollars for the 2011-2013 fiscal biennium may be expended in lieu of state general fund payments to hospitals;~~

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

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

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

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

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

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

(d) For one hundred eighty-three million sixty-seven thousand dollars in the 2013-2015 biennium, phasing down to zero by the end of the 2017-2019 biennium to be used in lieu of state general fund payments for medicaid hospital services, provided that if the full

amount of the payments required under RCW 74.60.120 and 74.60.130 cannot be distributed in a given fiscal year, this amount must be reduced proportionately;

(e) To repay the federal government for any excess payments made to hospitals from the fund if the assessments or payment increases set forth in this chapter are deemed out of compliance with federal statutes and regulations in a final determination by a court of competent jurisdiction with all appeals exhausted. In such a case, the authority may require hospitals receiving excess payments to refund the payments in question to the fund. The state in turn shall return funds to the federal government in the same proportion as the original financing;

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(ii) For purposes of (c) of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare hospital inpatient days for each hospital that is not exempt from the assessment under RCW 74.60.040, taken from the most recent publicly available hospital 2552-96 cost~~

~~report data file or successor data file available through the centers for medicare and medicaid services, as of a date to be determined by the department. If cost report data are unavailable from the foregoing source for any hospital subject to the assessment, the department shall collect such information directly from the hospital.~~

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

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

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

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

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

~~(c) For purposes of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare inpatient days for each hospital that is not exempt from the assessment as described in RCW 74.60.040 for the relevant state fiscal year 2008 portions included in the hospital's fiscal year end reports 2007 and/or 2008 cost reports. The department~~

~~shall use nonmedicare hospital inpatient day data for each hospital taken from the centers for medicare and medicaid services' hospital 2552-96 cost report data file as of November 30, 2009, or equivalent data collected by the department.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d)(i) For purposes of (a) and (b) of this subsection, the department shall determine each hospital's annual nonmedicare hospital inpatient days by summing the total reported nonmedicare inpatient days for each hospital that is not exempt from the assessment as described in RCW 74.60.040 for the relevant state fiscal year 2008 portions~~

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

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

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

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

(i) Each prospective payment system hospital, except psychiatric and rehabilitation hospitals, shall pay a monthly assessment of three hundred forty-five dollars for each annual nonmedicare hospital inpatient day, up to a maximum of fifty-four thousand dollars per year. For each nonmedicare hospital inpatient day in excess of fifty-four

thousand dollars, each prospective payment system hospital shall pay an assessment of seven dollars for each such day;

(ii) Each critical access hospital shall pay a monthly assessment of ten dollars for each annual nonmedicare hospital inpatient day;

(iii) Each psychiatric hospital shall pay a monthly assessment of sixty-seven dollars for each annual nonmedicare hospital inpatient day; and

(iv) Each rehabilitation hospital shall pay a monthly assessment of sixty-seven dollars for each annual nonmedicare hospital inpatient day.

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

(a) With the exception of eligible new prospective payment system hospitals as defined in RCW 74.60.010, for any hospital without a cost report for the relevant fiscal year, the authority shall work with the affected hospital to identify appropriate supplemental information that may be used to determine annual nonmedicare hospital inpatient days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(a) The fund balance;~~

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

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

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

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

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

(2) For each fiscal year following state fiscal year 2014, the assessment amounts established under RCW 74.60.030 must be adjusted as follows:

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

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

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

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

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

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

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

(3)(a) Any adjustment to the assessment amounts pursuant to this subsection, and the data supporting such adjustment, including, but not limited to, relevant data listed in (b) of this subsection, must be submitted to the Washington state hospital association for review and

comment at least sixty calendar days prior to implementation of such adjusted assessment amounts. Any review and comment provided by the Washington state hospital association does not limit the ability of the Washington state hospital association or its members to challenge an adjustment or other action by the authority that is not made in accordance with this chapter.

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

(i) The fund balance;

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

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

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

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

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

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

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

The incidence and burden of assessments imposed under this chapter shall be on hospitals and the expense associated with the assessments shall constitute a part of the operating overhead of hospitals. Hospitals shall not increase charges or billings to patients or third-

party payers as a result of the assessments under this chapter. The ((~~department~~)) authority may require hospitals to submit certified statements by their chief financial officers or equivalent officials attesting that they have not increased charges or billings as a result of the assessments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) Rehabilitation hospitals:~~

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

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

~~(d) Psychiatric hospitals:~~

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

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

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

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

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

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

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

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

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

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

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

~~(c) Rehabilitation hospitals:~~

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

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

~~(d) Psychiatric hospitals:~~

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

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

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

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

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

(b) Harborview medical center: Seven million six hundred thousand

dollars in fiscal year 2014, reduced in approximately equal increments per fiscal year until the grant amount is zero by July 1, 2019;

(c) All other certified public expenditure hospitals: Four million seven hundred thousand dollars in fiscal year 2014, reduced in approximately equal increments per fiscal year until the grant amount is zero by July 1, 2019. The amount of payments to individual hospitals under this subsection must be determined using the methodology set forth in RCW 74.60.120 (3) and (4).

(2) Payments must be made monthly, taking the total disbursement amount and dividing by twelve to calculate the monthly amount. The 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 days after satisfaction of the conditions in RCW 74.60.150(1). The authority shall provide a monthly report of such payments to the Washington state hospital association.

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

((~~Upon satisfaction of the applicable conditions set forth in RCW 74.60.150(1), the department shall pay critical access hospitals that do not qualify for or receive a small rural disproportionate share payment in the subject state fiscal year an access payment of fifty dollars for each medicaid inpatient day, exclusive of days on which a swing bed is used for subacute care, from and after July 1, 2009. Initial payments to hospitals, covering the period from July 1, 2009, to the date when the applicable conditions under RCW 74.60.150(1) are satisfied, shall be made within sixty calendar days after such conditions are satisfied. Subsequent payments shall be made to critical access hospitals on an annual basis at the time that disproportionate share eligibility and payment for the state fiscal year are established. These payments shall be in addition to any other amount payable with respect to services provided by critical access hospitals and shall not reduce any other payments to critical access hospitals.~~)) In each fiscal year commencing upon satisfaction of the conditions in RCW 74.60.150(1), the authority shall make access payments to critical access hospitals that do not qualify for or receive a small rural disproportionate share hospital payment in a given fiscal year in the total amount of five hundred twenty thousand

dollars from the fund. The amount of payments to individual hospitals under this section must be determined using the methodology set forth in RCW 74.60.120 (3) and (4). Payments must be made after the authority determines a hospital's payments under RCW 74.60.110. These payments shall be in addition to any other amount payable with respect to services provided by critical access hospitals and shall not reduce any other payments to critical access hospitals. The authority shall provide a report of such payments to the Washington state hospital association within thirty days after payments are made.

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

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

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

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

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

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

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

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

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

~~(a) Upon satisfaction of the applicable conditions under RCW 74.60.150(1), increase payments to managed care organizations and regional support networks as necessary to ensure that hospitals are reimbursed in accordance with RCW 74.60.090, and pay an additional~~

~~amount equal to the estimated amount of additional state taxes on managed care organizations or regional support networks due as a result of the payments under this section;~~

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

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

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

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

~~(5) The department may require managed care organizations and regional support networks to demonstrate compliance with this~~

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

(a) For inpatient fee-for-service payments for prospective payment hospitals other than psychiatric or rehabilitation hospitals, twenty-eight million one hundred twenty-five thousand dollars in fiscal year 2014 and amounts reduced in equal increments per fiscal year until the supplemental payment amount is zero by July 1, 2019, from the fund, plus federal matching funds;

(b) For outpatient fee-for-service payments for prospective payment hospitals other than psychiatric or rehabilitation hospitals, twenty-four million five hundred fifty thousand dollars in fiscal year 2014 and amounts reduced in equal increments per fiscal year until the supplemental payment amount is zero by July 1, 2019, from the fund, plus federal matching funds;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Payments must be made in monthly installments on or about the first of every month, except that the initial payment must be made within thirty days after satisfaction of the conditions in RCW 74.60.150(1) and must include all amounts due from July 1, 2013, to the date of the initial payment.

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

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

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

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

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

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

~~(c) Quality measures chosen for the system should be consistent with the standards that have been developed by national quality~~

~~improvement organizations, such as the national quality forum, the federal centers for medicare and medicaid services, or the federal agency for healthcare research and quality. New reporting burdens to hospitals should be minimized by giving priority to measures hospitals are currently required to report to governmental agencies, such as the hospital compare measures collected by the federal centers for medicare and medicaid services;~~

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

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

~~(2) Upon satisfaction of the applicable conditions set forth in RCW 74.60.150(1), and for state fiscal year 2013 and each fiscal year thereafter, assessments may be increased to support an additional one percent increase in inpatient hospital rates for noncritical access hospitals that meet the quality incentive benchmarks established under this section.~~)) For state fiscal year 2014, commencing within thirty days after satisfaction of the conditions in RCW 74.60.150(1) and subsection (6) of this section, and for the period of state fiscal years 2014 through 2019, the authority shall increase capitation payments to managed care organizations by an amount at least equal to the amount available from the fund after deducting disbursements authorized by RCW 74.60.020(4) (c) through (f) and payments required by RCW 74.60.080 through 74.60.120. Capitation payments must be no less than one hundred sixty million eight hundred sixty-three thousand dollars in fiscal year 2014 and the capitation payment amounts are reduced in equal increments per fiscal year until the capitation payment amount is zero by July 1, 2019, plus the maximum available amount of federal matching funds. The initial payment following satisfaction of the conditions in RCW 74.60.150(1) must include all amounts due from July 1, 2013.

(2) In fiscal years 2015, 2016, and 2017, the authority shall use any additional federal matching funds for the increased managed care

capitation payments under subsection (1) of this section available from medicaid expansion under the federal patient protection and affordable care act to substitute for assessment funds which otherwise would have been used to pay managed care plans under this section.

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

(4) If the federal government determines that total payments to managed care organizations under this section exceed what is permitted under applicable medicaid laws and regulations, payments must be reduced to levels that meet such requirements, and the balance remaining must be applied as provided in RCW 74.60.050.

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

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

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

(b) Within thirty days after receipt, managed care organizations shall expend the increased capitation payments under this section in a manner consistent with the purposes of this chapter;

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

(d) Providing that such organizations will submit such documentation as the authority may reasonably require in order to determine their compliance with this section, including monthly reports showing distribution to hospitals.

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

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

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

Sec. 13. RCW 74.09.522 and 2011 1st sp.s. c 15 s 29, 2011 1st sp.s. c 9 s 2, and 2011 c 316 s 4 are each reenacted and amended to read as follows:

(1) For the purposes of this section:

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

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

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

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

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

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

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

(e)(i) In negotiating with managed health care systems the authority shall adopt a uniform procedure to enter into contractual arrangements, to be included in contracts issued or renewed on or after January 1, 2012, including:

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

(B) The financial integrity of the responding system;

(C) Provider reimbursement methods that incentivize chronic care management within health homes;

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

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

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

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

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

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

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

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

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

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

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

(5) The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and

disruption to clients and health care providers should be minimized. To help ensure these goals are met, the following principles shall guide the authority in its healthy options managed health care purchasing efforts:

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

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

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

(ii) Quality of services provided to enrollees;

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

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

(v) Payment rates; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

days within the assessment period that each owned, operated, or maintained the hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Payments required by this chapter are reduced or not timely made, unless the payments are reduced for reasons allowed under this chapter; or

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

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

(1) The provisions of this chapter are not severable: If the conditions ((~~set forth~~)) in RCW 74.60.150(1) are not satisfied or if any of the circumstances ((~~set forth~~)) in RCW 74.60.150(2) should occur, this entire chapter shall have no effect from that point forward((~~, except that if the payment under RCW 74.60.100, or the application thereof to any hospital or circumstances does not receive approval by the centers for medicare and medicaid services as described in RCW 74.60.150(1)(b) or is determined to be unconstitutional or otherwise invalid, the other provisions of this chapter or its~~

~~application to hospitals or circumstances other than those to which it is held invalid shall not be affected thereby~~)).

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

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

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

The legislature may not enact legislation that increases assessment levels or reduces payments to any hospitals under this chapter unless that legislation is enacted as policy legislation that is limited to the single subject of the hospital safety net assessment program under this chapter and is separate and apart from any omnibus appropriations legislation.

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

(1) If sufficient funds are made available as provided in subsection (2) of this section the authority, in collaboration with the Washington state hospital association, shall design a system of hospital quality incentive payments for prospective payment system hospitals, psychiatric hospitals, and rehabilitation hospitals. The system must be based upon the following principles:

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

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

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

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

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

(2) If hospital safety net assessment funds under RCW 74.60.020 are made available, such funds must be used to support an additional one percent increase in inpatient hospital rates for noncritical access hospitals that meet the quality incentive benchmarks established under this section. Funds directed from any other lawful source may also be used to support the purposes of this section.

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

This chapter expires July 1, ((~~2013~~)) 2019.

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

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