S-2187.2

SUBSTITUTE SENATE BILL 5815

State of Washington 65th Legislature 2017 Regular Session

By Senate Ways & Means (originally sponsored by Senators Rivers, Cleveland, Becker, and Ranker)

READ FIRST TIME 03/22/17.

AN ACT Relating to the hospital safety net assessment; amending RCW 74.60.005, 74.60.010, 74.60.020, 74.60.030, 74.60.050, 74.60.090, 74.60.100, 74.60.120, 74.60.130, 74.60.150, 74.60.160, 74.60.901, and 74.60.902; adding a new section to chapter 74.60 RCW; providing an effective date; 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 2015 2nd sp.s. c 5 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 support additional payments to hospitals for medicaid services as specified in this chapter.

(2) The legislature finds that federal health care reform will result in an expansion of medicaid enrollment in this state and an increase in federal financial participation.

(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) To generate approximately ((~~nine hundred seventy-five million~~)) one billion dollars per state fiscal biennium in new state and federal funds by disbursing all of that amount to pay for medicaid hospital services and grants to certified public expenditure and critical access 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, but which include quality improvement incentive payments under RCW 74.09.611;

(c) To generate two hundred ninety-two million dollars per biennium during the ((~~2015-2017 and~~)) 2017-2019 and 2019-2021 biennia 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 payments authorized by this chapter;

(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 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~~)) rates the state paid for those services on July 1, 2015, as adjusted for current enrollment and utilization; and

(f) For each of the two biennia starting with fiscal year ((~~2016~~)) 2018 to generate:

(i) Four million dollars for new integrated evidence-based psychiatry residency program slots that did not receive state funding prior to 2016 at the integrated psychiatry residency program at the University of Washington; and

(ii) Eight million two hundred thousand dollars for new family medicine residency program slots that did not receive state funding prior to 2016, as directed through the family medicine residency network at the University of Washington, for slots where residents are employed by hospitals.

Sec. 2. RCW 74.60.010 and 2013 2nd sp.s. c 17 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~~)) 2017 is state fiscal year ((~~2011~~)) 2014. 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 and bordering cities as described in WAC 182-501-0175, or successor rules.

(4) "Certified public expenditure hospital" means a hospital participating in or that at any point from June 30, 2013, to July 1, 2019, has participated in the authority's certified public expenditure payment program as described in WAC 182-550-4650 or successor rule. For purposes of this chapter any such hospital shall continue to be treated as a certified public expenditure hospital for assessment and payment purposes through the date specified in RCW 74.60.901. 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.

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

(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.

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

(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.

(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 authority under a comprehensive risk contract to provide prepaid health care services to eligible clients under the authority's medicaid managed care programs, including the healthy options program.

(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 authority.

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

(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, 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.

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

(16) "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 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 182-501-0175 or successor rule.

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

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

(19) "Small rural disproportionate share hospital payment" means a payment made in accordance with WAC 182-550-5200 or successor rule.

(20) "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 2015 2nd sp.s. c 5 s 2 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 authority on audit or otherwise shall be returned to the fund.

(a) Any unexpended balance in the fund at the end of a fiscal year shall carry over into the following fiscal year or that fiscal year and the following fiscal year 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 after July 1, ((~~2019~~)) 2021, shall be 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 authority under RCW 74.60.030 and 74.60.050 shall be deposited into the fund.

(3) Disbursements from the fund 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, 2015, as adjusted for current enrollment and utilization.

(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 two hundred ((~~eighty-three~~)) ninety-two million dollars per 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. If a hospital is unable to refund payments, the state shall develop either a payment plan, or deduct moneys from future medicaid payments, or both;

(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 medicaid hospital inpatient rates to hospitals eligible for quality improvement incentives under RCW 74.09.611; and

(g) For each state fiscal year ((~~2016~~)) 2018 through ((~~2019~~)) 2021 to generate:

(i) Two million dollars for new integrated evidence-based psychiatry residency program slots that did not receive state funding prior to 2016 at the integrated psychiatry residency program at the University of Washington; and

(ii) Four million one hundred thousand dollars for new family medicine residency program slots that did not receive state funding prior to 2016, as directed through the family medicine residency network at the University of Washington, for slots where residents are employed by hospitals.

Sec. 4. RCW 74.60.030 and 2015 2nd sp.s. c 5 s 3 are each amended to read as follows:

(1)(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. Assessment notices must be sent on or about thirty days prior to the end of each quarter and payment is due thirty days thereafter.

(b) Effective July 1, 2015, and except as provided in RCW 74.60.050:

(i) Each prospective payment system hospital, except psychiatric and rehabilitation hospitals, shall pay a quarterly assessment. Each quarterly assessment shall be no more than one quarter of three

hundred ((~~fifty~~)) eighty dollars for each annual nonmedicare hospital inpatient day, up to a maximum of fifty-four thousand days per year. For each nonmedicare hospital inpatient day in excess of fifty-four thousand days, each prospective payment system hospital shall pay ((~~an~~)) a quarterly assessment of one quarter of seven dollars for each such day, unless such assessment amount or threshold needs to be modified to comply with applicable federal regulations;

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

(iii) Each psychiatric hospital shall pay a quarterly assessment of no more than one quarter of seventy-four dollars for each annual nonmedicare hospital inpatient day; and

(iv) Each rehabilitation hospital shall pay a quarterly assessment of no more than one quarter of seventy-four 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. The authority shall obtain inpatient data 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 ((~~2016~~)) 2017, the authority shall use cost report data for hospitals' fiscal years ending in ((~~2012~~)) 2013. For subsequent years, the hospitals' next succeeding fiscal year cost report data must be used.

(a) With the exception of a prospective payment system hospital commencing operations after January 1, 2009, 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 as defined in RCW 74.60.010.

Sec. 5. RCW 74.60.050 and 2015 2nd sp.s. c 5 s 4 are each amended to read as follows:

(1) The 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 notices of assessment by the authority to each hospital informing the hospital of its nonmedicare hospital inpatient days and the assessment amount due and payable;

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

(c) Adjustment of the assessment amounts in accordance with subsection (2) of this section.

(2) For ((~~state fiscal year 2016 and~~)) each ((~~subsequent~~)) state fiscal year, the assessment amounts established under RCW 74.60.030 must be adjusted as follows:

(a) 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 RCW 74.09.611 and 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;

(b) If the total amount of inpatient ((~~or~~)) and outpatient supplemental payments under RCW 74.60.120 is in excess of the upper payment limits 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;

(c) If the amount of payments to managed care organizations under RCW 74.60.130 cannot be distributed because of failure to meet federal 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;

(d) 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;

(e) 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 RCW 74.09.611 and 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 RCW 74.09.611 and 74.60.020(4)(f); and

(f) 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 or that fiscal year and the following fiscal years prior to and including fiscal year ((~~2019~~)) 2021.

(3)(a) Any adjustment to the assessment amounts pursuant to this section, 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.

(c) On a monthly basis, the authority shall provide the Washington state hospital association 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 74.60.090 and 2015 2nd sp.s. c 5 s 5 are each amended to read as follows:

(1) 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: Ten million five hundred fifty-five thousand dollars in each state fiscal year ((~~2016~~)) 2018 through ((~~2019~~)) 2021 paid as follows, except 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, the amounts in this subsection ((~~(ii) and (iii)~~)) must be reduced proportionately:

(i) Four million four hundred fifty-five thousand dollars;

(ii) Two million dollars to new integrated, evidence-based psychiatry residency program slots that did not receive state funding prior to 2016, at the integrated psychiatry residency program at the University of Washington; and

(iii) Four million one hundred thousand dollars to new family medicine residency program slots that did not receive state funding prior to 2016, as directed through the family medicine residency network at the University of Washington, for slots where residents are employed by hospitals;

(b) Harborview medical center: Ten million two hundred sixty thousand dollars in each state fiscal year ((~~2016 through 2019~~)) 2018 through 2021, except 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, the amounts in this subsection must be reduced proportionately;

(c) All other certified public expenditure hospitals: Six million three hundred forty-five thousand dollars in each state fiscal year ((~~2016 through 2019~~)) 2018 through 2021, except 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, the amounts in this subsection must be reduced proportionately. The amount of payments to individual hospitals under this subsection must be determined using a methodology that provides each hospital with a proportional allocation of the group's total amount of medicaid and state children's health insurance program payments determined from claims and encounter data using the same general methodology set forth in RCW 74.60.120 (3) and (4).

(2) Payments must be made quarterly, before the end of each quarter, taking the total disbursement amount and dividing by four to calculate the quarterly amount. The authority shall provide a quarterly report of such payments to the Washington state hospital association.

Sec. 7. RCW 74.60.100 and 2015 2nd sp.s. c 5 s 6 are each amended to read as follows:

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 ((~~seven hundred~~)) two million thirty-eight thousand dollars from the fund ((~~and to critical access hospitals that receive disproportionate share payments in the total amount of one million three hundred thirty-six thousand dollars~~)). The amount of payments to individual hospitals under this

section must be determined using a methodology that provides each hospital with a proportional allocation of the group's total amount of medicaid and state children's health insurance program payments determined from claims and encounter data using the same general 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. 8. RCW 74.60.120 and 2015 2nd sp.s. c 5 s 7 are each amended to read as follows:

(1) In each state fiscal year, commencing upon satisfaction of the applicable conditions in RCW 74.60.150(1), the authority shall make supplemental payments directly to Washington hospitals, separately for inpatient and outpatient fee-for-service medicaid services, as follows unless there are federal restrictions on doing so. If there are federal restrictions, to the extent allowed, funds that cannot be paid under (a) of this subsection, should be paid under (b) of this subsection, and funds that cannot be paid under (b) of this subsection, shall be paid under (a) of this subsection:

(a) For inpatient fee-for-service payments for prospective payment hospitals other than psychiatric or rehabilitation hospitals, twenty-nine million one hundred sixty-two thousand five hundred dollars per state fiscal year plus federal matching funds;

(b) For outpatient fee-for-service payments for prospective payment hospitals other than psychiatric or rehabilitation hospitals, thirty million dollars per state fiscal year plus federal matching funds;

(c) For inpatient fee-for-service payments for psychiatric hospitals, eight hundred seventy-five thousand dollars per state fiscal year plus federal matching funds;

(d) For inpatient fee-for-service payments for rehabilitation hospitals, two hundred twenty-five thousand dollars per state fiscal year plus federal matching funds;

(e) For inpatient fee-for-service payments for border hospitals, two hundred fifty thousand dollars per state fiscal year plus federal matching funds; and

(f) For outpatient fee-for-service payments for border hospitals, two hundred fifty thousand dollars per state fiscal year 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~~)) Totaling the inpatient fee-for-service claims payments and inpatient managed care encounter rate payments for each hospital during 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~~)) Totaling the inpatient fee-for-service claims payments and inpatient managed care encounter rate payments for all hospitals during 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~~)) Totaling the outpatient fee-for-service claims payments and outpatient managed care encounter rate payments for each hospital during 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~~)) Totaling the outpatient fee-for-service claims payments and outpatient managed care encounter rate payments for all hospitals during 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) Sixty 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 quarterly installments on or about the last day of every quarter.

(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. 9. RCW 74.60.130 and 2015 2nd sp.s. c 5 s 8 are each amended to read as follows:

(1) For state fiscal year 2016 and for each subsequent fiscal year, commencing within thirty days after satisfaction of the conditions in RCW 74.60.150(1) and subsection (5) of this section, the authority shall increase capitation payments in a manner consistent with federal contracting requirements 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. When combined with applicable federal matching funds, the capitation payment under this subsection must be ((~~no less than ninety-six million dollars per state fiscal year plus the maximum available amount of federal matching funds~~)) at least three hundred sixty million dollars per year. The initial payment following satisfaction of the conditions in RCW 74.60.150(1) must include all amounts due from July 1, 2015, to the end of the calendar month during which the conditions in RCW 74.60.150(1) are satisfied. Subsequent payments shall be made monthly.

(2) 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.

(3) 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. Further, in the event a managed care organization is legally obligated to repay amounts distributed to hospitals under this section to the state or federal government, a managed care organization may recoup the amount it is obligated to repay under the medicaid program from individual hospitals by not more than the amount of overpayment each hospital received from that managed care organization.

(4) 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.

(5) 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, which for purposes of this section includes psychiatric and rehabilitation 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) Managed care organizations shall expend the increased capitation payments under this section in a manner consistent with the purposes of this chapter, with the initial expenditures to hospitals to be made within thirty days of receipt of payment from the authority. Subsequent expenditures by the managed care plans are to be made before the end of the quarter in which funds are received from the authority;

(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.

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

(7) 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 (5) of this section.

(8) 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. 10. RCW 74.60.150 and 2015 2nd sp.s. c 5 s 9 are each amended to read as follows:

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

(a) 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 authority and managed care organizations in order to implement this chapter; and

(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) 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) Funds generated by the assessment for payments to prospective payment hospitals or managed care organizations are determined to be not eligible for federal ((~~match~~)) matching funds in addition to those federal funds that would be received without the assessment, or the federal government replaces medicaid matching funds with a block grant or grants;

(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~~)) rates the state paid for those services on July 1, 2015, as adjusted for current enrollment and utilization is not appropriated or available;

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

Sec. 11. RCW 74.60.160 and 2015 2nd sp.s. c 5 s 10 are each amended to read as follows:

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

(2) Each odd-numbered year after enactment of the biennial omnibus operating appropriations act, the authority shall ((~~offer to enter into a contract or to~~)) extend ((~~an~~)) the existing contract for the period of the fiscal biennium beginning July 1st with a hospital that is required to pay the assessment under this chapter or shall offer to enter into a contract with any hospital subject to this chapter that has not previously been a party to a contract or whose contract has expired. The contract must include the following terms:

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

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

(ii) Reduce aggregate payment levels to hospitals for inpatient and outpatient services covered by medicaid, including fee-for-service and managed care, adjusting for changes in enrollment and utilization, from the levels the state paid for those services on the first day of the contract period;

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

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

(v) For prospective payment system, psychiatric, and rehabilitation hospitals only, reduce the increased capitation payments to managed care organizations under RCW 74.60.130 below the levels specified in that section on the first day of the contract period unless the managed care payments are reduced under RCW 74.60.130(3); or

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

(b) As long as payment levels are maintained as required under this chapter, the hospital must agree not to challenge the authority's reduction of hospital reimbursement rates to July 1,

2009, levels, which results from the elimination of assessment supported rate restorations and increases, under 42 U.S.C. Sec. 1396a(a)(30)(a) either through administrative appeals or in court during the period of the contract.

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

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

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

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

Sec. 12. RCW 74.60.901 and 2015 2nd sp.s. c 5 s 11 are each amended to read as follows:

This chapter expires July 1, ((~~2019~~)) 2021.

Sec. 13. RCW 74.60.902 and 2010 1st sp.s. c 30 s 22 are each amended to read as follows:

Upon expiration of chapter 74.60 RCW, inpatient and outpatient hospital reimbursement rates shall return to a ((~~rate structure~~)) funding level as if the four percent medicaid inpatient and outpatient rate reductions did not occur on July 1, 2009, using the rate structure in effect July 1, 2015, or as otherwise specified in the ((~~2013-15~~)) 2019-2021 biennial operating appropriations act.

NEW SECTION. **Sec. 14.** A new section is added to chapter 74.60 RCW to read as follows:

(1) The estimated hospital net financial benefit under this chapter shall be determined by the authority by summing the following anticipated hospital payments, including all applicable federal matching funds, specified in RCW 74.60.090 for grants to certified public expenditure hospitals, RCW 74.60.100 for payments to critical access hospitals, RCW 74.60.110 for payments to small rural disproportionate share hospitals, RCW 74.60.120 for direct

supplemental payments to hospitals, RCW 74.60.130 for managed care capitation payments, RCW 74.60.020(4)(f) for quality improvement incentives, minus the total assessments paid by all hospitals under RCW 74.60.030 for hospital assessments, and minus any taxes paid on RCW 74.60.130 for managed care payments.

(2) If, for any reason including reduction or elimination of federal matching funds, the estimated hospital net financial benefit falls below one hundred thirty million dollars in any state fiscal year, the office of financial management shall direct the authority to modify the assessment rates provided for in RCW 74.60.030, and the office of financial management is authorized to direct the authority to adjust the amounts disbursed from the fund, including disbursements for payments under RCW 74.60.020(4)(f) and payments to hospitals under RCW 74.60.090 through 74.60.130 and 74.60.020(4)(g), such that the estimated hospital net financial benefit is equal to the amount disbursed from the fund for use in lieu of state general fund payments. Each category of adjusted payments to hospitals under RCW 74.60.090 through 74.60.130 and payments under RCW 74.60.020(4)(g) must bear the same relationship to the total of such adjusted payments as originally provided in this chapter.

NEW SECTION. **Sec. 15.** 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 July 1, 2017.

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