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**SUBSTITUTE SENATE BILL 5913**

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**State of Washington                      63rd Legislature                      2013 Regular Session**

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

READ FIRST TIME 04/23/13.

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

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

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

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

19            (2) The legislature finds that(+

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

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

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

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

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

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

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

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

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

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

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

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

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

20        (3) "Bordering city hospital" means a hospital as defined in WAC  
21 182-550-1050 and bordering cities as described in WAC 182-501-0175, or  
22 successor rules.

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

36        ~~((2))~~ (5) "Critical access hospital" means a hospital as  
37 described in RCW 74.09.5225.

1        ~~((3)) "Department" means the department of social and health~~  
2 ~~services.~~  
3        ~~(4))~~ (6) "Director" means the director of the health care  
4 authority.  
5        (7) "Eligible new prospective payment hospital" means a prospective  
6 payment hospital opened after January 1, 2009, for which a full year of  
7 cost report data as described in RCW 74.60.030(2) and a full year of  
8 medicaid base year data required for the calculations in RCW  
9 74.60.120(3) are available.  
10        (8) "Fund" means the hospital safety net assessment fund  
11 established under RCW 74.60.020.  
12        ~~((5))~~ (9) "Hospital" means a facility licensed under chapter  
13 70.41 RCW.  
14        ~~((6))~~ (10) "Long-term acute care hospital" means a hospital which  
15 has an average inpatient length of stay of greater than twenty-five  
16 days as determined by the department of health.  
17        ~~((7))~~ (11) "Managed care organization" means an organization  
18 having a certificate of authority or certificate of registration from  
19 the office of the insurance commissioner that contracts with the  
20 ~~((department))~~ authority under a comprehensive risk contract to provide  
21 prepaid health care services to eligible clients under the  
22 ~~((department's))~~ authority's medicaid managed care programs, including  
23 the healthy options program.  
24        ~~((8))~~ (12) "Medicaid" means the medical assistance program as  
25 established in Title XIX of the social security act and as administered  
26 in the state of Washington by the ~~((department of social and health~~  
27 ~~services))~~ authority.  
28        ~~((9))~~ (13) "Medicare cost report" means the medicare cost report,  
29 form 2552~~((96))~~, or successor document.  
30        ~~((10))~~ (14) "Nonmedicare hospital inpatient day" means total  
31 hospital inpatient days less medicare inpatient days, including  
32 medicare days reported for medicare managed care plans, as reported on  
33 the medicare cost report, form 2552~~((96))~~, or successor forms,  
34 excluding all skilled and nonskilled nursing facility days, skilled and  
35 nonskilled swing bed days, nursery days, observation bed days, hospice  
36 days, home health agency days, and other days not typically associated  
37 with an acute care inpatient hospital stay.

1       ~~((11))~~ (15) "Outpatient" means services provided classified as  
2 ambulatory payment classification services or successor payment  
3 methodologies as defined in WAC 182-550-7050 or successor rule and  
4 applies to fee-for-service payments and managed care encounter data.

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

15       ~~((12))~~ (17) "Psychiatric hospital" means a hospital facility  
16 licensed as a psychiatric hospital under chapter 71.12 RCW.

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

19       ~~(14))~~ (18) "Rehabilitation hospital" means a medicare-certified  
20 freestanding inpatient rehabilitation facility.

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

23       ~~(16))~~ (19) "Small rural disproportionate share hospital payment"  
24 means a payment made in accordance with WAC ~~((388-550-5200))~~ 182-550-  
25 5200 or ~~((subsequently filed regulation))~~ successor rule.

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

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

33       (1) A dedicated fund is hereby established within the state  
34 treasury to be known as the hospital safety net assessment fund. The  
35 purpose and use of the fund shall be to receive and disburse funds,  
36 together with accrued interest, in accordance with this chapter.  
37 Moneys in the fund, including interest earned, shall not be used or

1 disbursed for any purposes other than those specified in this chapter.  
2 Any amounts expended from the fund that are later recouped by the  
3 (~~department~~) authority on audit or otherwise shall be returned to the  
4 fund.

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

9 (b) Any amounts remaining in the fund (~~on~~) after July 1, (~~2013~~)  
10 2019, shall be (~~used to make increased payments in accordance with RCW~~  
11 ~~74.60.090 and 74.60.120 for any outstanding claims with dates of~~  
12 ~~service prior to July 1, 2013. Any amounts remaining in the fund after~~  
13 ~~such increased payments are made shall be refunded to hospitals, pro~~  
14 ~~rata according to the amount paid by the hospital, subject to the~~  
15 ~~limitations of federal law)) refunded to hospitals, pro rata according  
16 to the amount paid by the hospital since July 1, 2013, subject to the  
17 limitations of federal law.~~

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

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

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

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

32 ~~(c) Upon certification by the secretary that the conditions set~~  
33 ~~forth in RCW 74.60.150(1) have been met with respect to the assessments~~  
34 ~~imposed under RCW 74.60.030(3) and the payments provided under RCW~~  
35 ~~74.60.090 and 74.60.130, payments made subsequent to the initial~~  
36 ~~payments under RCW 74.60.100 and 74.60.110, and payments under RCW~~  
37 ~~74.60.120(3), funds shall be disbursed periodically as necessary to~~  
38 ~~make the payments as specified in those sections;~~

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

33 (d)(i) For purposes of (a) and (b) of this subsection, the  
34 department shall determine each hospital's annual nonmedicare hospital  
35 inpatient days by summing the total reported nonmedicare inpatient days  
36 for each hospital that is not exempt from the assessment as described  
37 in RCW 74.60.040 for the relevant state fiscal year 2008 portions  
38 included in the hospital's fiscal year end reports 2007 and/or 2008

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

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

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

23 (a) Prospective payment system hospitals.

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

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

36 (b) Each critical access hospital shall pay an assessment of ten  
37 dollars for each annual nonmedicare hospital inpatient day, multiplied  
38 by a ratio, the numerator of which is the number of days between June

1 30, 2009, and the day after the applicable conditions established by  
2 RCW 74.60.150(1) have been met and the denominator of which is three  
3 hundred sixty-five.

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

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

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

27 (i) Prospective payment system hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

36 (f) If the number of nonmedicare inpatient days applied to the  
37 rates provided in RCW 74.60.030 will not produce sufficient funds to  
38 support the payments required under this chapter and the state portion

1 of the quality incentive payments under section 18 of this act and RCW  
2 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may be  
3 increased proportionately by category of hospital to amounts no greater  
4 than necessary in order to produce the required level of funds needed  
5 to make the payments specified in this chapter and the state portion of  
6 the quality incentive payments under section 18 of this act and RCW  
7 74.60.020(4)(f); and

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

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

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

26 (i) The fund balance;

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

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

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

36 (v) The annual state share, federal share, and total payments made  
37 to each hospital under each of the following programs: Grants to

1 certified public expenditure hospitals under RCW 74.60.090, for  
2 critical access hospital payments under RCW 74.60.100; and  
3 disproportionate share programs under RCW 74.60.110;

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

6 (vii) The amount of payments made to managed care plans under RCW  
7 74.60.130, including the amount representing additional premium tax,  
8 and the data used to calculate those payments.

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

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

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

22 ~~((Upon satisfaction of the applicable conditions set forth in RCW~~  
23 ~~74.60.150(1), the department shall:~~

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

27 ~~(2) Recalculate the amount payable to each hospital that submitted~~  
28 ~~an otherwise allowable claim for inpatient and outpatient~~  
29 ~~medicaid covered services rendered from and after July 1, 2009, up to~~  
30 ~~and including the date when the applicable conditions under RCW~~  
31 ~~74.60.150(1) have been satisfied, as if the four percent medicaid~~  
32 ~~inpatient and outpatient rate reductions did not occur effective July~~  
33 ~~1, 2009, and, within sixty calendar days after the date upon which the~~  
34 ~~applicable conditions set forth in RCW 74.60.150(1) have been~~  
35 ~~satisfied, remit the difference to each hospital.)) In each fiscal year~~  
36 ~~and upon satisfaction of the conditions in RCW 74.60.150(1), after~~

1 deducting or reserving amounts authorized to be disbursed under RCW  
2 74.60.020(4) (d), (e), and (f), disbursements from the fund must be  
3 made as follows:

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

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

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

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

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

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

15 ~~(1) ((Upon satisfaction of the applicable conditions set forth in~~  
16 ~~RCW 74.60.150(1) and for services rendered on or after February 1,~~  
17 ~~2010, through June 30, 2011, the department shall increase the medicaid~~  
18 ~~inpatient and outpatient fee for service hospital reimbursement rates~~  
19 ~~in effect on June 30, 2009, by the percentages specified below:~~

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

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

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

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

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

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

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

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

30 ~~(c) Rehabilitation hospitals:~~

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

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

34 ~~(d) Psychiatric hospitals:~~

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

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

1       ~~(2) Upon satisfaction of the applicable conditions set forth in RCW~~  
2 ~~74.60.150(1) and for services rendered on or after July 1, 2011, the~~  
3 ~~department shall increase the medicaid inpatient and outpatient~~  
4 ~~fee for service hospital reimbursement rates in effect on June 30,~~  
5 ~~2009, by the percentages specified below:~~

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

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

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

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

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

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

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

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

17       ~~(c) Rehabilitation hospitals:~~

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

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

21       ~~(d) Psychiatric hospitals:~~

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

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

24       ~~(3) For claims processed for services rendered on or after February~~  
25 ~~1, 2010, but prior to satisfaction of the applicable conditions~~  
26 ~~specified in RCW 74.60.150(1), the department shall, within sixty~~  
27 ~~calendar days after satisfaction of those conditions, calculate the~~  
28 ~~amount payable to hospitals in accordance with this section and remit~~  
29 ~~the difference to each hospital that has submitted an otherwise~~  
30 ~~allowable claim for payment for such services.~~

31       ~~(4) By December 1, 2012, the department will submit a study to the~~  
32 ~~legislature with recommendations on the amount of the assessments~~  
33 ~~necessary to continue to support hospital payments for the 2013-2015~~  
34 ~~biennium. The evaluation will assess medicaid hospital payments~~  
35 ~~relative to medicaid hospital costs. The study should address current~~  
36 ~~federal law, including any changes on scope of medicaid coverage,~~  
37 ~~provisions related to provider taxes, and impacts of federal health~~  
38 ~~care reform legislation. The study should also address the state's~~

1 ~~economic forecast. Based on the forecast, the department should~~  
2 ~~recommend the amount of assessment needed to support future hospital~~  
3 ~~payments and the departmental administrative expenses. Recommendations~~  
4 ~~should be developed with the fiscal committees of the legislature,~~  
5 ~~office of financial management, and the Washington state hospital~~  
6 ~~association.)) In each fiscal year commencing upon satisfaction of the  
7 applicable conditions in RCW 74.60.150(1), funds must be disbursed from  
8 the fund and the authority shall make grants to certified public  
9 expenditure hospitals, which shall not be considered payments for  
10 hospital services, as follows:~~

11 (a) University of Washington medical center: Three million three  
12 hundred thousand dollars in fiscal year 2014, reduced in approximately  
13 equal increments per fiscal year until the grant amount is zero by July  
14 1, 2019;

15 (b) Harborview medical center: Seven million six hundred thousand  
16 dollars in fiscal year 2014, reduced in approximately equal increments  
17 per fiscal year until the grant amount is zero by July 1, 2019;

18 (c) All other certified public expenditure hospitals: Four million  
19 seven hundred thousand dollars in fiscal year 2014, reduced in  
20 approximately equal increments per fiscal year until the grant amount  
21 is zero by July 1, 2019. The amount of payments to individual  
22 hospitals under this subsection must be determined using a methodology  
23 that provides each hospital with a proportional allocation of the  
24 group's total amount of medicaid payments determined from claims and  
25 encounter data using the same general methodology set forth in RCW  
26 74.60.120 (3) and (4).

27 (2) Payments must be made quarterly, taking the total disbursement  
28 amount and dividing by four to calculate the quarterly amount. The  
29 initial payment, which must include all amounts due from and after July  
30 1, 2013, to the date of the initial payment, must be made within thirty  
31 days after satisfaction of the conditions in RCW 74.60.150(1). The  
32 authority shall provide a quarterly report of such payments to the  
33 Washington state hospital association.

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

36 ~~((Upon satisfaction of the applicable conditions set forth in RCW~~  
37 ~~74.60.150(1), the department shall pay critical access hospitals that~~

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

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

33 ((Upon satisfaction of the applicable conditions set forth in RCW  
34 74.60.150(1), small rural disproportionate share payments shall be  
35 increased to one hundred twenty percent of the level in effect as of  
36 June 30, 2009, for the period from and after July 1, 2009, until July  
37 1, 2013. Initial payments, covering the period from July 1, 2009, to

1 ~~the date when the applicable conditions under RCW 74.60.150(1) are~~  
2 ~~satisfied, shall be made within sixty calendar days after those~~  
3 ~~conditions are satisfied. Subsequent payments shall be made directly~~  
4 ~~to hospitals by the department on a periodic basis.)) In each fiscal  
5 year commencing upon satisfaction of the applicable conditions in RCW  
6 74.60.150(1), one million nine hundred nine thousand dollars must be  
7 distributed from the fund and, with available federal matching funds,  
8 paid to hospitals eligible for small rural disproportionate share  
9 payments under WAC 182-550-4900 or successor rule. Payments must be  
10 made directly to hospitals by the authority in accordance with that  
11 regulation. The authority shall provide a report of such payments to  
12 the Washington state hospital association within thirty days after  
13 payments are made.~~

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

16 ((~~Subject to the applicable conditions set forth in RCW~~  
17 ~~74.60.150(1), the department shall:~~

- 18 (1) ~~Amend medicaid managed care and regional support network~~  
19 ~~contracts as necessary in order to ensure compliance with this chapter;~~
- 20 (2) ~~With respect to the inpatient and outpatient rates established~~  
21 ~~by RCW 74.60.080:~~

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

36 (b) ~~Within sixty calendar days after satisfaction of the applicable~~  
37 ~~conditions under RCW 74.60.150(1), calculate the additional amount due~~



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

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

16 (a) Upon satisfaction of the applicable conditions under RCW  
17 74.60.150(1), increase payments to managed care organizations and  
18 regional support networks as necessary to ensure that hospitals are  
19 reimbursed in accordance with RCW 74.60.090, and pay an additional  
20 amount equal to the estimated amount of additional state taxes on  
21 managed care organizations or regional support networks due as a result  
22 of the payments under this section;

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

28 (c) Within sixty calendar days after satisfaction of the applicable  
29 conditions under RCW 74.60.150(1), calculate the additional amount due  
30 to each hospital to pay claims submitted for inpatient and outpatient  
31 medicaid-covered services rendered from and after February 1, 2010,  
32 through the date when the applicable conditions under RCW 74.60.150(1)  
33 are satisfied based on the rates required by RCW 74.60.090, make  
34 payments to managed care organizations and regional support networks in  
35 amounts sufficient to pay the additional amounts due to each hospital  
36 plus an additional amount equal to the estimated amount of additional  
37 state taxes on managed care organizations or regional support networks,  
38 and require managed care organizations and regional support networks to

1 make payments to each hospital in accordance with the department's  
2 calculations within forty five calendar days after the department  
3 disburses funds for those purposes;

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

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

18 ~~(5) The department may require managed care organizations and  
19 regional support networks to demonstrate compliance with this  
20 section.)~~ (1) Beginning in state fiscal year 2014, commencing thirty  
21 days after satisfaction of the applicable conditions in RCW  
22 74.60.150(1), and for the period of state fiscal years 2014 through  
23 2019, the authority shall make supplemental payments directly to  
24 Washington hospitals, separately for inpatient and outpatient fee-for-  
25 service medicaid services, as follows:

26 (a) For inpatient fee-for-service payments for prospective payment  
27 hospitals other than psychiatric or rehabilitation hospitals, twenty-  
28 eight million one hundred twenty-five thousand dollars in fiscal year  
29 2014 and amounts reduced in equal increments per fiscal year until the  
30 supplemental payment amount is zero by July 1, 2019, from the fund,  
31 plus federal matching funds;

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

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

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

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

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

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

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

33 (a) Applying the medicaid fee-for-service rates in effect on July  
34 1, 2009, without regard to the increases required by chapter 30, Laws  
35 of 2010 1st sp. sess. to each hospital's inpatient fee-for-services  
36 claims and medicaid managed care encounter data for the base year;

37 (b) Applying the medicaid fee-for-service rates in effect on July

1 1, 2009, without regard to the increases required by chapter 30, Laws  
2 of 2010 1st sp. sess. to all hospitals' inpatient fee-for-services  
3 claims and medicaid managed care encounter data for the base year; and

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

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

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

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

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

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

26 (6) Payments must be made in quarterly installments on or about the  
27 last day of every quarter, except that the initial payment must be made  
28 within thirty days after satisfaction of the conditions in RCW  
29 74.60.150(1) and must include all amounts due from July 1, 2013, to the  
30 date of the initial payment.

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

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

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

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

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

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

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

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

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

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

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

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

35       (4) If the federal government determines that total payments to  
36 managed care organizations under this section exceed what is permitted  
37 under applicable medicaid laws and regulations, payments must be

1 reduced to levels that meet such requirements, and the balance  
2 remaining must be applied as provided in RCW 74.60.050.

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

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

10 (a) All payments to managed care organizations under this chapter  
11 must be expended for hospital services provided by Washington hospitals  
12 in a manner consistent with the purposes and provisions of this  
13 chapter, and must be equal to all increased capitation payments under  
14 this section received by the organization or network, consistent with  
15 actuarial certification and enrollment, less an allowance for any  
16 estimated premium taxes the organization is required to pay under Title  
17 48 RCW associated with the payments under this chapter;

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

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

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

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

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

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

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

4       (1) For the purposes of this section:

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

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

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

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

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

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



1 (d) To the extent that this provision is consistent with section  
2 1903(m) of Title XIX of the federal social security act, participating  
3 managed health care systems shall not enroll a disproportionate number  
4 of medical assistance recipients within the total numbers of persons  
5 served by the managed health care systems, except as authorized by the  
6 authority under federal demonstration waivers granted under section  
7 1115(a) of Title XI of the federal social security act;

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

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

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

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

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

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

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

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

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

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

37 (h) The authority shall define those circumstances under which a

1 managed health care system is responsible for out-of-plan services and  
2 assure that recipients shall not be charged for such services;

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

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

9 (3) The authority shall ensure that publicly supported community  
10 health centers and providers in rural areas, who show serious intent  
11 and apparent capability to participate as managed health care systems  
12 are seriously considered as contractors. The authority shall  
13 coordinate its managed care activities with activities under chapter  
14 70.47 RCW.

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

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

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

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

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

3 (ii) Quality of services provided to enrollees;

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

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

8 (v) Payment rates; and

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

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

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

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

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

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

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

1 (8) For services covered under this chapter to medical assistance  
2 or medical care services enrollees and provided on or after August 24,  
3 2011, nonparticipating providers must accept as payment in full the  
4 amount paid by the managed health care system under subsection (7) of  
5 this section in addition to any deductible, coinsurance, or copayment  
6 that is due from the enrollee for the service provided. An enrollee is  
7 not liable to any nonparticipating provider for covered services,  
8 except for amounts due for any deductible, coinsurance, or copayment  
9 under the terms and conditions set forth in the managed health care  
10 system contract to provide services under this section.

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

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

25 (11) Subsections (7) through (9) of this section expire July 1,  
26 2016.

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

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

34 (2) Notwithstanding any other provision of this chapter, if a  
35 hospital subject to the assessment imposed under this chapter ceases to  
36 conduct hospital operations throughout a state fiscal year, the  
37 assessment for the quarter in which the cessation occurs shall be

1 adjusted by multiplying the assessment computed under RCW 74.60.030  
2 (~~((1) and (3))~~) by a fraction, the numerator of which is the number of  
3 days during the year which the hospital conducts, operates, or  
4 maintains the hospital and the denominator of which is three hundred  
5 sixty-five. Immediately prior to ceasing to conduct, operate, or  
6 maintain a hospital, the hospital shall pay the adjusted assessment for  
7 the fiscal year to the extent not previously paid.

8 ~~(3) ((Notwithstanding any other provision of this chapter, in the  
9 case of a hospital that commences conducting, operating, or maintaining  
10 a hospital that is not exempt from payment of the assessment under RCW  
11 74.60.040 and that did not conduct, operate, or maintain such hospital  
12 throughout the cost reporting year used to determine the assessment  
13 amount, the assessment for that hospital shall be computed on the basis  
14 of the actual number of nonmedicare inpatient days reported to the  
15 department by the hospital on a quarterly basis. The hospital shall be  
16 eligible to receive increased payments under this chapter beginning on  
17 the date it commences hospital operations.~~

18 ~~(4))~~ Notwithstanding any other provision of this chapter, if a  
19 hospital previously subject to assessment is sold or transferred to  
20 another entity and remains subject to assessment, the assessment for  
21 that hospital shall be computed based upon the cost report data  
22 previously submitted by that hospital. The assessment shall be  
23 allocated between the transferor and transferee based on the number of  
24 days within the assessment period that each owned, operated, or  
25 maintained the hospital.

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

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

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

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

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

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

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

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

20 ~~(a) ((An appellate court or the centers for medicare and medicaid~~  
21 ~~services)) The federal department of health and human services and a~~  
22 ~~court of competent jurisdiction makes a final determination, with all~~  
23 ~~appeals exhausted, that any element of this chapter, other than RCW~~  
24 ~~74.60.100, cannot be validly implemented;~~

25 ~~(b) ((Medicaid inpatient or outpatient reimbursement rates for~~  
26 ~~hospitals are reduced below the combined rates established by RCW~~  
27 ~~74.60.080 and 74.60.090;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20        (ii)    Reduce aggregate payment levels to hospitals for inpatient and  
21 outpatient services covered by medicaid, including fee-for-service and  
22 managed care, allowing for variations due to budget-neutral rebasing  
23 and adjusting for changes in enrollment and utilization, from the  
24 levels the state paid for those services on the first day of the  
25 contract period;

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

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

37        (v)    For prospective payment system, psychiatric, and rehabilitation  
38 hospitals only, reduce the increased capitation payments to managed



1 care organizations under RCW 74.60.130 below the levels specified in  
2 that section on the first day of the contract period unless the managed  
3 care payments are reduced under RCW 74.60.130(4); or

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

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

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

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

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

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

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

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

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

34 (b) Effective purchasing strategies to improve the quality of  
35 health care services should involve the use of common quality  
36 improvement measures by public and private health care purchasers,

1 while recognizing that some measures may not be appropriate for  
2 application to specialty pediatric, psychiatric, or rehabilitation  
3 hospitals;

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

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

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

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

25 (a) Meet the quality incentive benchmarks established under this  
26 section; and

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

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

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

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

35 NEW SECTION. **Sec. 20.** This act is necessary for the immediate

1 preservation of the public peace, health, or safety, or support of the  
2 state government and its existing public institutions, and takes effect  
3 immediately.

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