CERTIFICATION OF ENROLLMENT

# ENGROSSED SUBSTITUTE SENATE BILL 6570

Chapter 143, Laws of 2014

63rd Legislature
2014 Regular Session

HOSPITAL SAFETY NET ASSESSMENT--TIMELINES

EFFECTIVE DATE: 03/28/14

Passed by the Senate March 4, 2014
YEAS 42 NAYS 5

BRAD OWEN

**President of the Senate**

Passed by the House March 11, 2014
YEAS 75 NAYS 23

FRANK CHOPP

**Speaker of the House of Representatives**

Approved March 28, 2014, 3:09 p.m.

JAY INSLEE

**Governor of the State of Washington**

CERTIFICATE

I, Hunter G. Goodman, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 6570** as passed by the Senate and the House of Representatives on the dates hereon set forth.

HUNTER G. GOODMAN

**Secretary**

FILED

March 31, 2014

**Secretary of State**
**State of Washington**

## ENGROSSED SUBSTITUTE SENATE BILL 6570

Passed Legislature - 2014 Regular Session

**State of Washington 63rd Legislature 2014 Regular Session**

**By** Senate Ways & Means (originally sponsored by Senators Becker, Keiser, Hargrove, Braun, Hill, and Ranker; by request of Health Care Authority)

READ FIRST TIME 02/27/14.

AN ACT Relating to adjusting timelines for fiscal year 2014 regarding the hospital safety net assessment; amending RCW 74.60.030, 74.60.120, and 74.60.130; and declaring an emergency.

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

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

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

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

1 (i) For fiscal year 2014, an annual assessment for amounts
2 determined as described in (b)(ii) through (iv) of this subsection is
3 imposed for the time period of October 1, 2013, through June 30, 2014.
4 The initial assessment notice must cover amounts due from October 1,
5 2013, through either: (A) The end of the calendar quarter prior to the
6 satisfaction of the conditions in RCW 74.60.150(1) if federal approval
7 is received more than forty-five days prior to the end of a quarter; or
8 (B) the end of the calendar quarter after the satisfaction of the
9 conditions in RCW 74.60.150(1) if federal approval is received within
10 forty-five days of the end of a quarter. For subsequent assessments
11 during fiscal year 2014, the authority shall calculate the amount due
12 annually and shall issue assessments for the appropriate proportion of
13 the annual amount due from each hospital((. Initial assessment notices
14 must be sent to each hospital not earlier than thirty days after
15 satisfaction of the conditions in RCW 74.60.150(1) and must include all
16 amounts due from and after July 1, 2013. Payment is due not sooner
17 than thirty days thereafter. Subsequent notices must be sent on or
18 about thirty days prior to the end of each subsequent quarter and
19 payment is due thirty days thereafter.
20 (b) Beginning July 1, 2013, and except as provided in RCW
21 74.60.050:
22 (i)));
23 (ii) After the assessments described in (b)(i) of this subsection,
24 each prospective payment system hospital, except psychiatric and
25 rehabilitation hospitals, shall pay a quarterly assessment. Each
26 quarterly assessment shall be one quarter of three hundred forty-four
27 dollars for each annual nonmedicare hospital inpatient day, up to a
28 maximum of fifty-four thousand days per year. For each nonmedicare
29 hospital inpatient day in excess of fifty-four thousand days, each
30 prospective payment system hospital shall pay an assessment of one
31 quarter of seven dollars for each such day;
32 (((ii))) (iii) After the assessments described in (b)(i) of this
33 subsection, each critical access hospital shall pay a quarterly
34 assessment of one quarter of ten dollars for each annual nonmedicare
35 hospital inpatient day;
36 (((iii))) (iv) After the assessments described in (b)(i) of this
37 subsection, each psychiatric hospital shall pay a quarterly assessment

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

3 ((~~(iv)~~)) <u>(v) After the assessments described in (b)(i) of this</u>
4 <u>subsection, e</u>ach rehabilitation hospital shall pay a quarterly
5 assessment of one quarter of sixty-seven dollars for each annual
6 nonmedicare hospital inpatient day.

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

17 (a) With the exception of a prospective payment system hospital
18 commencing operations after January 1, 2009, for any hospital without
19 a cost report for the relevant fiscal year, the authority shall work
20 with the affected hospital to identify appropriate supplemental
21 information that may be used to determine annual nonmedicare hospital
22 inpatient days.

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

27 **Sec. 2.** RCW 74.60.120 and 2013 2nd sp.s. c 17 s 11 are each
28 amended to read as follows:

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

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

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

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

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

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

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

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

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

1 (3) The amount of such fee-for-service inpatient payments to
2 individual hospitals within each of the categories identified in
3 subsection (1)(a), (c), (d), and (e) of this section must be determined
4 by:
5 (a) Applying the medicaid fee-for-service rates in effect on July
6 1, 2009, without regard to the increases required by chapter 30, Laws
7 of 2010 1st sp. sess. to each hospital's inpatient fee-for-services
8 claims and medicaid managed care encounter data for the base year;
9 (b) Applying the medicaid fee-for-service rates in effect on July
10 1, 2009, without regard to the increases required by chapter 30, Laws
11 of 2010 1st sp. sess. to all hospitals' inpatient fee-for-services
12 claims and medicaid managed care encounter data for the base year; and
13 (c) Using the amounts calculated under (a) and (b) of this
14 subsection to determine an individual hospital's percentage of the
15 total amount to be distributed to each category of hospital.
16 (4) The amount of such fee-for-service outpatient payments to
17 individual hospitals within each of the categories identified in
18 subsection (1)(b) and (f) of this section must be determined by:
19 (a) Applying the medicaid fee-for-service rates in effect on July
20 1, 2009, without regard to the increases required by chapter 30, Laws
21 of 2010 1st sp. sess. to each hospital's outpatient fee-for-services
22 claims and medicaid managed care encounter data for the base year;
23 (b) Applying the medicaid fee-for-service rates in effect on July
24 1, 2009, without regard to the increases required by chapter 30, Laws
25 of 2010 1st sp. sess. to all hospitals' outpatient fee-for-services
26 claims and medicaid managed care encounter data for the base year; and
27 (c) Using the amounts calculated under (a) and (b) of this
28 subsection to determine an individual hospital's percentage of the
29 total amount to be distributed to each category of hospital.
30 (5) Thirty days before the initial payments and sixty days before
31 the first payment in each subsequent fiscal year, the authority shall
32 provide each hospital and the Washington state hospital association
33 with an explanation of how the amounts due to each hospital under this
34 section were calculated.
35 (6) Payments must be made in quarterly installments on or about the
36 last day of every quarter((~~, except that~~)). The initial payment must
37 be made within thirty days after satisfaction of the conditions in RCW
38 74.60.150(1) and must include all amounts due from July 1, 2013, to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 4.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

Passed by the Senate March 4, 2014.
Passed by the House March 11, 2014.
Approved by the Governor March 28, 2014.
Filed in Office of Secretary of State March 31, 2014.