
SENATE BILL 5815

State of Washington 65th Legislature 2017 Regular Session

By Senators Rivers, Cleveland, Becker, and Ranker

Read first time 02/15/17. Referred to Committee on Ways & Means.

1 AN ACT Relating to the hospital safety net assessment; amending
2 RCW 74.60.005, 74.60.010, 74.60.020, 74.60.030, 74.60.050, 74.60.090,
3 74.60.100, 74.60.120, 74.60.130, 74.60.150, 74.60.160, 74.60.901, and
4 74.60.902; adding a new section to chapter 74.60 RCW; providing an
5 expiration date; and declaring an emergency.

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

7 **Sec. 1.** RCW 74.60.005 and 2015 2nd sp.s. c 5 s 1 are each
8 amended to read as follows:

9 (1) The purpose of this chapter is to provide for a safety net
10 assessment on certain Washington hospitals, which will be used solely
11 to augment funding from all other sources and thereby support
12 additional payments to hospitals for medicaid services as specified
13 in this chapter.

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

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

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

1 (b) To generate approximately (~~nine hundred seventy five~~
2 ~~million~~) one billion dollars per state fiscal biennium in new state
3 and federal funds by disbursing all of that amount to pay for
4 medicaid hospital services and grants to certified public expenditure
5 and critical access hospitals, except costs of administration as
6 specified in this chapter, in the form of additional payments to
7 hospitals and managed care plans, which may not be a substitute for
8 payments from other sources, but which include quality improvement
9 incentive payments under RCW 74.09.611;

10 (c) To generate two hundred ninety-two million dollars per
11 biennium during the (~~2015-2017 and~~) 2017-2019 and 2019-2021 biennia
12 in new funds to be used in lieu of state general fund payments for
13 medicaid hospital services;

14 (d) That the total amount assessed not exceed the amount needed,
15 in combination with all other available funds, to support the
16 payments authorized by this chapter;

17 (e) To condition the assessment on receiving federal approval for
18 receipt of additional federal financial participation and on
19 continuation of other funding sufficient to maintain aggregate
20 payment levels to hospitals for inpatient and outpatient services
21 covered by medicaid, including fee-for-service and managed care, at
22 least at the levels the state paid for those services on July 1,
23 2015, as adjusted for current enrollment and utilization; and

24 (f) For (~~each of the two biennia~~) the next biennium, starting
25 with state fiscal year (~~2016~~) 2018 and ending with state fiscal
26 year 2019, to generate:

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

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

36 **Sec. 2.** RCW 74.60.010 and 2013 2nd sp.s. c 17 s 2 are each
37 amended to read as follows:

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

- 1 (1) "Authority" means the health care authority.
- 2 (2) "Base year" for medicaid payments for state fiscal year
3 (~~(2014)~~) 2017 is state fiscal year (~~(2011)~~) 2014. For each following
4 year's calculations, the base year must be updated to the next
5 following year.
- 6 (3) "Bordering city hospital" means a hospital as defined in WAC
7 182-550-1050 and bordering cities as described in WAC 182-501-0175,
8 or successor rules.
- 9 (4) "Certified public expenditure hospital" means a hospital
10 participating in (~~(or that at any point from June 30, 2013, to July~~
11 ~~1, 2019, has participated in)~~) the authority's certified public
12 expenditure payment program as described in WAC 182-550-4650 or
13 successor rule. (~~(For purposes of this chapter any such hospital~~
14 ~~shall continue to be treated as a certified public expenditure~~
15 ~~hospital for assessment and payment purposes through the date~~
16 ~~specified in RCW 74.60.901. The eligibility of such hospitals to~~
17 ~~receive grants under RCW 74.60.090 solely from funds generated under~~
18 ~~this chapter must not be affected by any modification or termination~~
19 ~~of the federal certified public expenditure program, or reduced by~~
20 ~~the amount of any federal funds no longer available for that~~
21 ~~purpose.)~~)
- 22 (5) "Critical access hospital" means a hospital as described in
23 RCW 74.09.5225.
- 24 (6) "Director" means the director of the health care authority.
- 25 (7) "Eligible new prospective payment hospital" means a
26 prospective payment hospital opened after January 1, 2009, for which
27 a full year of cost report data as described in RCW 74.60.030(2) and
28 a full year of medicaid base year data required for the calculations
29 in RCW 74.60.120(3) are available.
- 30 (8) "Fund" means the hospital safety net assessment fund
31 established under RCW 74.60.020.
- 32 (9) "Hospital" means a facility licensed under chapter 70.41 RCW.
- 33 (10) "Long-term acute care hospital" means a hospital which has
34 an average inpatient length of stay of greater than twenty-five days
35 as determined by the department of health.
- 36 (11) "Managed care organization" means an organization having a
37 certificate of authority or certificate of registration from the
38 office of the insurance commissioner that contracts with the
39 authority under a comprehensive risk contract to provide prepaid
40 health care services to eligible clients under the authority's

1 medicaid managed care programs, including the healthy options
2 program.

3 (12) "Medicaid" means the medical assistance program as
4 established in Title XIX of the social security act and as
5 administered in the state of Washington by the authority.

6 (13) "Medicare cost report" means the medicare cost report, form
7 2552, or successor document.

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

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

20 (16) "Prospective payment system hospital" means a hospital
21 reimbursed for inpatient and outpatient services provided to medicaid
22 beneficiaries under the inpatient prospective payment system and the
23 outpatient prospective payment system as defined in WAC 182-550-1050
24 or successor rule. For purposes of this chapter, prospective payment
25 system hospital does not include a hospital participating in the
26 certified public expenditure program or a bordering city hospital
27 located outside of the state of Washington and in one of the
28 bordering cities listed in WAC 182-501-0175 or successor rule.

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

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

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

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

1 **Sec. 3.** RCW 74.60.020 and 2015 2nd sp.s. c 5 s 2 are each
2 amended to read as follows:

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

11 (a) Any unexpended balance in the fund at the end of a fiscal
12 year shall carry over into the following fiscal year or that fiscal
13 year and the following fiscal year and shall be applied to reduce the
14 amount of the assessment under RCW 74.60.050(1)(c).

15 (b) Any amounts remaining in the fund after July 1, ((2019))
16 2021, shall be refunded to hospitals, pro rata according to the
17 amount paid by the hospital since July 1, 2013, subject to the
18 limitations of federal law.

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

22 (3) Disbursements from the fund are conditioned upon
23 appropriation and the continued availability of other funds
24 sufficient to maintain aggregate payment levels to hospitals for
25 inpatient and outpatient services covered by medicaid, including fee-
26 for-service and managed care, at least at the levels the state paid
27 for those services on July 1, 2015, as adjusted for current
28 enrollment and utilization.

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

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

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

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

37 (d) For two hundred ((~~eighty-three~~)) ninety-two million dollars
38 per biennium, to be used in lieu of state general fund payments for
39 medicaid hospital services, provided that if the full amount of the
40 payments required under RCW 74.60.120 and 74.60.130 cannot be

1 distributed in a given fiscal year, this amount must be reduced
2 proportionately;

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

14 (f) (~~Beginning in state fiscal year 2015,~~) To pay an amount
15 sufficient, when combined with the maximum available amount of
16 federal funds necessary to provide a one percent increase in medicaid
17 hospital inpatient rates to hospitals eligible for quality
18 improvement incentives under RCW 74.09.611; and

19 (g) For (~~each~~) state fiscal (~~year 2016 through~~) years 2018
20 and 2019 to generate:

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

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

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

32 (1)(a) Upon satisfaction of the conditions in RCW 74.60.150(1),
33 and so long as the conditions in RCW 74.60.150(2) have not occurred,
34 an assessment is imposed as set forth in this subsection. Assessment
35 notices must be sent on or about thirty days prior to the end of each
36 quarter and payment is due thirty days thereafter.

37 (b) Effective July 1, 2015, and except as provided in RCW
38 74.60.050:

1 (i) Each prospective payment system hospital, except psychiatric
2 and rehabilitation hospitals, shall pay a quarterly assessment. Each
3 quarterly assessment shall be no more than one quarter of three
4 hundred (~~(fifty)~~) eighty dollars for each annual nonmedicare hospital
5 inpatient day, up to a maximum of fifty-four thousand days per year.
6 For each nonmedicare hospital inpatient day in excess of fifty-four
7 thousand days, each prospective payment system hospital shall pay
8 (~~(a)~~) a quarterly assessment of one quarter of seven dollars for
9 each such day, unless such assessment amount or threshold needs to be
10 modified to comply with applicable federal regulations;

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

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

17 (iv) Each rehabilitation hospital shall pay a quarterly
18 assessment of no more than one quarter of seventy dollars for each
19 annual nonmedicare hospital inpatient day.

20 (2) The authority shall determine each hospital's annual
21 nonmedicare hospital inpatient days by summing the total reported
22 nonmedicare hospital inpatient days for each hospital that is not
23 exempt from the assessment under RCW 74.60.040. The authority shall
24 obtain inpatient data from the hospital's 2552 cost report data file
25 or successor data file available through the centers for medicare and
26 medicaid services, as of a date to be determined by the authority.
27 For state fiscal year (~~(2016)~~) 2017, the authority shall use cost
28 report data for hospitals' fiscal years ending in (~~(2012)~~) 2013. For
29 subsequent years, the hospitals' next succeeding fiscal year cost
30 report data must be used.

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

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

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

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

8 (a) Transmittal of notices of assessment by the authority to each
9 hospital informing the hospital of its nonmedicare hospital inpatient
10 days and the assessment amount due and payable;

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

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

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

18 (a) If sufficient other funds, including federal funds, are
19 available to make the payments required under this chapter and fund
20 the state portion of the quality incentive payments under RCW
21 74.09.611 and 74.60.020(4)(f) without utilizing the full assessment
22 under RCW 74.60.030, the authority shall reduce the amount of the
23 assessment to the minimum levels necessary to support those payments;

24 (b) If the total amount of inpatient ~~((€))~~ and outpatient
25 supplemental payments under RCW 74.60.120 is in excess of the upper
26 payment limits and the entire excess amount cannot be disbursed by
27 additional payments to managed care organizations under RCW
28 74.60.130, the authority shall proportionately reduce future
29 assessments on prospective payment hospitals to the level necessary
30 to generate additional payments to hospitals that are consistent with
31 the upper payment limit plus the maximum permissible amount of
32 additional payments to managed care organizations under RCW
33 74.60.130;

34 (c) If the amount of payments to managed care organizations under
35 RCW 74.60.130 cannot be distributed because of failure to meet
36 federal actuarial soundness or utilization requirements or other
37 federal requirements, the authority shall apply the amount that
38 cannot be distributed to reduce future assessments to the level
39 necessary to generate additional payments to managed care

1 organizations that are consistent with federal actuarial soundness or
2 utilization requirements or other federal requirements;

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

7 (e) If the number of nonmedicare inpatient days applied to the
8 rates provided in RCW 74.60.030 will not produce sufficient funds to
9 support the payments required under this chapter and the state
10 portion of the quality incentive payments under RCW 74.09.611 and
11 74.60.020(4)(f), the assessment rates provided in RCW 74.60.030 may
12 be increased proportionately by category of hospital to amounts no
13 greater than necessary in order to produce the required level of
14 funds needed to make the payments specified in this chapter and the
15 state portion of the quality incentive payments under RCW 74.09.611
16 and 74.60.020(4)(f); and

17 (f) Any actual or estimated surplus remaining in the fund at the
18 end of the fiscal year must be applied to reduce the assessment
19 amount for the subsequent fiscal year or that fiscal year and the
20 following fiscal years prior to and including fiscal year ((2019))
21 2021.

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

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

37 (i) The fund balance;

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

39 (iii) The state share, federal share, and total annual medicaid
40 fee-for-service payments for inpatient hospital services made to each

1 hospital under RCW 74.60.120, and the data used to calculate the
2 payments to individual hospitals under that section;

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

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

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

14 (vii) The amount of payments made to managed care plans under RCW
15 74.60.130, including the amount representing additional premium tax,
16 and the data used to calculate those payments.

17 (c) On a monthly basis, the authority shall provide the
18 Washington state hospital association the amount of payments made to
19 managed care plans under RCW 74.60.130, including the amount
20 representing additional premium tax, and the data used to calculate
21 those payments.

22 **Sec. 6.** RCW 74.60.090 and 2015 2nd sp.s. c 5 s 5 are each
23 amended to read as follows:

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

29 (a) University of Washington medical center: (~~Ten million five~~
30 ~~hundred fifty five thousand dollars in each state fiscal year 2016~~
31 ~~through 2019~~) Amounts paid as follows, except if the full amount of
32 the payments required under RCW 74.60.120 and 74.60.130 cannot be
33 distributed in a given fiscal year, the amounts in this subsection
34 (~~((ii) and (iii))~~) must be reduced proportionately:

35 (i) In each state fiscal year 2018 through 2021, four million
36 four hundred fifty-five thousand dollars;

37 (ii) In each state fiscal year 2018 and 2019, two million dollars
38 to new integrated, evidence-based psychiatry residency program slots

1 that did not receive state funding prior to 2016, at the integrated
2 psychiatry residency program at the University of Washington; and

3 (iii) In each state fiscal year 2018 and 2019, four million one
4 hundred thousand dollars to new family medicine residency program
5 slots that did not receive state funding prior to 2016, as directed
6 through the family medicine residency network at the University of
7 Washington, for slots where residents are employed by hospitals;

8 (b) Harborview medical center: Ten million two hundred sixty
9 thousand dollars in each state fiscal year ~~((2016 through 2019))~~ 2018
10 through 2021, except if the full amount of the payments required
11 under RCW 74.60.120 and 74.60.130 cannot be distributed in a given
12 fiscal year, the amounts in this subsection must be reduced
13 proportionately;

14 (c) All other certified public expenditure hospitals: Six million
15 three hundred forty-five thousand dollars in each state fiscal year
16 ~~((2016 through 2019))~~ 2018 through 2019, except if the full amount of
17 the payments required under RCW 74.60.120 and 74.60.130 cannot be
18 distributed in a given fiscal year, the amounts in this subsection
19 must be reduced proportionately. The amount of payments to individual
20 hospitals under this subsection must be determined using a
21 methodology that provides each hospital with a proportional
22 allocation of the group's total amount of medicaid and state
23 children's health insurance program payments determined from claims
24 and encounter data using the same general methodology set forth in
25 RCW 74.60.120 (3) and (4).

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

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

33 In each fiscal year commencing upon satisfaction of the
34 conditions in RCW 74.60.150(1), the authority shall make access
35 payments to critical access hospitals that do not qualify for or
36 receive a small rural disproportionate share hospital payment in a
37 given fiscal year in the total amount of ~~((seven hundred))~~ two
38 million thirty-eight thousand dollars from the fund ~~((and to critical~~
39 ~~access hospitals that receive disproportionate share payments in the~~

1 ~~total amount of one million three hundred thirty six thousand~~
2 ~~dollars~~)). The amount of payments to individual hospitals under this
3 section must be determined using a methodology that provides each
4 hospital with a proportional allocation of the group's total amount
5 of medicaid and state children's health insurance program payments
6 determined from claims and encounter data using the same general
7 methodology set forth in RCW 74.60.120 (3) and (4). Payments must be
8 made after the authority determines a hospital's payments under RCW
9 74.60.110. These payments shall be in addition to any other amount
10 payable with respect to services provided by critical access
11 hospitals and shall not reduce any other payments to critical access
12 hospitals. The authority shall provide a report of such payments to
13 the Washington state hospital association within thirty days after
14 payments are made.

15 **Sec. 8.** RCW 74.60.120 and 2015 2nd sp.s. c 5 s 7 are each
16 amended to read as follows:

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

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

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

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

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

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

4 (f) For outpatient fee-for-service payments for border hospitals,
5 two hundred fifty thousand dollars per state fiscal year plus federal
6 matching funds.

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

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

20 (a) Applying the medicaid fee-for-service rates in effect on July
21 1, (~~((2009, without regard to the increases required by chapter 30,~~
22 ~~Laws of 2010 1st sp. sess.))~~ 2014, to each hospital's inpatient fee-
23 for-services claims and medicaid managed care encounter data for the
24 base year;

25 (b) Applying the medicaid fee-for-service rates in effect on July
26 1, (~~((2009, without regard to the increases required by chapter 30,~~
27 ~~Laws of 2010 1st sp. sess.))~~ 2014, to all hospitals' inpatient fee-
28 for-services claims and medicaid managed care encounter data for the
29 base year; and

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

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

36 (a) Applying the medicaid fee-for-service rates in effect on July
37 1, (~~((2009, without regard to the increases required by chapter 30,~~
38 ~~Laws of 2010 1st sp. sess.))~~ 2014, to each hospital's outpatient fee-
39 for-services claims and medicaid managed care encounter data for the
40 base year;

1 (b) Applying the medicaid fee-for-service rates in effect on July
2 1, (~~2009, without regard to the increases required by chapter 30,~~
3 ~~Laws of 2010 1st sp. sess.~~) 2014, to all hospitals' outpatient fee-
4 for-services claims and medicaid managed care encounter data for the
5 base year; and

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

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

13 (6) Payments must be made in quarterly installments on or about
14 the last day of every quarter.

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

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

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

23 (1) For state fiscal year 2016 and for each subsequent fiscal
24 year, commencing within thirty days after satisfaction of the
25 conditions in RCW 74.60.150(1) and subsection (5) of this section,
26 the authority shall increase capitation payments in a manner
27 consistent with federal contracting requirements to managed care
28 organizations by an amount at least equal to the amount available
29 from the fund after deducting disbursements authorized by RCW
30 74.60.020(4) (c) through (f) and payments required by RCW 74.60.080
31 through 74.60.120. When combined with applicable federal matching
32 funds, the capitation payment under this subsection must be ((no less
33 than ninety six million dollars per state fiscal year plus the
34 maximum available amount of federal matching funds)) at least three
35 hundred sixty million dollars per year. The initial payment following
36 satisfaction of the conditions in RCW 74.60.150(1) must include all
37 amounts due from July 1, 2015, to the end of the calendar month
38 during which the conditions in RCW 74.60.150(1) are satisfied.
39 Subsequent payments shall be made monthly.

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

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

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

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

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

37 (b) Managed care organizations shall expend the increased
38 capitation payments under this section in a manner consistent with
39 the purposes of this chapter, with the initial expenditures to
40 hospitals to be made within thirty days of receipt of payment from

1 the authority. Subsequent expenditures by the managed care plans are
2 to be made before the end of the quarter in which funds are received
3 from the authority;

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

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

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

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

17 **Sec. 10.** RCW 74.60.150 and 2015 2nd sp.s. c 5 s 9 are each
18 amended to read as follows:

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

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

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

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

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

37 (a) The federal department of health and human services and a
38 court of competent jurisdiction makes a final determination, with all

1 appeals exhausted, that any element of this chapter, other than RCW
2 74.60.100, cannot be validly implemented;

3 (b) Funds generated by the assessment for payments to prospective
4 payment hospitals or managed care organizations are determined to be
5 not eligible for federal match;

6 (c) Other funding sufficient to maintain aggregate payment levels
7 to hospitals for inpatient and outpatient services covered by
8 medicaid, including fee-for-service and managed care, at least at the
9 levels the state paid for those services on July 1, ((2015)) 2009, as
10 adjusted for current enrollment and utilization is not appropriated
11 or available;

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

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

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

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

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

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

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

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

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

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

17 (v) For prospective payment system, psychiatric, and
18 rehabilitation hospitals only, reduce the increased capitation
19 payments to managed care organizations under RCW 74.60.130 below the
20 levels specified in that section on the first day of the contract
21 period unless the managed care payments are reduced under RCW
22 74.60.130(3); or

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

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

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

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

38 (b) May discontinue supplemental payments, increased managed care
39 payments, disproportionate share hospital payments, and access

1 payments made subsequent to the breach for the hospital that are
2 required under this chapter.

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

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

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

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

12 Upon expiration of chapter 74.60 RCW, inpatient and outpatient
13 hospital reimbursement rates shall return to a rate structure as if
14 the four percent medicaid inpatient and outpatient rate reductions
15 did not occur on July 1, 2009(~~(, or as otherwise specified in the~~
16 ~~2013-15 biennial operating appropriations act)~~)).

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

19 The estimated hospital net financial benefit under this chapter
20 shall be determined by the authority by summing the anticipated
21 hospital payments, plus all applicable federal matching funds as
22 follows: From RCW 74.60.090 for grants to certified public
23 expenditure hospitals, plus RCW 74.60.100 for payments to critical
24 access hospitals, plus RCW 74.60.110 for payments to small rural
25 disproportionate share hospitals, plus RCW 74.60.120 for direct
26 supplemental payments to hospitals, plus RCW 74.60.130 for managed
27 care capitation payments, plus RCW 74.60.020(4)(f) for quality
28 improvement incentives, minus the total assessments paid by all
29 hospitals under RCW 74.60.030 for hospital assessments, and minus any
30 taxes paid on RCW 74.60.130 for managed care payments. If the
31 anticipated hospital net financial benefit falls below one hundred
32 thirty million dollars in any state fiscal year, the authority is
33 directed to modify the payment levels in the following sections in
34 order to and equalize the anticipated hospital net financial benefit
35 and the state net financial benefit: RCW 74.60.020(4)(d) for state
36 general fund, RCW 74.60.090 for grants to certified public
37 expenditure hospitals, RCW 74.60.100 for payments to critical access

1 hospitals, RCW 74.60.110 for payments to small rural disproportionate
2 share hospitals, RCW 74.60.120 for direct supplemental payments to
3 hospitals, RCW 74.60.130 for managed care capitation payments, and
4 RCW 74.60.020(4)(g) for residency programs.

5 NEW SECTION. **Sec. 15.** This act is necessary for the immediate
6 preservation of the public peace, health, or safety, or support of
7 the state government and its existing public institutions, and takes
8 effect immediately.

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