Z-0766.2

SENATE BILL 6570

State of Washington 63rd Legislature 2014 Regular Session

By Senators Becker, Keiser, Hargrove, Braun, Hill, and Ranker; by request of Health Care Authority

Read first time 02/19/14. Referred to Committee on Ways & Means.

AN ACT Relating to adjusting timelines regarding the hospital safety net assessment; and amending RCW 74.60.030, 74.60.120, and 74.60.130.

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:

(i) For fiscal year 2014, an annual assessment for amounts determined as described in (b)(ii) through (iv) of this subsection is imposed for the time period of October 1, 2013, through June 30, 2014. The initial assessment notice must cover amounts due from October 1, 2013, through either: (A) The end of the calendar quarter prior to the satisfaction of the conditions in RCW 74.60.150(1) if federal 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 federal approval is received within forty-five days of the end of a quarter. For subsequent assessments during fiscal year 2014, the authority shall calculate the amount due annually and shall issue assessments for the appropriate proportion of the annual amount due from each hospital((~~. Initial assessment notices must be sent to each hospital not earlier than thirty days after satisfaction of the conditions in RCW 74.60.150(1) and must include all amounts due from and after July 1, 2013. Payment is due not sooner than thirty days thereafter. Subsequent notices must be sent on or about thirty days prior to the end of each subsequent quarter and payment is due thirty days thereafter.~~

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

~~(i)~~));

(ii) After the assessments described in (b)(i) of this subsection, each prospective payment system hospital, except psychiatric and rehabilitation hospitals, shall pay a quarterly assessment. Each quarterly assessment shall be one quarter of three hundred forty-four dollars for each annual nonmedicare hospital inpatient day, up to a maximum of fifty-four thousand days per year. For each nonmedicare hospital inpatient day in excess of fifty-four thousand days, each prospective payment system hospital shall pay an assessment of one quarter of seven dollars for each such day;

((~~(ii)~~)) (iii) After the assessments described in (b)(i) of this subsection, each critical access hospital shall pay a quarterly assessment of one quarter of ten dollars for each annual nonmedicare hospital inpatient day;

((~~(iii)~~)) (iv) After the assessments described in (b)(i) of this subsection, each psychiatric hospital shall pay a quarterly assessment

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

((~~(iv)~~)) (v) After the assessments described in (b)(i) of this subsection, each rehabilitation hospital shall pay a quarterly assessment of one quarter of sixty-seven dollars for each annual nonmedicare hospital inpatient day.

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

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

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

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

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

(a) For inpatient fee-for-service payments for prospective payment hospitals other than psychiatric or rehabilitation hospitals, twenty-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.

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

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

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

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

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

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

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

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

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

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

((~~the date of the initial payment~~)) 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.

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