HOUSE BILL REPORT
E2SHB 2956

As Passed House:
March 9, 2010

Title: An act relating to a hospital safety net assessment for increased hospital payments to improve health care access for the citizens of Washington.

Brief Description: Concerning the hospital safety net.

Sponsors: House Committee on Ways & Means (originally sponsored by Representatives Pettigrew, Williams and Maxwell; by request of Governor Gregoire).

Brief History:
Committee Activity:
Health & Human Services Appropriations: 2/4/10, 2/5/10 [DPS];
Ways & Means: 2/8/10, 2/27/10 [DP2S(w/o sub APPH)].
Floor Activity:
Passed House: 3/9/10, 79-18.

Brief Summary of Engrossed Second Substitute Bill

- Establishes the Hospital Safety Net Assessment Fund.
- Creates assessments on hospitals based on non-Medicare inpatient hospital days.
- Increases inpatient and outpatient hospital payment rates and Disproportionate Share Hospital payments.
- Requires the Department of Social and Health Services to design a system for providing quality incentive payments to hospitals starting in Fiscal Year 2013.

HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES APPROPRIATIONS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Pettigrew, Chair; Seaquist, Vice Chair; Appleton, Cody, Dickerson, Miloscia, Morrell, O'Brien, Roberts, Walsh and Wood.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Alexander, Assistant Ranking Minority Member; Fagan and Johnson.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Staff: Erik Cornellier (786-7116).

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health & Human Services Appropriations. Signed by 18 members: Representatives Linville, Chair; Ericks, Vice Chair; Sullivan, Vice Chair; Dammeier, Assistant Ranking Minority Member; Chandler, Cody, Conway, Darneille, Haigh, Hinkle, Hunt, Kagi, Kenney, Kessler, Pettigrew, Priest, Ross and Seaquist.

Minority Report: Do not pass. Signed by 4 members: Representatives Alexander, Ranking Minority Member; Bailey, Assistant Ranking Minority Member; Hunter and Schmick.

Staff: Erik Cornellier (786-7116).

Background:

Medical assistance is available to eligible low-income state residents and their families from the Department of Social and Health Services (DSHS), primarily through the Medicaid program. Most of the state medical assistance programs are funded with matching federal funds in various percentages. Federal funding for the Medicaid program is conditioned on the state having an approved Medicaid state plan and related state laws to enforce the plan. Coverage is provided through fee-for-service and managed care systems.

Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services. Healthy Options is the DSHS Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under 19, and pregnant women a complete medical benefits package.

In 1989 the Washington Legislature created county-based Regional Support Networks (RSNs) to design and administer publicly-funded mental health services. There are currently 13 RSNs that contract with the state for outpatient, crisis, residential, and inpatient services through licensed mental health agencies. The system currently serves approximately 50,000 individuals per year. The majority of persons served are Medicaid eligible adults who have chronic and persistent mental illness, and children/youth with severe emotional disturbances. Approximately 6,500 persons who are served by the mental health system are not Medicaid eligible.

The federal government also matches state funding for Disproportionate Share Hospitals (DSH), which are hospitals that serve a disproportionate share of Medicaid clients or the uninsured. States make DSH payments directly to hospitals, and the federal government reimburses them for part of the payments based on each state's Medicaid matching rate. States receive a DSH allotment that sets an upper limit on how much federal Medicaid money states can spend on DSH payments.

Provider taxes have been used by some states to help fund the costs of the Medicaid program. States collect funds from providers and pay them back as Medicaid payments, and states can claim the federal matching share of those payments.

Provider taxes must conform to federal laws requiring that the taxes are generally redistributive in nature and that no hospitals are "held harmless" from the burden of the tax. The taxes must be broad-based, which means they must be imposed on all providers in a given class, and uniform, which means the same tax rate must apply across providers. If a tax is not broad-based and uniform it must meet statistical tests that demonstrate that the amount of the tax is not directly correlated to Medicaid payments. Additionally, Medicaid payments for these services cannot exceed Medicare reimbursement levels.

'The Health Care Authority (Authority) administers the Basic Health Plan (BHP), which is a health care insurance program for low-income Washington residents. The BHP assists enrollees by providing a state subsidy to offset the costs of premiums. The BHP currently has approximately 70,000 subsidized enrollees statewide.

Summary of Engrossed Second Substitute Bill:

Intent.

The bill states that its purpose is to provide for a safety net assessment on certain Washington hospitals, which will be used solely to augment funding from all other sources and thereby obtain additional funds to restore recent reductions and to support additional payments to hospitals for Medicaid services.

The Legislature finds that Washington hospitals, working with the DSHS, have proposed a hospital safety net assessment to generate additional state and federal funding for the Medicaid program, which will be used to partially restore recent reductions in hospital reimbursement rates and provide for an increase in hospital payments. The Hospital Safety Net Assessment Fund (Fund) allows the state to generate additional federal financial participation for the Medicaid program and provides for increased reimbursement to hospitals.

It is the intent of the Legislature:

- to impose a hospital safety net assessment to be used solely for the purposes specified in this act;
- that funds generated by the assessment shall be used solely to augment all other funding sources and not as a substitute for any other funds;
- the total amount assessed shall not exceed the amount needed, in combination with all other available funds, to support the reimbursement rates and other payments in this act; and
- to condition the assessment on receiving federal approval for receipt of additional federal financial participation and on continuation of other funding sufficient to maintain hospital rates and Small Rural DSH payments at least at levels in effect on June 30, 2009.

Assessments.

Hospital provider assessments are imposed on certain hospitals unless exempted. Exempted hospitals include those that are owned or operated by the federal or state government, hospitals that participate in the Certified Public Expenditure program, hospitals that do not charge directly or indirectly for hospital services, and long-term acute care hospitals.

The hospital assessments are based on the number of non-Medicare inpatient days. The amount of the assessment varies by hospital type and is reduced if a hospital has more than 60,000 patient days per year. The assessments increase periodically in four phases, and they range from $10 to $200 depending on the phase and the type of hospital.

During the period after the expiration of enhanced federal matching funds under the American Recovery and Reinvestment Act, the DSHS may adjust the assessments or the number of non-Medicare inpatient days used to calculate the assessments on Prospective Payment System hospitals with more than 60,000 non-Medicare inpatient days to comply with federal statutes and regulations. Assessments will also be reduced if new hospital funding is available to fund the rate restorations or payment increases.

Hospital Safety Net Assessment Fund.

The Fund is created within the State Treasury. The DSHS, in cooperation with the Office of Financial Management (OFM), will administer and monitor the Fund. Proceeds from the assessments are deposited into the Fund, and the interest earned on money in the Fund is credited to the Fund.

Increased Hospital Payments.

Money in the Fund may be used for various increases in hospital payments. Inpatient and outpatient payment rates are restored to levels in place on June 30, 2009. Small Rural DSH payments are restored to 120 percent of the levels in place on June 30, 2009. Starting February 1, 2010, hospitals receive payment rate increases ranging from 3 percent to 13 percent for inpatient services and 21 percent to 41 percent for outpatient services, depending on the hospital type. Critical Access Hospitals that are not eligible for Small Rural DSH payments receive payments of $50 per Medicaid inpatient day. Hospitals that are exempt from the assessments are not excluded from the rate increases.

The sum of $49.3 million per biennium may be dispersed from the fund for the purpose of ensuring that hospital payment rates are not reduced from the effective date of this act until July 2013.

Quality Incentive Payments.

The DSHS, in collaboration with the Health Care Authority, the Department of Health, the Department of Labor and Industries, the Washington State Hospital Association (WSHA), the Puget Sound Health Alliance, and the Forum, is required to design a system for providing quality incentive payments to hospitals.
The design of the system shall be based upon evidence-based treatments and processes, effective purchasing strategies that involve the use of common quality improvement organizations, and quality measures consistent with the standards developed by national

quality improvement organizations. Reporting burdens on hospitals should be minimized by giving priority to measures that hospitals are currently required to report to government agencies. Measures should be set at levels that are feasible for hospitals to achieve and represent real improvements in quality and performance for a majority of hospitals. Payments should be designed so that all non-critical access hospitals are able to receive the payments.

The DSHS must submit the design of the hospital quality incentive payment system to the Legislature by December 15, 2010.

Starting in fiscal year 2013, assessments may be increased to support an additional 1 percent increase in inpatient hospital payments for non-critical access hospitals that meet quality incentive benchmarks.

Managed Care Payments.

The DSHS shall pay managed care organizations (MCOs) and Regional Support Networks (RSNs) for the additional state taxes due as a result of the payments to MCOs and RSNs to fund the hospital rate restorations and increases in this act. The DSHS shall require MCOs and RSNs to pay hospitals within 45 days after the MCOs or RSNs receive payments from the DSHS for hospital rate restorations and increases.

The MCOs are required to pay hospitals at rates that are no lower than the restored and increased rates established in this act. The DSHS is required to ensure that the hospital rate increases are included in the development of Healthy Options managed care premiums.

The MCOs that subcontract with prepaid or capitated health care organizations are required to pay those organizations for the increased hospital rates, and the health care organizations are required to pay hospitals for the increased rates.

Administration.

The sum of $1 million per biennium may be disbursed from the Fund for payment of administrative expenses incurred by the DSHS related to this act.

If other funding becomes available to support increased reimbursement rates, the DSHS must reduce the assessment amount. Conversely, if the DSHS determines that there are insufficient funds to support the increased payment rates, the assessment rates will be increased accordingly along with a contingency factor of up to 10 percent.

Any funds left over in the Fund at the end of a biennium carry over into the next biennium and are used to reduce the assessments applied in the following fiscal year.

The DSHS must submit any adjustments to the assessments and the supporting data for the adjustments to the WSHA for review and comment at least 60 calendar days prior to implementing the adjustments.

The DSHS, in cooperation with the OFM, must develop rules for calculating the assessments to individual hospitals, notifying hospitals of the assessed amounts, and collecting the amounts due.

The DSHS must provide data on the Fund balance, assessments paid by each hospital, and annual Medicaid fee-for-service and Healthy Options payments for inpatient and outpatient hospital services to WSHA by November 30 of each year.

The DSHS must amend its DSH reporting instructions to ensure that it receives the necessary data to report on Healthy Options hospital payments.

Hospitals must treat the assessments as operating overhead expenses, and they may not pass on the costs of the assessments to patients or other payers. The DSHS may require hospital chief financial officers to submit certified statements that they have not increased charges or billings as a result of the assessments. Hospitals may include the assessments on their Medicaid and Medicare cost reports.

Conditions.

The assessment, collection, and disbursement of funds is subject to four conditions. First, the federal Center for Medicare and Medicaid Services (CMS) must approve any necessary state plan amendments or waivers. Second, the DSHS must withdraw the aspects of the pending state plan amendment related to reducing hospital inpatient and outpatient rates by 4 percent. Third, the DSHS must amend its contracts with MCOs to the extent necessary to comply with the provisions of the bill. Fourth, the OFM must certify that the Legislature has provided appropriations for the next fiscal year to support the increased payments.

The act does not take effect or ceases to be imposed if one of five conditions is met. First, an appellate court or CMS determines that any portion of the act is invalid, except for the section related to payments to Critical Access Hospitals that are not eligible for Small Rural DSH payments. Second, Medicaid inpatient or outpatient payment rates are reduced below levels specified in the act. Third, the increased hospital payments are not eligible for federal matching funds, except for payments for the University of Washington Medical Center and Harborview Medical Center. Fourth, other funding available for the Medicaid program is not sufficient to maintain Medicaid inpatient or outpatient reimbursement rates for hospitals and Small Rural DSH payments at 100 percent of levels in effect on July 1, 2009. Fifth, the Fund is used to supplant other funds.

Basic Health Plan.

The increases in inpatient and outpatient reimbursement rates in this act shall not be reflected in hospital payment rates for services provided to Basic Health enrollees.

2009-11 Operating Budget.

The provisions in the 2009-11 operating budget related to Small Rural Indigent Assistance DSH payments and the prorated inpatient payment policy are restored.

Expiration.

This act expires on July 1, 2013.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony (Health & Human Services Appropriations):

(In Support) The Legislature reduced hospital Medicaid payments by over $200 million in the current biennium, and it reduced hospital Basic Health and GAU payments by about $100 million. The Governor proposed a new 5 percent reduction in hospital rates in the book one budget. For all hospitals in aggregate, this bill would restore approximately 61 percent of those losses, and the source of the increased rates is the hospitals' own funds. The hospitals want to mitigate these reductions without impacting the state general fund. One option is litigation, but the hospitals would rather not pursue that option. The majority of states are implementing hospital taxes to increase hospital rates and bring in more federal matching funds. Medicaid payments have always been below cost. Even with the new increases hospitals will still be paid below Medicare payment rates. This bill particularly helps large hospitals with a lot of Medicaid patients and small rural hospitals on edge of survival. It does not make them healthy or better off, but it keeps them from going under. This bill should not impact the state's general fund or cash flow. It also does not put a burden on hospitals by requiring them to put payments into the fund before receiving payment increases. This bill would also allow $32 million of the assessment funds to reduce general fund state expenditures on hospital costs. It also allows one million dollars of the assessments to be used for administrative costs in the DSHS. Under this proposal, some hospitals do very well and some do not do as well. All but one hospital is supportive of this bill, and that hospital is neutral. Some hospitals would receive more in payments than they pay in assessments, and others would pay more assessments than they would receive in payments. The hospitals that would pay more than they would receive will take care of that within their own systems. The assessments cannot be passed on to patients. This bill is intended to reverse the hospital inpatient and outpatient rate reductions in the 2009-11 Budget. It is not intended to reverse policy changes such as the change in Cesarean birth rates and the prorated inpatient policy. There is a four-year sunset provision in the bill, but every state that has used this mechanism has continued to use it after the specified sunset date. The purpose of the sunset provision is to restart the discussion on the appropriate shares between the state and the hospitals for supporting Medicaid patients.

(Opposed) Independent physician groups that subcontract with Medicaid Managed Care Organizations (MCOs) oppose this bill because it could create an unfunded rate increase for the physician groups. The bill provides funding to the MCOs for the hospital rate increases, but it does not require MCOs to pass those costs to the physician groups that the MCOs subcontract with. This unfunded rate increase could force the physician groups to close or stop working with the Medicaid MCOs.

Staff Summary of Public Testimony (Ways & Means):

(In support) The purpose of the bill is to mitigate the $315 million in impacts on hospitals in the 2009-11 budget. The additional $32 million general fund reduction in the Governor's budget would have a $76 million total impact after including federal dollars. This proposal would restore approximately 61 percent of the previous hospital cuts. The assessments are used for increased hospital rates and payments that generate federal matching funds. The proposed assessment meets the statistical test required by the federal government when an assessment is not broad-based and uniform. This is an assessment, not a tax. The difference is that businesses pass taxes on to customers, but hospitals are prohibited from passing the costs of the assessments on to patients.

Community clinics serve as the safety net that keeps people out of more expensive emergency room care. The provision requiring hospitals to fund emergency department diversion agreements with community and migrant health centers would not replace Health Care Authority grants, which allow clinics to provide care on a sliding fee scale. The state should use a different mechanism if the goal is to replace the grants.

(Opposed) Increasing hospital rates will increase costs to independent physician organizations that sub-contract with managed care organizations in Washington's Medical Assistance program. The state should provide funding for the rate increases. The substitute attempts to do that, but it does not provide the full rate increase. This will force independent physician groups to close, which will result in a move from managed care to fee-for-service care. This would reduce access to care.

Persons Testifying (Health & Human Services Appropriations): (In support) Leo Greenwalt, CEO, Washington State Hospital Association; and Len McComb, Washington State Hospital Association.

(Oppose) Stohn Nishino, Wilson Strategic Communications

Persons Testifying (Ways & Means): (In support) Len McComb, Washington Hospital Association; and Kate White Tudor, Washington Association of Community and Migrant Health Centers.

(Opposed) Stohn Nishino, Wilson Strategic Communications.

Persons Signed In To Testify But Not Testifying (Health & Human Services Appropriations):

Persons Signed In To Testify But Not Testifying (Ways & Means): None.