# FINAL BILL REPORT
# SSB 5815

**C 228 L 17**
Synopsis as Enacted

**Brief Description**: Concerning the hospital safety net assessment.

**Sponsors**: Senate Committee on Ways & Means (originally sponsored by Senators Rivers, Cleveland, Becker and Ranker).

**Senate Committee on Ways & Means**
**House Committee on Appropriations**

**Background**: Health care provider-related charges, such as assessments, fees, or taxes, have been used in some states to help fund the costs of the Medicaid program. Under federal rules, these provider-related charges include any mandatory payment where at least 85 percent of the burden falls on health care providers. States collect funds from health care providers and pay them back as Medicaid payments. States use these provider-related payments to claim federal matching funds.

To conform to federal laws, health care provider-related assessments, fees, and taxes must be broad based, uniform, and in compliance with hold harmless provisions. To be broad based and uniform, respectively, they must be applied to all providers of the same class and be imposed at the same rate to each provider in that class. If a provider-related assessment, fee, or tax is not broad based or uniform, these provisions may be waived if the assessment, fee, or tax is generally redistributive. The hold harmless provision may not be waived. Additionally, Medicaid payments for these services cannot exceed Medicare reimbursement levels.

The Legislature created a Hospital Safety Net Assessment (HSNA) program pursuant to E2SHB 2956 - hospital safety net assessment in 2010; EHB 2069 - hospital payments/safety net in 2011; ESSB 5913 - hospital payments/quality incentive in 2013; and EHB 2151 - extending the hospital safety net assessment in 2015. An assessment on non-Medicare inpatient days is imposed on most hospitals, and proceeds from the assessments are deposited into the HSNA Fund (Fund).

Money in the Fund may be used for various increases in hospital payments. In 2010, inpatient and outpatient payment rates were restored to levels in place on June 30, 2009. Beyond that restoration, most hospitals received additional payment rate increases for inpatient and outpatient services. In 2013, the way in which the increases were addressed was changed from a specific percentage of inpatient and outpatient rate increases to an

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overall level of increase. The overall level of increase was split between fee for service and managed care payments.

The sum of $199.8 million in the 2013-15 biennium may be expended from the Fund in lieu of State General Fund payments to hospitals. An additional sum of $1 million per biennium may be disbursed from the Fund for payment of administrative expenses incurred by the Health Care Authority (HCA) related to the assessment program.

The HSNA program was to originally expire on July 1, 2013. Under the 2013 legislation, the program was to expire on July 1, 2017. Upon expiration of the program, hospital rates would either return to the levels in place on June 30, 2009, or to a rate structure specified in the 2013-15 operating budget.

Additionally, under the 2013 legislation, the HSNA program would phase down in equal increments over four years beginning in 2016. The phase down applied to both payments to hospitals and the amounts used in lieu of state General Fund payments to hospitals and would phase to zero by the end of fiscal year 2019.

As a condition of these changes under the 2013 legislation, HCA was required to offer to contract with a hospital required to pay the assessment for two-year periods each fiscal biennium. HCA was required to agree to maintain the levels of the assessment, reimbursement rates, and increased payments during that period. In exchange, the hospitals were required to agree not to challenge, administratively or in court, the adequacy of the reduced reimbursement rates in place after the rate restorations. Increases from the current HSNA program are removed.

The 2015 legislation eliminated the phase down of the program and extended the HSNA program until July 1, 2019. Upon expiration, rates will return to the level they were on July 1, 2015. This legislation also increased the amount that may be expended from the Fund in lieu of state General Fund payments to hospitals from $199.8 million per biennium to $242 million beginning in 2015-2017.

Additionally, funding was provided for increased payments for hospital services and grants to Certified Public Expenditure and Critical Access Hospitals. New funding was provided for family and integrated, evidence-based psychiatry residencies through the University of Washington.

Provisions for contracting between hospitals and HCA were changed to allow extension of existing contracts and to disallow for reductions in aggregate payments based on variations based on budget-neutral rebasing of payment rates.

**Summary**: The HSNA program is extended.

The act specifies that the intent of the Legislature is to:

- increase payments to hospitals to approximately $1 billion per fiscal biennia in state and federal funds to pay for Medicaid hospital services and grants to Certified Public Expenditure (CPE) and Critical Access Hospitals (CAHs);

- extend funds per biennium to be used in lieu of State General Fund payments for Medicaid hospital services through the 2019-2021 biennium; and
- continue funding for integrated evidence-based psychiatry and family residency programs through the 2019-2021 biennium.

Hospitals are assessed based on their non-Medicare inpatient bed days. Assessments are billed on a quarterly basis. The amount of annual assessments per non-Medicare bed day paid by hospitals are revised to the following amounts:

- Prospective Payment System (PPS) hospitals must be no more than $380—up to a maximum of 54,000 bed days per year;
- psychiatric hospitals must be no more than $74; and
- rehabilitation hospitals must be no more than $74.

Other assessment amounts remain unchanged.

Hospitals receive payments through the HSNA program under both fee-for-service and managed care. Fee-for-service payments are made quarterly, before the end of each quarter. Managed care payments are made through the managed care plans. Payments to hospitals are specifically changed to the following annual levels.

Fee-for-service changes are as follows:

- CAHs that do not receive Disproportionate Share Hospital (DSH) payments—$2,038,000; and
- CAHs that do receive DSH payments—$0.

Managed care change is as follows:

- at least $360 million, including federal matching funds.

Most payment amounts remain unchanged.

Substantial compliance with RCW 43.70.052 and RCW 70.01.040 reporting requirements are required for hospitals eligible to receive quality improvement payments. These new provisions require HCA in cooperation with Department of Health (DOH) to verify that hospitals have submitted nine of twelve monthly reports by the due date in order to be in substantial compliance. HCA and DOH certify that hospitals have met reporting requirements.

Provisions for contracting between hospitals and HCA are changed to require HCA to offer to contract with hospitals not previously party to a contract, but subject to the assessment or whose contract had expired.

A new provision allows for the assessment to cease to be imposed if Medicaid matching funds are replaced with a block grant.

The Office of Financial Management (OFM) is directed to equalize the net financial benefit between the state and hospitals if the net financial benefit to the hospitals is anticipated to fall below $130 million in any given fiscal year.

The expiration of the chapter is extended from July 1, 2019, to July 1, 2021. Upon expiration, rates return to a rate structure as though the July 1, 2009 inpatient and outpatient 4 percent rate reductions did not occur.

**Votes on Final Passage:**

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| Senate | 47 | 2 | |
| House | 91 | 5 | (House amended) |
| Senate | 47 | 2 | (Senate concurred) |

**Effective:** July 1, 2017