# FINAL BILL REPORT
# SHB 1850

**C 430 L 23**
Synopsis as Enacted

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

**Sponsors:** House Committee on Appropriations (originally sponsored by Representatives Macri, Schmick, Tharinger, Stokesbary, Ormsby, Bergquist, Schmidt, Chopp, Berg, Bronoske and Thai).

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

**Background:**

Medicaid.
Medicaid is a federal-state partnership with programs established in the federal Social Security Act and implemented at the state level with federal matching funds. The Health Care Authority (HCA) administers the Medicaid program for health care for low-income state residents who meet certain eligibility criteria. Washington's Medicaid program, known as Apple Health, offers a complete medical benefits package, including prescription drug coverage, to eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women. While some clients receive services through the HCA on a fee-for-service (FFS) basis, the large majority receive coverage for medical services through managed care systems. Managed care is a prepaid, comprehensive system for delivering a complete medical benefits package that is available for eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women. The HCA contracts with managed care organizations (MCOs) under a comprehensive risk contract to provide prepaid health care services to persons enrolled in a managed care Apple Health plan.

Provider Assessments.
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

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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, 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.

Hospital Safety Net Assessment Program.
The Legislature created a Hospital Safety Net Assessment (HSNA) program in 2010 and has subsequently modified and extended it several times. 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 Medicaid 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 methodology for increases was changed from a specific percentage of inpatient and outpatient rate increases to an overall level of increase. The overall level of increase was split between FFS and managed care payments.

During the 2019-21 and 2021-23 biennia, a total of $292 million from the Fund may be used in lieu of General Fund-State 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 HCA related to the assessment program. For the 2019-21 and 2021-23 biennia, funds may be used for family medicine and integrated, evidence-based psychiatry residencies through the University of Washington. The HSNA program expires on July 1, 2025. Upon expiration of the program, Medicaid hospital rates return to the levels in place on June 30, 2009.

Prospective Payment System.
Larger, urban hospitals are reimbursed under the Prospective Payment System (PPS), which is a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (e.g., diagnosis-related groups for inpatient hospital services). The Centers for Medicare and Medicaid Service (CMS) uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Critical Access Hospitals.
The Critical Access Hospital (CAH) Program allows rural hospitals under Washington's

medical assistance programs to receive payment for hospital services based on allowable costs, rather than a set amount per diagnosis or procedure, and to have more flexibility in staffing. There are 39 hospitals in Washington that are federally certified by CMS as CAHs. To be eligible for CAH status, a rural hospital must have 25 beds or fewer acute care inpatient beds, offer 24/7 emergency department care services, and have an average length of stay of 96 hours or less for acute care patients. Most CAHs are operated by public hospital districts.

Intergovernmental Transfers.
Intergovernmental transfers (IGT) are transfers of public dollars between governmental entities. Localities and other public entities may transfer their own tax revenues to the state to help fund the state's Medicaid program.

Managed Care Directed Payment Programs.
The CMS governs how states may direct plan expenditures when implementing delivery system and provider payment initiatives under Medicaid MCO contracts. These types of payment arrangements permit states to direct specific payments made by MCOs to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs. States must obtain written approval of state-directed payments before approval of the corresponding MCO contract(s). States can use permissible funding sources to fund the nonfederal share of state-directed payments, including IGTs and provider taxes that comply with federal statute and regulations.

**Summary:**

The Hospital Safety Net Assessment is changed to the Hospital Safety Net Program (Program).

Intent.
The Program is established to maintain and improve equity of access to and quality of care of hospital services for Medicaid clients, including those served by MCOs. The Program includes:

- an assessment on non-Medicare net inpatient and outpatient revenue for certain nongovernmental Medicaid PPS hospitals and CAHs; and
- an allowance for IGTs for designated public hospitals.

The Legislature finds that the Program will benefit Medicaid clients by generating additional federal financial participation in the Medicaid program to address expanded Medicaid enrollment.

It is the intent of the Legislature:

- to condition the assessment on receiving federal approval for payment of additional federal financial participation to support the payments to CAHs, small rural disproportionate share hospitals, and the continuation of funding sufficient to

maintain aggregate payment levels to hospitals for inpatient and outpatient services covered by Medicaid at least at the rates the state paid for those services on July 1, 2022, as adjusted for current enrollment and utilization;
- that funds generated by the assessment will be matched with federal dollars whenever possible to achieve the maximum level of benefits;
- that the total amount assessed under the Program does not exceed the amount needed, in combination with all other available funds, to support Program payments; and
- that designated public hospitals will receive additional federal matching funds.

Assessments.
An annual assessment is imposed and must be paid in equal quarterly installments. For calendar year (CY) 2024, the inpatient and outpatient assessment rates will produce $510 million from the inpatient assessment and $386.4 million from the outpatient assessment. For subsequent years, the assessment rates must be adjusted to fund adjustments in directed payments and quality incentive payments.

The HCA must determine standard assessment rates for hospital inpatient and outpatient assessments that are sufficient, when applied to net non-Medicare inpatient and outpatient revenue, to produce the inpatient and outpatient assessment amounts needed to fund the Program payments. Standard assessment rates applied to net non-Medicare inpatient and outpatient revenue for Medicaid PPS hospitals are as follows:
- for standard Medicaid PPS hospitals, 100 percent for inpatient and 100 percent for outpatient;
- for rehabilitation hospitals, 50 percent for inpatient and 50 percent for outpatient;
- for psychiatric hospitals, 100 percent for inpatient and 50 percent for outpatient;
- for cancer hospitals, 100 percent for inpatient and 40 percent for outpatient;
- for children's hospitals, 5 percent for inpatient and 20 percent for outpatient;
- for high government payer independent hospitals, 20 percent for inpatient and 90 percent for outpatient; and
- for each CAH, 5 percent for inpatient and 40 percent for outpatient.

Exemptions.
Hospitals owned or operated by a county government, designated public hospitals, and hospitals owned or operated by health maintenance organizations are added to the list of exemptions from the assessment. Public hospitals that participate in the certified public expenditure program are removed from the exemptions.

Medicaid Directed Payment Program.
The HCA must implement a Medicaid directed payment program (DPP) to promote equitable distribution of high-quality care by increasing payments to MCOs to increase reimbursement of designated public hospitals' inpatient and outpatient services provided to Medicaid MCO enrollees. These payments are derived from IGTs voluntarily made by, and accepted from, designated public hospitals. The IGTs are used to fund additional MCO payments to benefit designated public hospitals. The DPP must also support hospital

participation in the Quality Incentive Program.

Hospital Safety Net Assessment Fund and Disbursements to Hospitals.
Fee-for-service and managed care payments to hospitals are revised.

The sum of $226 million per fiscal year may be expended from the Fund in lieu of General Fund-State payments to hospitals for Medicaid services. Of this amount, $80 million must be used for post-acute hospital transitions. An additional $1 million per year from the Fund may be used for HCA administrative expenses for the Program.

*Fee-for-Service*. The HCA provides supplemental payments from the Fund to PPS, psychiatric, rehabilitation, and border hospitals based on prior FFS utilization of inpatient and outpatient services. Beginning in CY 2024, these payments, excluding additional federal matching funds, include the following:

- PPS hospitals receive $21.8 million for inpatient payments and $12.4 million for outpatient payments;
- psychiatric hospitals receive $875,000 for inpatient payments;
- rehabilitation hospitals receive $225,000 for inpatient payments;
- border hospitals receive $250,000 for inpatient payments and $250,000 for outpatient payments;
- small rural disproportionate share hospitals receive $2 million; and
- the University of Washington Medical Center receives $6.1 million for integrated evidence-based psychiatry and family residency programs.

*Grants to Financially Distressed Hospitals*. For each CY, the authority may distribute $10 million for grants to financially distressed hospitals. To qualify for a grant, a hospital must:

- be located in Washington;
- not be part of a system of three or more hospitals;
- serve individuals enrolled in state and federal medical assistance programs;
- continue to provide services to Medicaid clients;
- demonstrate a plan for long-term financial sustainability;
- meet one or more of the following criteria at the time of application:
    - have 60 or fewer days cash on hand;
    - have negative net income during the prior or current hospital fiscal year; or
    - be at risk of bankruptcy; and
- not have received these grants for more than five consecutive years.

*Managed Care-Directed Payments for Hospital Services*. The HCA must make quarterly payments from the Fund to Medicaid MCOs consistent with federal requirements. These payments are directed from MCOs to hospitals to support access to care and quality improvement of hospital services. These payments do not reduce the amounts that otherwise would be paid to MCOs, provided that such payments are consistent with actuarial certification and enrollment.

Directed MCO inpatient payments to Medicaid PPS hospitals, plus federal matching funds, are based on a fixed amount per Medicaid inpatient discharge, excluding normal newborns as follows:

- for the first six months of CY 2024, a total of $158.7 million;
- for the second six months of CY 2024, a total of $182.5 million; and
- for CY 2025, $365 million.

Directed MCO outpatient payments to Medicaid PPS hospitals, plus federal matching funds, are based on Medicaid managed care outpatient payments and are paid as follows:

- for the first six months of CY 2024, $99 million;
- for the second six months of CY 2024, $114 million; and
- for CY 2025, $228 million.

*Rural Hospitals*. For MCO-directed inpatient payments, rural CAHs receive $400,000, plus federal matching funds, in CYs 2024 and 2025. For MCO-directed outpatient payments, rural CAHs receive $8.1 million for the first six months of CY 2024; $9.3 million for the second six months of CY 2024; and $18.6 million for CY 2025, plus federal matching funds.

Administration.
Provisions regarding rulemaking and assessment notices, administration, and collection are updated for the new Program. The HCA must transmit notices to each hospital with assessment amounts due and payable. If a hospital fails to make a payment within 60 calendar days of its due date, interest is collected on late payments and deposited into the Fund.

Provisions for how assessment amounts are adjusted for each CY are changed. Multiple provisions for how the HCA consults with and shares data with the Washington State Hospital Association (WSHA) are revised. The HCA must provide data to the WSHA annually and 60 calendar days before implementing any revised assessment level. Data must include:

- the fund balance for distressed hospitals and designated public hospitals;
- the assessment amounts paid by each hospital and amounts transferred by each designated public hospital;
- the state share, federal share, and total annual Medicaid FFS payments for inpatient and outpatient hospital services and the data used to calculate the payments to individual hospitals; and
- the annual state share, federal share, and total payments made to each hospital for grants to distressed hospitals and disproportionate share programs.

The HCA must provide the WSHA with the amount of payments made to MCOs and directed distribution to hospitals, including the amount representing additional premium tax, and the data used to calculate those payments on both a quarterly and annual basis.

The bill contains a severability clause.

The expiration date for the HSNA is removed.

**Votes on Final Passage:**

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| House | 92 | 4 |
| Senate | 49 | 0 |

**Effective:** Contingent
July 23, 2023 (Sections 17 and 18)