SENATE BILL REPORT
SB 5764

As of March 30, 2023

Title: An act relating to the hospital safety net program.

Brief Description: Concerning the hospital safety net program.

Sponsors: Senators Robinson, Muzzall, Boehnke, Braun, Cleveland, Dhingra, Mullet, Randall, Van De Wege, Wagoner and Warnick.

Brief History:
Committee Activity: Ways & Means: 3/30/23.

Brief Summary of Bill

- Changes the Hospital Safety Net Assessment (HSNA) to the Hospital Safety Net Program.
- Changes how hospitals are assessed from non-Medicare bed days to non-Medicare patient revenue.
- Includes an assessment on both inpatient and outpatient services.
- Creates a Medicaid directed payment program for designated public hospitals.
- Changes the amounts of payments to hospitals from the HSNA Fund.
- Increases the amount of assessment dollars the state may use in lieu of state general fund payments for Medicaid hospital services, designating a part for post-acute hospital transitions.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Sandy Stith (786-7710)

Background: Health care provider-related charges, such as assessments, fees, or taxes

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

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. Medicaid payments for these services cannot exceed Medicare reimbursement levels.

The Legislature created a Hospital Safety Net Assessment (HSNA) Program in 2010; hospital payments/safety net in 2011; hospital payments/quality incentive in 2013; and extended 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.

Money in the HSNA 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 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 HSNA fund in lieu of state general fund payments to hospitals. An additional $1 million per biennium may be disbursed from the HSNA fund for 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. 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 were 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 HSNA fund in lieu of state general fund payments to hospitals from $199.8 million per biennium to $292 million beginning in 2015-2017. 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 reductions in aggregate payments based on variations based on budget-neutral rebasing of payment rates.

In 2017, the Legislature extended the program until July 1, 2021. Payment and assessment levels determined under the 2015 legislation were adjusted.

In 2019, the Legislature extended the program until July 1, 2023. Language was added making clarifications to certified public expenditure hospitals. Provisions were added allowing HCA to offset amounts due from payments scheduled to be made to a hospital from hospitals failing to pay assessments within 90 days of their due date. Payment levels determined under the 2017 legislation were adjusted.

In 2021, the Legislature extended the program until July 1, 2025.

Summary of Bill: The HSNA is renamed the Hospital Safety Net Program (HSNP) and the expiration date of the program is repealed.

The intent of the Legislature is to:

- establish an HSNP to be used solely for the purposes specified in this act;
- establish an assessment on certain nongovernmental, prospective payment system (PPS) hospitals and critical access hospitals (CAH);
- maintain and improve equity of access to and quality of care of hospital services for Medicaid clients;
- increase inpatient and outpatient payments to hospitals;
- create a directed payment program for large governmental hospitals, using intergovernmental transfers (IGT);
- increase funds per biennium to be used in lieu of state general fund payments for Medicaid hospital services to $452 million in 2023-25, of which $160 million shall be used for post-acute hospital transitions;
- match funds collected generated by the assessment whenever possible to achieve the maximum level of benefit; and

- carry any unexpended balance from a fiscal year into the following two fiscal years to reduce the amount of assessments paid under RCW 74.60.050(1)(c).

Assessments. Hospitals are assessed based on their net non-Medicare inpatient (IP) and outpatient (OP) revenue. Assessments are billed on a quarterly basis. For calendar year (CY) 2024, hospitals shall be assessed $510,000 from the inpatient assessment and $386.4 million from the outpatient assessment. For subsequent years, HCA, in consultation with the Washington State Hospital Association (WSHA), shall adjust the assessment to fund adjustments in directed payments and quality incentive payments.

The annual aggregate amount sufficient to fund payments as described in this act, when applied to net non-Medicare inpatient and outpatient hospital revenue, is determined annually by HCA, in compliance with federal rules. This is the standard rate. Hospitals pay the following rates, as compared to the standard rate:

- PPS hospitals—IP 100 percent, OP 100 percent;
- rehabilitation hospitals—IP 50 percent, OP 50 percent;
- psychiatric hospitals—IP 100 percent, OP 50 percent;
- children's hospitals—IP 5 percent, OP 20 percent;
- high government payer independent hospitals—IP 20 percent, OP 90 percent; and
- CAH—IP 5 percent, OP 40 percent.

Hospitals owned or operated by any agency of the federal, state, or county government and those owned or operated by a health maintenance organization are exempt from the assessment.

Payments. Hospitals receive payments through the HSNP through both fee-for-service and managed care and for both IP and OP services. Fee-for-service payments are made quarterly, before the end of each quarter. Managed care payments are made through the managed care organizations (MCO) as directed payments. These payments are made quarterly and must subsequently be paid to hospitals within 21 days of receipt by the MCOs.

Some payments are in the form of grants and are not eligible to receive federal financial participation (FFP).

Payments under the HSNP begin January 1, 2024. Inpatient payments are made based on Medicaid IP discharges, excluding normal newborns and outpatient payments are made based on a percentage of Medicaid OP payments. Payments to MCOs are reconciled on an annual basis.

Grants. Grants under this section are the assessment amount only. These payments are not eligible for FFP:

- University of Washington Medical Center—$6,100,000, of which:
    1. $4,100,000 is for family residency; and

2. $2,000,000 is for integrated, evidence-based psychiatry residency; and

- distressed hospitals—$10,000,000

Fee-for-Service. The following payments are the assessment amount only. All payments under this section are eligible for FFP:

- PPS fee-for-service (FFS), IP Acute—$21,800,000
- PPS FFS, OP Acute—$12,400,000
- PPS FFS, IP Psych—$875,000
- PPS FFS, IP Rehab—$225,000
- PPS FFS, IP Border Hospital—$250,000
- PPS FFS, OP Border Hospital—$250,000
- PPS Quality Incentive Program (QIP)—$3,453,817
- IP Rural Disproportionate Share hospital—$2,040,000

Managed Care. The following payments are the assessment amounts only. All payments under this section are eligible for FFP. Payments in this section are proportionately altered in CY 2024 to reflect a shift between payment methodologies in overlapping state fiscal years (SFYs), a change to a CY method and a first year increased funding level for funds to be used for post-acute hospital transitions:

- PPS Directed Payment IP—$365,000,000;
- CAH Directed Payment IP—$400,000;
- PPS Directed Payment OP—$228,000,000; and
- CAH Directed Payment OP—$18,600,000.

Large Public Hospital Directed Payment. The following payments are the federal share only, and are net of IGT. These payments may be made up to 95 percent of the allowable federal limit:

- Large Public Hospital Directed Payment IP—$49,386,000; and
- Large Public Hospital Directed Payment OP—$113,999,000.

Quality Improvement Payment. Requires hospitals to be in substantial compliance with reporting requirements to qualify for QIP. Reporting requirements are contained in RCW 43.70.052 and 70.01.040. To be in compliance, hospitals must have submitted at least 75 percent of the reports required in those chapters.

Administration. Provisions regarding rulemaking and assessment notices, administration, and collection are updated for the HSNP. 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 Hospital Safety Net Assessment Fund.

Most provisions for how the HSNP is administered is adjusted from the SFY to the CY. Multiple provisions for how HCA consults with and shares data with WSHA are revised. HCA must provide data to WSHA annually and 60 calendar days before implementing any revised assessment level. Additional funding is provided to HCA to administer the program.

HCA must provide 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.

Appropriation: None.

Fiscal Note: Requested on March 24, 2023.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony: PRO: Hospitals lost $2.1 billion in 2022. This is not sustainable. This was related to increased costs coming out of the pandemic related to inflation, staff costs, and personal protective equipment. This type of program is similar to programs approved in other states by CMS. Sometimes hospitals are the only provider in a community providing health care services to Medicaid clients. This bill will raise payments to be in line with Medicare. This is still short of cost, but will go a long way toward shoring up hospital losses. Medicaid is well below cost. This helps all kinds of hospitals and will help critical access hospitals remain viable.

OTHER: This raises questions about how this makes sense for the public. The bill lacks provisions for accountability and transparency for how the payments are being spent. It doesn't include provisions for equity, access, and inclusion, and hopefully this will be addressed as this progresses.

Persons Testifying: PRO: Len McComb, Washington State Hospital Association; Chelene Whiteaker, Washington State Hospital Association; Mike Glenn, Jefferson Healthcare and WSHA.

OTHER: Emily Brice, Northwest Health Law Advocates.

Persons Signed In To Testify But Not Testifying: No one.