FINAL BILL REPORT
E2SHB 2956

C 30 L10 E1
Synopsis as Enacted

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).

House Committee on Health & Human Services Appropriations
House Committee on Ways & Means
Senate Committee on Ways & Means

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 legislation was enacted creating county-based Regional Support Networks (RSNs) to design and administer publicly-funded mental health services. There are 13 RSNs that contract with the state for outpatient, crisis, residential, and inpatient services through licensed mental health agencies. The system 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

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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 may not 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:

Intent.

The acts stated 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 July 1, 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 (CPE) 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 December 31, 2010, 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.

Upon expiration of the act in July 2013, hospital rates will either return to the rates that would have been in effect July 1, 2009, if the DSHS had not implemented 4 percent rate reductions, or to a rate structure specified in the 2013-15 operating budget.

The sum of $49.3 million per biennium may be expended in lieu of state general fund payments to hospitals. An additional sum of $17.5 million for the 2009-11 biennium may be expended in lieu of state general fund payments to hospitals if additional matching funds

under the federal American Recovery and Reinvestment Act of 2009 are extended beyond December 31, 2010.

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 must 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 must 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.

The DSHS must submit a study to the Legislature by December 1, 2012, recommending the amount of assessments required to continue to support hospital payments based on an evaluation of Medicaid hospital payments relative to Medicaid hospital costs, the state's economic condition, and the impacts of federal health care reform.

Hospitals participating in the CPE program will receive rate increases from the Fund rather than through the baseline mechanism that provides state grants to hospitals that receive less under the CPE program than they would if they did not participate.

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 Centers 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 act. 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 State Omnibus Operating Appropriations Act related to Small Rural Indigent Assistance DSH payments and the prorated inpatient payment policy are restored.

Expiration.

This act expires on July 1, 2013.

Votes on Final Passage:

House	78	19	

First Special Session

House	71	22	
Senate	28	17	(Senate amended)
House			(House refuses to concur)
Senate	26	15	(Senate amended)
House	65	31	(House concurred)

Effective: April 27, 2010