SENATE BILL REPORT
SHB 1635

As Reported by Senate Committee On:
Ways & Means, March 27, 2013

Title: An act relating to disproportionate share hospital adjustments.

Brief Description: Concerning disproportionate share hospital adjustments.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Morrell, Cody, Jinkins, Ryu and Pollet; by request of Health Care Authority).

Brief History: Passed House: 3/05/13, 96-0.
Committee Activity: Ways & Means: 3/19/13, 3/27/13 [DP].

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.
Signed by Senators Hill, Chair; Baumgartner, Vice Chair; Honeyford, Capital Budget Chair; Hargrove, Ranking Member; Nelson, Assistant Ranking Member; Bailey, Becker, Braun, Conway, Dammeier, Fraser, Hasegawa, Hatfield, Hewitt, Keiser, Kohl-Welles, Murray, Padden, Parlette, Ranker, Rivers, Schoesler and Tom.

Staff: Michael Bezanson (786-7449)

Background: Medical assistance is available to eligible low-income state residents and their families from the Health Care Authority (HCA), primarily through the Medicaid program. Most of the state medical assistance programs are funded with federal matching funds in various percentages.

The federal government 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 they can spend on DSH payments.

The DSH program offers flexibility to states in how they distribute DSH funds. States must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs.

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.

To the extent that funds are appropriated specifically for these purposes, HCA must provide DSH payments considering three components: the low-income component, the medical indigency components, and the state-only component for hospitals that do not qualify for federal payments.

The first component, low income, must be based on a hospital's Medicaid utilization rate, its low-income utilization rate, its provision of obstetric services, and other factors authorized by federal law.

Of the second components, the Medically Indigent program expired in 2003, and the calculation of the medical indigency care component was eliminated.

Funding for the state-only component was eliminated in the 2009-11 state Omnibus Operating Appropriations Act.

Summary of Bill: The requirements for the low-income component of the DSH payments are reduced in consideration of the situation of hospitals serving a disproportionate number of low-income patients with special needs, and compliance with federal requirements.

The medical indigency and state-only components of the DSH payments are removed.

HCA's expenditures on DSH payments may not exceed the federal DSH allotment.

HCA may create DSH payment mechanisms in addition to the low-income component if sufficient funds are specifically appropriated for that purpose.

The Director of HCA may adopt rules to implement these provisions.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: The last time DSH requirements were updated was in 1987. This bill brings Washington into compliance with federal rules and current practice. This bill is strictly cleanup.

Persons Testifying: PRO: Sandy Stith, HCA.