SENATE BILL REPORT
E2SHB 2956

As of Second Reading

Title: An act relating to a hospital safety net assessment for increased hospital payments to improve health care access for the citizens of Washington.

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).

Brief History: Passed House: 3/09/10, 79-18; 3/09/10, 78-19.
Committee Activity:

Staff: Elaine Deschamps (786-7441)

Background: Medical assistance is available to eligible low-income state residents and their families from the Department of Social and Health Services (DSHS/the department), 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.

Provider taxes have been used by states to help fund the costs of the Medicaid program. Under these taxes, states collect funds from providers and pay the money back to providers as Medicaid payments, while claiming the federal matching share of those payments. These taxes must conform to federal laws to ensure that they are generally redistributive in nature and that no hold harmless provisions are in place that would guarantee repayment 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 payment for these services cannot exceed Medicare reimbursement levels.

Summary of Bill: Hospital provider assessments are imposed on certain hospitals unless exempt. Exempt hospitals include those that are owned or operated by the federal or state government, hospitals that participate in the Certified Public Expenditure program, hospitals

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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 the expiration of enhanced federal matching funds under the American Recovery and Reinvestment Act, 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.

The Fund is created within the state treasury. DSHS, in cooperation with the Office of Financial Management, 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.

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.

The sum of $49.3 million per biennium may be dispersed from the fund for the purpose of ensuring that hospital payment rates are not reduced from the effective date of this act until July 2013. One million dollars per biennium may be disbursed from the fund for DSHS's administrative expenses.

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.

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.

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. DSHS must require MCOs and RSNs to pay hospitals within 45 days after the MCOs or RSNs receive payments from DSHS for hospital rate restorations and increases.

MCOs are required to pay hospitals at rates that are no lower than the restored and increased rates established in this act. DSHS must ensure that the hospital rate increases are included in the development of Healthy Options managed care premiums.

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.

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. 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.

The assessment, collection, and disbursement of funds is subject to four conditions: (1) the federal Center for Medicare and Medicaid Services (CMS) must approve any necessary state plan amendments or waivers; (2) DSHS must withdraw the aspects of the pending state plan amendment related to reducing hospital inpatient and outpatient rates by 4 percent; (3) DSHS must amend its contracts with MCOs to the extent necessary to comply with the provisions of the act; and (4) 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: (1) 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; (2) Medicaid inpatient or outpatient payment rates are reduced below levels specified in the act; (3) 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; (4) 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; and (5) the Fund is used to supplant other funds.

The increases in inpatient and outpatient reimbursement rates in this act must not be reflected in hospital payment rates for services provided to Basic Health enrollees.

The provisions in the 2009-11 Operating Budget related to Small Rural Indigent Assistance DSH payments and the prorated inpatient payment policy are restored.

This act expires on July 1, 2013.

Appropriation: None.

Fiscal Note: Available.
[OFM requested ten-year cost projection pursuant to I-960.]

Committee/Commission/Task Force Created: No.

Effective Date: The bill contains an emergency clause and takes effect immediately.