Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Appropriations Committee

HB 1635

Brief Description: Concerning disproportionate share hospital adjustments.

Sponsors: Representatives Morrell, Cody, Jinkins, Ryu and Pollet; by request of Health Care Authority.

Brief Summary of Bill

- Removes some requirements for calculating payments under the Low-Income Disproportionate Share Hospital (DSH) program.
- Requires the Health Care Authority (HCA) to comply with federal laws regarding the Low-Income DSH program.
- Removes the requirement that the Legislature appropriate funds specifically for the Low-Income DSH program.
- Eliminates provisions requiring the HCA to maintain a Medical Indigency DSH program and state-only hospital grants.
- Requires the HCA to keep expenditures on DSH payments within the federal DSH allotment.
- Authorizes the HCA to create DSH payment mechanisms in addition to the low-income component if sufficient funds are specifically appropriated for that purpose.

Hearing Date: 2/11/13

Staff: Erik Cornellier (786-7116).

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.

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.

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 are required to take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

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

The low-income component 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.

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 operating budget.

Summary of Bill:

The requirements for the low-income component of the DSH payments are reduced to consideration of the situation of hospitals serving a disproportionate number of low-income patients with special needs and compliance with federal requirements. The low-income component is no longer limited to funds appropriated specifically for that purpose.

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

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

The 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 the HCA may adopt rules to implement these provisions.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.