
Appropriations Committee

HB 2016

Brief Description: Concerning a hospital safety net assessment.

Sponsors: Representatives Jinkins, Hunter and Alexander.

Brief Summary of Bill

- Moves the expiration of the Hospital Safety Net Assessment program from July 1, 2013, to July 1, 2017.
- Continues and increases assessments on hospitals based on non-Medicare inpatient hospital days.
- Replaces increased inpatient and outpatient hospital payment rates with grants, supplemental payments, and increased managed care payment rates.
- Continues the Health Care Authority's system of quality incentive payments if funds are made available for that purpose.

Hearing Date: 3/25/13

Staff: Erik Cornellier (786-7116).

Background:

Medical Assistance.

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 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 (FFS) and managed care systems.

Managed Care.

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.

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 HCA Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under age 19, certain disabled individuals, and pregnant women a complete medical benefits package.

Disproportionate Share Hospitals.

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 uninsured. States make DSH payments directly to hospitals, and the federal government reimburses states 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.

Hospital Payment Systems.

The Federal Balanced Budget Act of 1997 established the Critical Access Hospital (CAH) Program. The program allows more flexibility in staffing and simplified billing methods, and it creates incentives to integrate health delivery systems. Washington currently has 38 hospitals certified as CAHs. Payments to CAHs under Washington's medical assistance programs are based on allowable costs.

Larger urban private hospitals are reimbursed under the Prospective Payment System (PPS) for inpatient services and the Outpatient Prospective Payment System for outpatient services.

The Certified Public Expenditures (CPE) program is a payment methodology that applies to public hospitals, including government-owned and operated hospitals that are not CAHs or state psychiatric hospitals. The CPE program's payment method applies to inpatient claims and DSH payments. The CPE program allows public hospitals to certify their expenses as the state share in order to receive federal matching Medicaid funds, which means that the state does not have to contribute the matching share of these expenditures.

Supplemental Payments.

In addition to reimbursement for Medicaid services, states can make supplemental payments to certain providers that are separate from and in addition to reimbursements made at standard payment rates. Supplemental payments are eligible for federal matching funds if aggregate payments to the providers receiving the supplemental payments are less than what Medicare would pay for the same services.

Medicaid Provider Taxes.

Provider taxes, including licensing fees and assessments, 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. Under federal rules, provider taxes include any mandatory payment, including licensing fees or assessments, in which at least 85 percent of the burden falls on health care providers.

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 cannot exceed Medicare reimbursement levels.

Hospital Safety Net Assessment Program.

Pursuant to Engrossed Second Substitute House Bill 2956 (hospital safety net assessment) in 2010 and Engrossed House Bill 2069 (hospital payments/safety net) in 2011, assessments are imposed on most hospitals, and proceeds from the assessments are deposited into the Hospital Safety Net Assessment Fund (Fund).

Money in the 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. The CAHs receive DSH payments or state-only access payments for hospitals that are not eligible for DSH payments.

The sum of \$199.8 million in the 2011-13 biennium may be expended from the Fund in lieu of State General Fund payments to hospitals. An additional sum of \$1 million per biennium may be disbursed from the Fund for payment of administrative expenses incurred by the HCA related to the assessment program.

The Hospital Safety Net Assessment (HSNA) program expires on July 1, 2013. Upon expiration of the program, hospital rates will either return to the levels in place on June 30, 2009, or to a rate structure specified in the 2013-15 operating budget.

Quality Incentive Payments.

As part of the original HSNA program the DSHS (now the HCA), in collaboration with the Department of Health, the Department of Labor and Industries, the Washington State Hospital Association (WSHA), the Puget Sound Health Alliance, and the Forum, was directed to design a system for providing quality incentive payments to hospitals.

The design of the system was required to 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. The system was required to minimize reporting burdens on hospitals by giving priority to measures that hospitals are currently required to report to government agencies. Measures were required to 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 were required to be designed so that all non-CAHs are able to receive the payments.

Starting in fiscal year 2013, the HCA could increase assessments to support an additional 1 percent increase in inpatient hospital payments for non-CAHs that meet quality incentive benchmarks.

Summary of Bill:

Expiration.

The expiration date of the HSNA program is moved from July 1, 2013, to July 1, 2017.

Intent.

The bill states that its 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 support additional payments to hospitals for Medicaid services.

The Legislature finds that federal health care reform will result in an expansion of Medicaid enrollment in the state. The Fund will improve the state's ability to provide Medicaid clients with access to hospital care by generating additional federal financial participation for the Medicaid program and to provide for additional reimbursement for hospital services and grants to CPE 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;
- to generate approximately \$345 million per state fiscal year in new state and federal funds to pay for Medicaid hospital services and grants to CPE hospitals in the form of additional payments to hospitals and managed care plans, which may not substitute for payments from other sources;
- the total amount assessed shall not exceed the amount needed, in combination with all other available funds, to support the 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 aggregate payment levels to hospitals for inpatient and outpatient services covered by Medicaid at least at the levels the state paid for those services on July 1, 2009, without the payment increases provided under the original Hospital Safety Net Assessment program.

Assessments.

Hospital provider assessments are imposed on PPS hospitals, CAHs, psychiatric hospitals, and rehabilitation 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 PPS hospital has more than 54,000 patient days per year. If required to obtain federal matching funds, that threshold may be adjusted to comply with federal requirements. The assessments range from \$7 to \$260 depending on the type of hospital and number of patient days. The HCA will calculate the amounts due annually and collect the assessments on a monthly basis.

If sufficient other funds are available to make the increased payments, including the quality incentive payments, the HCA will reduce the amount of the assessments to the minimum levels necessary to support those payments. Any actual or estimated surplus in the Fund at the end of a fiscal year must be applied to reduce the assessment amounts in the following fiscal year.

If the assessments will not produce sufficient funds to support the increased hospital payments, excluding the quality incentive payments, the HCA may increase the assessment rates proportionately by category of hospital to amounts no greater than necessary to make the payments.

The HCA, in cooperation with the Office of Financial Management (OFM), must develop rules for calculating the assessments to individual hospitals, notifying hospitals of the assessed amounts, and collecting the amounts due.

The HCA must provide data to the WSHA for review and comment at least 60 days before implementation of any revised assessment levels.

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 unless any of the specified hospital payments are reduced or eliminated. The HCA 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.

Increased Hospital Payments.

The increases in hospital payment rates provided under the original HSNA program are replaced with grants to CPE hospitals, supplemental payments to PPS, psychiatric, and rehabilitation hospitals, and increased managed care payment rates.

Public CPE hospitals receive grants from the Fund every fiscal year. The University of Washington Medical Center receives \$3.3 million. Harborview Medical Center receives \$7.6 million. Other CPE hospitals receive \$4.7 million divided between the individual hospitals based on managed care enrollment and utilization.

The HCA will provide supplemental payments from the Fund to PPS, psychiatric, rehabilitation, and border hospitals based on prior FFS utilization of inpatient and outpatient services every fiscal year. These payments will also include additional federal matching funds.

- The PPS hospitals will receive \$24,490,000 for inpatient payments and \$10,750,000 for outpatient payments.
- Psychiatric hospitals will receive \$625,000 for inpatient payments.
- Rehabilitation hospitals will receive \$150,000 for inpatient payments.
- Border hospitals will receive \$250,000 for inpatient payments and \$250,000 for outpatient payments.

If the HCA cannot disburse the entire amount of supplemental payments because they exceed the maximum allowable payments under federal law, the HCA will disburse the maximum allowable amount on supplemental payments and use the remaining assessment funds to increase payments to managed care organizations to the maximum allowable level. The HCA will use any remaining surplus assessment funds to proportionately reduce future assessments on PPS hospitals.

Rural CAHs receive \$1.9 million per fiscal year from the Fund plus federal matching funds in DSH payments. Critical Access Hospitals that are not eligible for DSH receive \$525 thousand that is divided between the individual hospitals based on prior FFS utilization.

The HCA will also use moneys from the Fund to increase capitation payments to managed care organizations by an amount at least equal to the amount available in the Fund after deducting disbursements for other specified purposes. The amount will be no less than \$128 million along

with the maximum available amount of federal funds. Payments to individual managed care organizations will be divided based on anticipated enrollment, utilization, or other factors that are reasonable and appropriate. The HCA will require managed care organizations to spend these funds for hospital services within 30 days after receipt. In fiscal years 2015, 2016, and 2017, the HCA will use any additional federal matching funds available from the Medicaid expansion under the federal Affordable Care Act to substitute for assessment funds that otherwise would have been used for the increased capitation payments. If total payments to managed care organizations exceed what is permitted under Medicaid laws and regulations, payments will be reduced to levels that meet the requirements and the balance of assessment funds remaining will be used to reduce future assessments.

The sum of \$150 million per biennium may be expended from the Fund in lieu of State General Fund payments to hospitals.

Quality Incentive Payments.

The HCA's authority to increase assessments to make quality incentive payments is removed. Instead, the HCA may provide the quality incentive payments if assessment funds or funds directed from any other lawful source are made available. The HCA may use assessment funds for these payments starting in fiscal year 2015.

Conditions.

The assessment, collection, and disbursement of assessment revenues is subject to three conditions. First, the federal Centers for Medicare and Medicaid Services (CMS) must approve any necessary state plan amendments or waivers. Second, the HCA must amend its contracts with managed care organizations to the extent necessary to comply with the provisions of the bill. Third, 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 any of five conditions is met. First, an appellate court or the CMS determines that any portion of the act is invalid, except for the section related to payments to CAHs that are not eligible for DSH payments. Second, funds generated by the assessment for payments to PPS hospitals or managed care organizations are determined ineligible for federal matching funds. Third, other funding sufficient to maintain aggregate payment levels to hospitals for inpatient and outpatient services at least at the levels the state paid on July 1, 2009, is not appropriated or available. Fourth, the new hospital payments from the Fund are reduced or not timely made. Fifth, the Fund is used as a substitute or to supplant other funds.

Appropriation: None.

Fiscal Note: Requested on March 19, 2013.

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