HOUSE BILL REPORT
ESSB 5913

As of Second Reading

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

Brief Description: Concerning a hospital safety net assessment and quality incentive program for increased hospital payments.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senator Becker).

Brief History:
Committee Activity:
None.

Brief Summary of Engrossed Substitute 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.
- Phases out assessments and payments over a four-year period starting in fiscal year 2016.
- Continues the Health Care Authority's system of quality incentive payments.

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Background:

Medical Assistance.

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.

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.

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 Department of Social and Health Services (now the HCA), in collaboration with the Department of Health, the Department of Labor and Industries, the Washington State Hospital Association (WSHA), and the Puget Sound Health

Alliance, 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 Engrossed Substitute 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 and in increase in federal financial participation. As a result, the assessment and the Fund will begin phasing down over a four-year period beginning in fiscal year 2016. The state will end its reliance on the assessment and the fund by the end of fiscal year 2019.

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 $446,338,000 per state fiscal year in fiscal years 2014 and 2015, and then phasing down in equal increments to zero by the end of fiscal year 2019, 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;
- to generate $199,800,000 million in assessment funds in the 2013-15 fiscal biennium, phasing down to zero by the end of the 2017-19 fiscal biennium, to be used in lieu of State General Fund payments for Medicaid hospital services;

- that 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 HSNA 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 assessment amounts range from $7 to $344 depending on the type of hospital and number of patient days.

Beginning in fiscal year 2015, the assessment amount will be reduced in approximately equal yearly increments each fiscal year until the assessment amount is zero by fiscal year 2020.

The HCA will calculate the amounts due annually and collect the assessments on a quarterly 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, including 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 others. 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.

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 total Medicaid payments.

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 $29,225,000 for inpatient payments and $30,000,000 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 the payments exceed the maximum allowable amount 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 $525,000 in access payments that are divided between the individual hospitals based on total Medicaid and State Children's Health Insurance Program payments.

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 $153,131,600 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 for the increased managed care payments resulting from the Medicaid expansion under the federal Patient Protection and 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.

Starting in fiscal year 2016, all of these payments, except for the DSH payments and access payments for CAHs, phase down to zero in approximately equal increments annually by the end of fiscal year 2019.

The sum of $199.8 million per biennium may be expended from the Fund in lieu of State General Fund payments to hospitals. That sum also phases down to zero in equal increments annually over four years starting in fiscal year 2016.

Quality Incentive Payments.

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. Hospitals must participate in the WSHA's collaboratives for setting quality incentive benchmarks to receive quality incentive payments.

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 ceases to be imposed if any of five conditions is met. First, the federal Department of Health and Human Services (HHS) and a court 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.

Contracts.

The HCA must offer to contract with a hospital that is required to pay the assessment for two-year periods each fiscal biennium. The HCA must agree to maintain the levels of the assessment, reimbursement rates, and increased payments during that period. In exchange, the hospital must agree not to challenge, administratively or in court, the adequacy of the reduced reimbursement rates in place after the rate restorations and increases from the current HSNA program are removed.

Appropriation: None.

Fiscal Note: Requested on April 24, 2013.

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

Staff Summary of Public Testimony:

(In support) None.

(Opposed) None.

Persons Testifying: None.

Persons Signed In To Testify But Not Testifying: None.