FINAL BILL REPORT
ESSB 5913

C 17 L 13 E 2
Synopsis as Enacted

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).

Senate Committee on Ways & Means
House Committee on Appropriations

Background: Provider charges, either assessments, fees, or taxes, have been used by some states to help fund the costs of the Medicaid program. Under federal rules, this would include any mandatory payment where at least 85 percent of the burden falls on health care providers. States collect funds from providers and pay them back as Medicaid payments, and states can claim the federal matching share of those payments.

To conform to federal laws, assessments, fees, and taxes must be generally redistributive in nature and no hospitals are held harmless from the burden of the assessment, fee, or tax. The charges must be broad based and uniform, which means they must be imposed on all providers in a given class and the same rate must apply across providers. If a charge is not broad based and uniform it must meet statistical tests which demonstrate that the amount of the charge is not directly correlated to Medicaid payments. Additionally, Medicaid payments for these services cannot exceed Medicare reimbursement levels.

The Legislature created a Hospital Safety Net Assessment (HSNA) 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. An assessment on non-Medicare inpatient days is imposed on most hospitals, and proceeds from the assessments are deposited into the HSNA 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 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

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may be disbursed from the Fund for payment of administrative expenses incurred by the Health Care Authority (HCA) related to the assessment program.

The 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.

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 PPS 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 Disproportionate Share Hospital (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 need to contribute the matching share of these expenditures.

As part of the original HSNA program, the Department of Social and Health Services – now 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 (FY) 2013, HCA could increase assessments to support an additional 1 percent increase in inpatient hospital payments for non-CAHs that meet quality incentive benchmarks.

Summary: The HSNA program is extended. The safety net assessment and the Fund will be phased down in equal increments over a four-year period starting in FY 2016 until the amounts are zero by the end of FY 2019.

The act specifies the intent of the Legislature:

- is to impose an HSNA to be used solely for the purposes specified in this act;
- is to generate approximately $446,938,000 for FY 2014 and FY 2015, and then phasing down in equal increments to zero by the end of FY 2019, in state and federal funds to pay for Medicaid hospital services and grants to CPE hospitals;
- is to generate $199,800,000 million in the 2013-15 biennium, phasing down to zero by the end of the 2017-19 biennium, in assessment funds per biennium to be used in lieu of state General Fund payments for Medicaid hospital services;
- is that the total amount assessed must not exceed the amount needed, in combination with all other available funds, to support the payments in this act; and
- is to condition the assessments 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. 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 $345 depending on the type of hospital and number of patient days. 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, 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 an FY must be applied to reduce the assessment amounts in the following FY.

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

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

HCA must provide data to 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. HCA may require hospital chief financial officers to submit certified statements that they did not increase 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.

Grants to CPE Hospitals. Public CPE hospitals receive grants from the Fund every FY. Starting in FY 2016, the grants from the Fund will be reduced in equal increments to zero by the end of FY 2019. The initial allocations in FY 2014 and FY 2015 include the following:

- the University of Washington Medical Center receives $3.3 million;
- Harborview Medical Center receives $7.6 million; and
- other CPE hospitals receive $4.7 million divided between the individual hospitals based on total Medicaid payments.

Fee-for-Service (FFS). 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 FY. Starting in FY 2016, the supplemental payments are reduced in equal increments from FY 2016 to zero in FY 2019. These payments will also include additional federal matching funds. The initial allocations in FY 2014 and FY 2015 include the following:

- the PPS hospitals will receive $28,125,000 for inpatient payments and $24,550,000 for outpatient payments;
- psychiatric hospitals will receive $625,000 for inpatient payments;
- rehabilitation hospitals will receive $150,000 for inpatient payments; and
- border hospitals will receive $250,000 for inpatient payments and $250,000 for outpatient payments.

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

Rural CAHs receive $1.9 million in FY 2014 and FY 2015 from the Fund plus federal matching funds in DSH payments, reduced in equal increments to zero in FY 2019. CAHs that are not eligible for DSH receive $520,000 in FY 2014 and FY 2015, reduced in equal increments to zero in FY 2019 that is divided between the individual hospitals based on total Medicaid payments.

Managed Care. HCA will also use monies 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 in FY 2014 and FY 2015, decreasing in equal increments to zero in FY 2019, 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. HCA will require managed care organizations to spend these funds for hospital services within 30 days after receipt. In FYs 2015, 2016, and 2017, HCA will use any additional federal matching funds available for the increased managed care payments resulting from the Medicaid expansion under the federal Affordable

Care Act to substitute for assessment funds that otherwise would be 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 $199.8 million in the 2013-15 biennium, phasing down to zero by the end of the 2017-19 biennium may be expended from the Fund in lieu of state General Fund payments to hospitals.

Quality Incentive Payments. If sufficient funds are made available, HCA and WSHA must design a quality incentive payment system based on the following principles:

- evidence-based treatment and processes to improve health outcomes for hospital patients;
- effective purchasing strategies to improve quality;
- quality measures chosen for the system should be consistent with the standards that were developed by the national quality improvement organizations;
- benchmarks for each quality improvement measure should be set at levels that are feasible for hospitals to achieve; and
- incentive payments should be designed so that all non-CAHs are able to receive the payments if performance is at or above the benchmark score.

Conditions. 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 hospitals 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.

Expiration . The chapter expires July 1, 2017.

Votes on Final Passage:

Senate	35	11

Second Special Session

Senate	33	13
House	70	22

Effective: June 30, 2013