Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Appropriations Committee

SSB 6045

Brief Description: Extending the hospital safety net assessment.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Becker and Frockt).

Brief Summary of Substitute Bill

- Moves the expiration of the Hospital Safety Net Assessment (HSNA) program from July 1, 2017, to July 1, 2019.
- Removes provisions requiring a phase down of the HSNA by FY 2019.
- Increases assessment amounts on some hospitals.
- Changes the amounts of payments to hospitals from the HSNA Fund.
- Increases the amount of assessment dollars that the state may use in lieu of State General Fund payments to hospitals.

Hearing Date: 4/20/15

Staff: Erik Cornellier (786-7116).

Background:

Medicaid Provider Charges.
Provider charges, such as 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 can be 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

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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.

Hospital Payment Methods.
The Health Care Authority (HCA) manages the Hospital Safety Net Assessment (HSNA) program. An assessment on non-Medicare inpatient days is imposed on most hospitals, and proceeds from the assessment are deposited into the HSNA Fund (Fund).

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.

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 $344 depending on the type of hospital and number of patient days. The HCA calculates the amounts due annually and collects 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 amounts 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 (FY) must be applied to reduce the assessment amounts in the following FY.

Hospital Payments.
Money in the Fund may be used for various increases in hospital payments, including grants to CPE hospitals; fee-for-service 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. 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. The HCA provides supplemental payments from the Fund to PPS, psychiatric, rehabilitation, and border hospitals based on prior FFS utilization of inpatient and outpatient services. Starting in FY 2016, the supplemental payments are reduced in equal increments from FY 2016 to zero in FY 2019. These payments also include additional federal matching funds. The initial allocations in FY 2014 and FY 2015 include the following:

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

Managed Care. The HCA uses 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 must 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 are divided based on anticipated enrollment, utilization, or other factors that are reasonable and appropriate. The HCA requires managed care organizations to spend these dollars for hospital services within 30 days after receipt. In FYs 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 Affordable Care Act to substitute for assessment dollars 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.

Rural 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. Critical Access Hospitals that are not DSH eligible 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.

The HCA uses any remaining surplus assessment dollars to proportionately reduce future assessments on PPS hospitals.

The sum of $199.8 million in the 2013-15 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 Health Care Authority (HCA) related to the assessment program.

Phase-Down and Expiration.
The HSNA expires on July 1, 2017. The assessments and payments phase down in equal increments over a four-year period starting in FY 2016 until the amounts are zero by the end of FY 2019.

Summary of Bill:

Phase-Down and Expiration.
The expiration of the HSNA program is extended from July 1, 2017, to July 1, 2019. The assessments and payments no longer phase down to zero by the end of FY 2019.

Assessments.
The amounts of annual assessments per non-Medicare bed day paid by hospitals are revised to the following amounts:

- Prospective Payment System hospitals must pay no more than $367 instead of $344.
- Psychiatric hospitals must pay more than $72 instead of $67.
- Rehabilitation hospitals must pay no more than $72 instead of $67.

Other assessment amounts remain unchanged.

Hospital Payments.
Fee-for-service and managed care payments to hospitals are revised.

Fee-for-service payments are as follows:

- University of Washington Medical Center receives $14,605,000, of which:
  - $4,455,000 is a grant;
  - $8,150,000 is for family residency; and
  - $2,000,000 is for integrated, evidence-based psychiatry residency.
- Harborview Medical Center receives $10,260,000.
- All other CPE hospitals receive $6,345,000.
- Critical Access Hospitals that do not receive Disproportionate Share Hospital (DSH) payments receive $702,000.
- Critical Access Hospitals that are eligible for DSH receive $1,336,000 in DSH payments.
- Inpatient PPS hospitals receive $24,087,500 plus federal matching funds.
- Inpatient psychiatric hospitals receive $875,000 plus federal matching funds.
- Inpatient rehabilitation hospitals receive $225,000 plus federal matching funds.

Managed care payments must be no less than $100 million, plus federal matching funds. Additional federal matching dollars from the Medicaid expansion will no longer substitute for HSNA dollars.

The sums of $330 million in the 2015-17 biennium and $314 million in the 2017-19 biennium may be expended from the Fund in lieu of state general fund payments to hospitals.

Other payment amounts remain unchanged.

HSNA Administration.

The HCA must provide the Washington State Hospital Association with a monthly report showing the amount of payments made to managed care plans, including the amount of additional premium tax payments.

Provisions for contracting between hospitals and the HCA are changed to allow extension of existing contracts and to disallow reductions in aggregate payments based on variations based on budget-neutral rebasing of payment rates.

Appropriation: None.

Fiscal Note: Available.

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