HOUSE BILL REPORT
SSB 6045

As Reported by House Committee On:
Appropriations

Title: An act relating to continuation of the hospital safety net assessment for two additional biennia.

Brief Description: Extending the hospital safety net assessment.

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

Brief History:
Committee Activity:
Appropriations: 4/20/15, 4/21/15 [DPA].

Brief Summary of Substitute Bill
(As Amended by Committee)

- 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 fiscal year 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.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended. Signed by 30 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Chandler, Ranking Minority Member; Parker, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Carlyle, Cody, Dent, Dunshee, Fagan, Haler, Hansen, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, MacEwen, Magendanz, Pettigrew, Sawyer, Schmick, Senn, Springer, Stokesbary, Sullivan, Tharinger, Van Werven and Walkinshaw.

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.

Minority Report: Do not pass. Signed by 3 members: Representatives Condotta, G. Hunt and Taylor.

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 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, 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.
- 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 fee-for-service 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.
- 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 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 Amended 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 $345 instead of $344.
- Psychiatric hospitals must pay more than $68 instead of $67.
- Rehabilitation hospitals must pay no more than $68 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:

- The University of Washington Medical Center receives $4,455,000.
- 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 $29,162,500 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 $283 million per biennium may be expended from the Fund in lieu of State General Fund payments to hospitals.

Other payment amounts remain unchanged.

Hospital Safety Net Assessment 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 from variations based on budget-neutral rebasing of payment rates.

Amended Bill Compared to Substitute Bill:

Assessments.
The maximum assessment on private urban hospitals is decreased from $367 to $345 per non-Medicare bed day.

The maximum assessment on psychiatric and rehabilitation hospitals is reduced from $72 to $68 per non-Medicare bed day.

Hospital Payments.
The annual payments of $10,150,000 from the Hospital Safety Net Assessment Fund (Fund) to the University of Washington Medical Center for family and psychiatric residencies are removed.

Annual payments from the Fund for fee-for-service inpatient services are increased by $5,075,000.

The amount that the state may use from the Fund in lieu of General Fund-State payments to hospitals is reduced from $330,000,000 in the 2015-2017 fiscal biennium and $314,000,000 in the 2017-2019 fiscal biennium to $283,000,000 in both biennia.

Hospital Safety Net Assessment Administration.

The HCA may use a surplus in the Fund to reduce assessments in the following years through FY 2019.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) None.

(Opposed) The House approach to extending the HSNA program is better than the Senate approach. There is a great risk in the ability to sustain the Senate approach statewide.

Hospitals have been in this conversation since 2010 and, with the recession, hospitals recognized the potential for decreased access to services and decreased payment rates. The hospitals wanted to stabilize the system.

It has been a bumpy ride, but it has been working lately. In the past, hospitals felt that their trust was pushed aside. The Legislature had redirected the assessments, making many hospitals net losers, which set off a dynamic that is difficult to manage in the state. This is a partnership with the state and a way for hospitals to voluntarily agree to be taxed in a way that leverages the State General Fund.

The HSNA program is supported by only a fragile coalition of hospitals. In 2010 hospitals supported the program because it was important to support the safety net in the state. Hospitals support it today with trepidation. Getting to this point took a lot of work among Washington hospitals. It is a fragile consensus.

There are concerns with the Senate budget. Just a few years ago, the Legislature redirected funds. Hospitals paid more in assessments than they received in payments. Prospective Payment System hospitals lost $80 million. The Senate seems to be heading down the same path.

The House proposal would increase hospital funding and care for thousands of new Medicaid enrollees. It would remove the ratchet and maximize federal dollars. The idea of securing additional funds is an idea that the hospitals brought forward. The version the hospitals brought forward brings $140 million to the state and enjoys the support of the hospitals. National experts helped develop the House proposal.

The Senate version is undesirable. It increases the tax rate. The Senate bill takes a substantially increased amount of assessment dollars into the State General Fund. Hospitals

have been voluntarily bringing this forward, but they cannot maintain support at the Senate level.

The Senate bill treats hospitals inequitably. Hospitals receive money through different routes and, regardless of the source, the benefits to hospitals must be equitable. Some hospitals are not taxed, but all benefit significantly. The House bill carefully balances the benefits to hospitals regardless of how they pay taxes. Under the Senate bill, some hospitals are insulated. In particular, public hospitals are insulated while others are impacted. Virginia Mason pays millions and gets little direct return. Funds for residencies are taken directly from non-public urban hospitals.

The House budget achieves the shared goal of increasing state funds and preserving high-quality medical services for Medicaid beneficiaries. Small rural hospitals get more funding, safety net hospitals sustain funding during the downturn, there are more dollars for Healthy Options, and the Medicaid Quality Incentive program is funded.

Questions have emerged about how to support increased coverage under the Affordable Care Act (ACA). The coverage expansion was achieved primarily through Medicaid, which pays below the cost of care. Without the assessments, Medicaid pays less than 90 percent of inpatient costs and 50 percent of outpatient costs. The assessment is important to support institutions seeing Medicaid patients. The ACA was funded through significant Medicare cuts. Over 10 years Medicare payments will decrease by $5 billion. That was designed to be reconciled with increased coverage under the Medicaid expansion.

While hospitals support residencies, they do not support the way they are funded in the Senate bill. It localizes the benefit from taxes imposed on all hospitals.

(Other) There is a need for more graduate medical education and residencies. The level of funding in the bill and the Senate budget will support residencies in rural areas. Hospitals have spent millions to get residencies nationally accredited. There are 167 slots ready the minute the Legislature writes the check. It would be a shame for the network to get to this point and then not have the funding.

This bill grants the University of Washington significant and meaningful funding to expand the family residency program. This funding should be maintained in some form. If the Legislature determines that the assessment is not the appropriate source, then it should find the funding elsewhere. The question should not be whether residencies are funded, just the source of the funding.

Residencies are critical for integrated care, prevention, early detection, and treatment of mental illness. The location of a doctor's residency is the primary factor in determining where that doctor will practice.

The Legislature invested in the Medicaid expansion. There is a workforce shortage coming. Residencies are vital to the sustainability of the programs the Legislature has invested in.

The House funded residencies at $4.9 million of a $16 million request, and $4.9 million is insufficient to fund the program. The source of funding is not as important as the level of

funding. Hopefully, the Legislature will provide more than the $4.9 million provided in the proposed House budget.

Please do not forget family medicine residencies.

Persons Testifying: (Opposed) Scott Bond, Washington State Hospital Association; Sarah Patterson, Virginia Mason Medical Center; and Joel Gilbertson, Providence Health and Services.

(Other) Susie Tracy, Family Medicine Residency Network; Jonathan Seib, Washington Academy of Family Physicians; and Katie Kolan, Washington State Medical Association.

Persons Signed In To Testify But Not Testifying: None.