SENATE BILL REPORT
SB 6045

As Reported by Senate Committee On:
Ways & Means, April 1, 2015

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: Senators Becker and Frockt.

Brief History:
Committee Activity: Ways & Means: 3/24/15, 4/01/15 [DPS, DNP].

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 6045 be substituted therefor, and the substitute bill do pass.

Signed by Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Honeyford, Vice Chair, Capital Budget Chair; Bailey, Becker, Brown, Hewitt, O'Ban, Padden, Parlette, Schoesler and Warnick.

Minority Report: Do not pass.

Signed by Senators Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Ranking Minority Member, Operating; Billig, Conway, Fraser, Hasegawa, Hatfield, Kohl-Welles and Rolfes.

Staff: Sandy Stith (786-7710)

Background: Health care provider-related charges, such as assessments, fees, or taxes, have been used in some states to help fund the costs of the Medicaid program. Under federal rules, these provider-related charges include any mandatory payment where at least 85 percent of the burden falls on health care providers. States collect funds from health care providers and pay them back as Medicaid payments. States use these provider-related payments to claim federal matching funds.

To conform to federal laws, health care provider-related assessments, fees, and taxes must be broad based, uniform, and in compliance with hold harmless provisions. To be broad based and uniform, respectively, they must be applied to all providers of the same class and be

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imposed at the same rate to each provider in that class. If a provider-related assessment, fee, or tax is not broad based or uniform, these provisions may be waived if the assessment, fee or tax is generally redistributive. The hold harmless provision may not be waived. 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; Engrossed House Bill 2069 – hospital payments/safety net in 2011; and Engrossed Senate Substitute Bill 5913 – hospital payments/quality incentive in 2013. 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. In 2013 the way in which the increases were addressed was changed from a specific percentage inpatient and outpatient rate increases to an overall level of increase. The overall level of increase was split between fee for service and managed care payments.

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.

The HSNA program was to originally expire on July 1, 2013. Under the 2013 legislation, the program will now expire on July 1, 2017. 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.

Additionally, under the 2013 legislation, the HSNA program will phase down in equal increments over four years beginning in 2016. The phase down applies to both payments to hospitals and the amounts used in lieu of general fund payments to hospitals and will phase to zero by the end of fiscal year (FY) 2019.

As a condition of these changes under the 2013 legislation, HCA was required to offer to contract with a hospital required to pay the assessment for two-year periods each fiscal biennium. HCA was required to agree to maintain the levels of the assessment, reimbursement rates, and increased payments during that period. In exchange, the hospitals were required to 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.

Summary of Bill (Recommended Substitute): The HSNA program is extended. The phase down of the program over a four-year period, beginning in 2016, is eliminated.

The act specifies the intent of the Legislature is to:

- impose an HSNA to be used solely for the purposes specified in this act;
- increase payments to hospitals to approximately $501 million for FY 2016 and FY 2017 in state and federal funds to pay for Medicaid hospital services and grants to Certified Public Expenditure (CPE) and Critical Access Hospitals (CAHs);
- increase funds per biennium to be used in lieu of state general fund payments for Medicaid hospital services to $330 million in 2015-17 and $314 million in 2017-19; and
- carry any unexpended balance from a fiscal year into the following two fiscal years to reduce the amount of assessments paid under RCW 74.60.050(1)(c).

Hospitals are assessed based on their non-Medicare inpatient bed days. Assessments are billed on a quarterly basis. The amount of annual assessments per non-Medicare bed day paid by hospitals are revised to the following amounts:

- Prospective Payment System (PPS) hospitals must be no more than $367 – up to a maximum of 54,000 bed days per year;
- psychiatric hospitals must be no more than $72; and
- rehabilitation hospitals must be no more than $72.

Some assessment amounts remain unchanged.

Hospitals receive payments through the HSNA program under both fee-for-service and managed care. Fee-for-service payments are made quarterly, before the end of each quarter. Managed care payments are made through the managed care plans. Payments to hospitals are specifically changed to the following annual levels.

Fee-for-service increases are as follows:

1. University of Washington Medical Center – $14,605,000, of which:
    a. $4,455,000 is a grant;
    b. $10,150,000 is for family residency; and
    c. $2,000,000 is for integrated, evidence-based psychiatry residency;
2. Harborview Medical Center – $10,260,000;
3. all other CPE hospitals – $6,345,000;
4. CAHs that do not receive Disproportionate Share Hospital (DSH) payments – $702,000;
5. CAHs that do receive DSH payments – $1,336,000;
6. inpatient PPS hospitals – $24,087,500 plus federal matching funds;
7. inpatient psychiatric hospitals – $875,000 plus federal matching funds; and
8. inpatient rehabilitation hospitals – $225,000 plus federal matching funds.

Managed care change is as follows:

- no less than $100 million, plus federal matching funds. Additional federal matching funds from the Medicaid expansion will no longer substitute for HSNA funds.

Some payment amounts remain unchanged.

HCA must provide the Washington State Hospital Association a monthly report showing the amount of payments made to managed care plans, including the amount of additional premium tax, under RCW 74.60.130.

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

The expiration of the chapter is extended from July 1, 2017, to July 1, 2019. Upon expiration, rates return to the level they were on July 1, 2015.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Recommended Substitute):

- Increases the amount to be used in lieu of state general fund payments for Medicaid hospital services from $283 million to $330 million in 2015-17, and $314 million in 2017-19.
- Increases the maximum amount of assessment per non-Medicaid inpatient hospital bed day from $345 to $367 – PPS hospitals.
- Increases the maximum amount of assessment per non-Medicaid inpatient hospital bed day from $68 to $72 – psychiatric and rehabilitation hospitals.
- Reduces fee-for-service inpatient hospital payments from $29,162,500 to $24,087,500.
- Increases payments to University of Washington from $4,455,000 to $14,605,000, including $8,150,000 for family residency and $2,000,000 for integrated, evidence-based psychiatry residency.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony on Original Bill: PRO: We did a work session earlier with the committee. We are enthusiastically in support of the bill. It provides the state general fund an additional $140 million this biennium. It does this in two ways: by removing the ratchet down and by maximizing the federal match that can be achieved through the program. It is a very important piece in balancing the budget. The bill has been worked and the returns to the state have been modeled over a four-year period. HCA supports the bill as it is consistent with the Governor's budget. In addition to eliminating the phase down, it updates some of the provisions related to hospital payment levels. HCA has actively communicated with the Hospital Association, Office of Financial Management and legislative staff on this bill.

Persons Testifying: PRO: Len McComb, WA State Hospital Assn.; Carl Yanagida, HCA, Deputy Chief Financial Officer; Dylan Oxford, HCA.

Persons Signed in to Testify But Not Testifying: No one.