Washington State Hospital Association

2019
POLICY BRIEF

Hospital Safety Net Assessment Program

Background

The Medicaid program significantly underpays hospitals for the costs of providing services to its clients. This creates financial problems for Washington's safety net hospitals, which provide services to a significant proportion of Medicaid patients.

In 2010, to help support safety net providers following a $400 million budget cut to Medicaid rates during the recession, Washington State enacted a hospital-supported assessment program. This program assesses hospitals and then uses the funds to augment the state contribution for Medicaid payment. This enables the state to obtain additional federal matching funds for hospital services. Depending on the hospital type, hospitals receive Medicaid supplemental fee-for-service or grants and managed care payments and, where appropriate, Small Rural DSH program payments. Hospitals also receive payments from the Medicaid Quality Incentive Program, which provides a one percent Medicaid inpatient payment rate increase for hospitals that meet quality and financial reporting criteria.

In addition to supporting payments for Medicaid services, the assessment provides significant additional revenue for the state general fund. It also supports family practice residencies and training for integrated behavioral health care.

In 2012, hospitals worked with the legislature to reformulate the program. The program currently provides approximately $146 million per year to hospitals, and about $146 million to the state general fund. The program is currently set to expire on July 1, 2021 but needs to be extended for another two years to meet the state's four-year budget outlook requirements.

WSHA Position

WSHA strongly supports extension of the Hospital Safety Net Assessment program. The funding provided by the program is urgently needed for hospitals to meet the needs of Medicaid patients in their communities. The program also provides additional revenue for the state.

Key Messages

- The Hospital Safety Net Assessment program provides about $146 million in funding for hospital services for Medicaid patients and about $146 million in additional revenue to the state general fund.
- The program requires no state funds. The funding comes from assessments from hospitals and federal match.
- The expiration date of the safety net program must be extended to meet state budget requirements, allowing the state to count the revenue in the 4-year balanced budget calculations.
- The bill retains the existing structure of the program. It includes minor changes to assist in the collection of assessments by the Health Care Authority and makes the program more equitable for several hospitals with recent changes in ownership.

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Washington State Hospital Association

2019
POLICY BRIEF

Rural Multi-Payer Model

Background

The Health Care Authority (HCA) is currently engaging rural providers, payers, and other partners to participate in a rural multi-payer model aimed at supporting rural health system transformation. HCA is also in the process of negotiating with the Centers for Medicare and Medicaid Services about Medicare's participation in a new payment model. To date, WSHA and its rural hospital members have actively engaged in this process with HCA. Details regarding the plan continue to evolve.

WSHA Position

WSHA supports the legislature establishing reasonable guardrails for the new payment model that will ensure the long-term sustainability of the rural health system and maintain local community decision making. We believe that transformation is crucial to ensure our rural hospitals are able to continue to deliver high quality, local care. Rural hospitals vary in size and each rural community is unique and the challenges they face are complex. Some rural hospitals are struggling financially. Any new payment system must work for all rural hospitals.

Key Messages

- Participation in any new payment model must be voluntary.
- Washington's rural hospitals are committed to transforming to better meet the needs of their local communities.
- Care transformation requires investment; hospitals must be supported as they transition to a new model.
- Different sized hospitals have different needs. Any new payment model must work for the unique needs of small and large hospitals alike.
- WSHA's members are committed to working with the legislature and the Health Care Authority to find a sustainable model for rural health care.

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Washington State Hospital Association

2019 **POLICY** BRIEF

Medical Debt: Ensure Hospitals are Paid for Care Provided

Background

Hospitals and health care providers must be financially stable in order to provide quality, safe, affordable health care, yet there are proposals that would significantly reduce their ability to be paid for services provided. Hospitals and health care providers will be harmed if laws are passed that encourage patients to pay medical debts last. Health care is provided to patients with the understanding that they will pay. Unlike many other services, there is no requirement that patients prepay for hospital care. However, hospitals incur significant expenses to provide care.

WSHA Position

WSHA supports measures to ensure consumers are aware of amounts owed for medical services and have the information to resolve their accounts, including information about charity care. WSHA strongly opposes discouraging paying medical debt by prohibiting or limiting prejudgment, post-judgment, and garnishment only for medical debt. WSHA supports a thoughtful approach to the challenge of the cost of health care, but the approach must recognize that hospital services are expensive. Labor-intensive care, pharmaceuticals, equipment and supplies – all these must be paid for. Patients who can pay should do so.

Key Messages

- WSHA supports measures to ensure that patients have the time and information needed to pay bills and resolve outstanding debts. These measures include:
  - Requiring a set time period before a debt can be assigned or sold to a collection agency, during which time patients are protected from interest and adverse credit actions.
  - Requiring that collection agencies provide information regarding financial assistance and cease collection efforts if a patient applies for financial assistance.
  - Prohibiting the use of bench warrants and certain other practices used by collection agencies.
- The use of prejudgment and post-judgment interest is an important tool for creditors to collect amounts owed for services provided. If medical debt is singled out as less important, hospitals will have difficulty collecting from patients who can and should pay their portion of a bill. Hospitals, particularly those that receive taxpayer support, have a fiduciary responsibility to collect from patients who are able to pay.
- WSHA worked with the state legislature in 2018 to strengthen the state charity care law to ensure patients are aware of the opportunity to request charity care. Hospitals currently provide notice about the availability of charity care on all patient bills, on hospital websites, and on signs posted in hospitals. Patients who earn up to 300% of the federal poverty level are eligible for free or reduced cost care and many hospitals are more generous.
- There are already safeguards in place to give patients notice about a bill and time to pay. Hospitals do not assess prejudgment interest on delinquent bills until a bill is assigned to collections. The current practice is for hospitals to allow significant time before a patient is sent to collections – typically 4-6 months.

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Washington State Hospital Association

2019
POLICY BRIEF

Wrongful Death: Maintaining a Stable Structure for Health Care-Related Liability

Background

"Wrongful death" is a legal term for a death caused by the act of another. Long-standing state law allows certain people to sue and recover certain damages for the wrongful death of a loved one; a spouse or child may sue, but a parent or sibling may sue only if they are economically dependent on the deceased and are US citizens. A tragic accident involving a Ride-the-Ducks vehicle in 2015 identified the unfairness of the US citizen requirement. A 2018 bill proposed removing the citizenship requirement, but it also proposed removing the financial dependence requirements for parents and siblings and would have greatly expanded the damages that all relatives can recover.

WSHA Position

Changes to the wrongful death statute should be limited to the removal of residency requirements. WSHA is very concerned about, and opposes, expanding the basis for recovery and the categories of damages that may be recovered.

Key Messages

- Washington State law currently maintains a strong and stable structure for health care-related liability, including wrongful death.
- Changes to the wrongful death statute should be limited to the removal of residency requirements. This would address the unfairness identified in the Ride-the-Ducks tragedy.
- Current law strikes a delicate balance: certain family members and those who are financially dependent may be compensated for their loss while recognizing health care providers cannot have unending liability. Under current state law, hospitals face the entire cost of a wrongful death award - even if it is only 1% at fault.
- Hospitals provide vital services and are pillars of our communities. Expanding the law on who may sue and for what types of damages dramatically expands liability. In turn, this may result in liability insurance premiums spiking and may make it more difficult for hospitals to provide patients access to services, particularly in more rural areas.

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Washington State Hospital Association

2019
POLICY BRIEF

Public Option Health Insurance Plans on the Individual Market

Background

In recent years, Washington State has made great strides in increasing health care coverage by expanding Medicaid eligibility and creating the Health Benefit Exchange (exchange). As a result, the state's uninsured rate is 5.5 percent (about 400,000 people) – among the lowest in the nation and in Washington State history. Hospitals were and continue to be at the forefront in advocating for increased access to health care and health insurance.

Despite these efforts, some people seeking coverage on the individual health insurance market, usually middle-income people who do not have employer-sponsored coverage and do not qualify for Medicaid, face affordability challenges. This includes higher premiums, smaller service areas, and narrower provider networks. This instability has been intensified by the federal government recently removing the penalty for not having health insurance coverage. As a result, premiums and deductibles continue to rise. During the 2019 open enrollment period, over 220,000 Washingtonians enrolled in a health plan through the exchange – slightly lower than last year.

To help address the remaining number of uninsured, our state's lawmakers are examining ways to stabilize the individual insurance market. One chief way being considered is creating a public option health insurance plan for individuals who may not otherwise be able to afford to purchase coverage on the exchange.

WSHA Position

WSHA supports efforts to expand access to health care and health coverage. Washingtonians should have comprehensive, high-quality health care, and not solely in an emergency room. During the last several years, WSHA was a leading advocate for expanding health care coverage to children and adults.

WSHA supports a comprehensive strategy to develop funding mechanisms to increase coverage for low- and middle-income Washingtonians. However, hospitals have concerns about any proposal that would reimburse providers below the cost of delivering patient care. This includes benchmarking any provider and hospital rates to Medicare. Currently, hospital and health system financing is a delicate balance with commercial plans, including those on the exchange, paying above the cost of care in order to offset the known underpayments from Medicare and Medicaid.

Key Messages

- Hospitals support expanding coverage to Washingtonians across the state. Stable insurance markets can help ensure access, which in turn, can help patients get the right care, at the right time, and in the right place.
- Washingtonians need access to a robust network of caregivers. Currently, Medicare patients find it difficult to access an array of services, such as specialty care and rehabilitative services, because Medicare rates are artificially low and do not reflect the cost of care. If more people have coverage that reimburses at Medicare rates, then this difficulty in accessing necessary services at hospitals and throughout the full spectrum of care will only increase. Coverage without access creates a false promise to patients.
- Through the Affordable Care Act (ACA), hospitals took cuts in Medicare and disproportionate share hospital payments to help finance expanded Medicaid coverage and subsidized commercial coverage in the exchange.

The ACA provided a comprehensive array of funding mechanisms and incentives to providers. On balance, the cuts and increased access in the ACA made sense. However, a plan that pulls funding entirely from provider payments is untenable. Our state's hospitals stand ready to care for all Washingtonians, but they need a stable and feasible financial structure.

- Any solution involving a public option for Washingtonians will have a significant impact on our state's health care system. It needs to be thoughtful and factor in core principles of insurance including adequate provider reimbursement rates, utilization management, and network adequacy standards. Hospitals want to be part of addressing affordability issues.
- Safety-net and rural hospitals, those with high concentrations of patients on Medicare and Medicaid, will have significant difficultly providing care to patients while absorbing the additional losses from a public option plan.
- While this coverage expansion is aimed at the individual market, if the premium costs are lower, it is likely that small groups would move their enrollees to it, further destabilizing the balance of the insurance market.

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Washington State Hospital Association

2019
POLICY BRIEF

Increase Access to Mental Health Services

Background

WSHA supports a comprehensive behavioral health plan. In particular, WSHA is working on policy areas that can improve the behavioral health system including:

Long-term mental health care in the community. Concentrating all long-term mental health placements at Eastern and Western State Hospitals is not working. Some general-acute care and freestanding psychiatric community hospitals are interested in providing long-term, court-ordered mental health services, but we need to change state law to allow it.

Certificate of Need for psychiatric beds. The current Certificate of Need (CN) exemption for psychiatric beds expires on June 30, 2019. This exemption allows hospitals licensed under 70.41 RCW to be exempt from CN requirements for the addition of new psychiatric beds and allow freestanding psychiatric hospitals licensed under 71.12 RCW to be exempt from CN requirements for a one-time addition of 30 beds if they serve the safety-net population.

WSHA Position

Our patients and families need more mental health services closer to home. WSHA has identified policy areas where changes in law would create more mental health treatment capacity so that hospitals/health systems and other providers could do more to serve people with mental health needs. We support legislation to:

- Direct the state to contract with community hospitals to provide long-term care and treatment for mental health services in communities across the state for 90- and 180-day commitment orders; and
- Continue to exempt licensed hospitals for two years from the arduous CN process for psychiatric beds.

Key Messages

Long-term mental health in the community

- Patients on long-term civil commitment orders will be better served not in state hospitals, but when they are closer to their home, communities, and families. They may be less likely to be readmitted for care and have shorter durations of stay. Washington hospitals stand ready to help the state address the growing demand for long-term civil commitment services.
- Legislation would help expand the state's inpatient psychiatric capacity by permitting acute care and freestanding psychiatric hospitals to serve patients on 90- and 180-day civil commitment orders. Currently, there are four acute care hospitals in Pierce, Snohomish, and Yakima counties willing to provide 35 long-term involuntary commitment psychiatric beds and three psychiatric hospitals in King County that can provide 46 more beds to help expand the state's mental health capacity in the community.

Certificate of Need for psychiatric beds

- The legislature has twice allowed licensed hospitals to be exempted from CN requirements for new beds, but those provisions will expire on June 30, 2019. Legislation would extend that exemption for two more years.
- At least six beds dedicated to patients on 90- and 180-day involuntary commitment orders would be added to the state's capacity if the legislature extends the CN exemption. Other beds that could be added include 30 short-term psychiatric beds.

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Washington State Hospital Association

2019
POLICY BRIEF

Opioids: Combating the Crisis

Background

Communities across the state are experiencing an opioid crisis. To address the crisis, WSHA in collaboration with the Washington State Medical Association (WSMA) and the state Department of Health advanced legislation in both the 2016 and 2017 legislative sessions. The laws established new guidelines for opioid prescribing, increased access to the state's prescription drug monitoring program (PMP) and provided information to stop overdose deaths. While additional work remains to increase access to treatment for those struggling with opioid use disorder, as a state, we should make sure that any new laws and requirements take in to account that much of this work is currently in progress, and time and resources are needed to fully implement the new rules.

WSHA Position

We strongly support efforts to expand access to non-opioid interventions for pain treatment and enhancements to the PMP with interstate data sharing. Access to non-opioid interventions for pain treatment would better address patient needs while reducing the risk of substance use disorder.

We oppose legislative efforts that would establish pill count limits and mandate providers to check the PMP – they ignore the work under HB 1427 passed in 2017, and the recent prescribing rules implemented by state boards and commissions. We also oppose rigid PMP and electronic medical record (EMR) integration requirements as they ignore local challenges and fail to consider that many EMR vendors do not offer integration options. Many hospitals have already integrated and are in the process of integration; for those remaining, focusing on addressing the challenges to integration would be a more effective approach, rather than a mandate.

Key Messages

- Combatting the opioid crisis is a top priority for WSHA.
- Patients need access to non-opioid therapies to help treat pain and reduce the risk of substance use disorder. For example, Medicaid currently does not pay for physical therapy.
- This fall, several boards and commissions adopted opioid prescribing rules, which hospitals and health care entities are now in the midst of implementing.
- In an effort to reduce opioid prescribing, WSHA and our partners are giving reports on individual prescribing rates to hospitals/health systems and large provider groups. To date, we have over 18,000 providers participating, and we are actively recruiting more.
- Hospitals and providers want PMP data integrated in their EMR, but integration needs to be done in a way that works with existing IT systems and has appropriate support and fiscal resources.

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Washington State Hospital Association

2019
POLICY BRIEF

Health Care Decision Making for Incapacitated Patients

Background

WSHA strongly supports a bill to improve decision making for patients who lack capacity. Hospitals want to help patients make sure their health care decisions are honored.

Expanding surrogate decision makers. Washington State's current informed consent law allows a very limited range of people to make medical decisions on behalf of a patient who is incapacitated. More than 30 other states let additional adult relatives and close friends make medical decisions for a loved one.

Authorizing advance directives. Patients can use several types of legal documents to express their wishes for health care, including a durable power of attorney and an advance directive. These documents can be especially important for end of life care. Currently, these two documents can't be finalized in the same way, making it difficult and confusing for people to legally express their wishes.

WSHA Position

WSHA supports a bill to improve decision making for patients who lack capacity. The bill addresses (1) who is authorized to be a surrogate decision maker; and (2) who is authorized to formally witness an advance directive by:

- Adding specific family members and close friends to the hierarchy of who may act as a decision maker.
- Aligning the execution of an advance directive with a durable power of attorney by allowing a notary to acknowledge the advance directive and allowing a witness to verify the identity of a person executing an advance directive.

Key Messages

- Current state law has a hierarchy that allows only a few types of family members to make medical decisions for an incapacitated loved one. Unfortunately, there are patients who do not have these people in their lives. Other family members or close friends who are willing to be a decision maker for the patient cannot do so unless they go through a long and costly guardian process in the court system.
- Advance directives allow patients to thoughtfully express end-of-life health care wishes in a way that health care providers can legally honor. Changing the law will help patients get end-of-life planning documents executed at the same time.

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Washington State Hospital Association

2019
POLICY BRIEF

Timely Access to Quality Care for Sexual Assault Survivors

Background

Most hospitals in Washington State (75%) provide sexual assault forensic evidence examinations and collection via trained medical providers, including Sexual Assault Nurse Examiners (SANEs). If a trained provider is not available, hospitals should develop a plan, in consultation with the local community sexual assault agency, to assist patients to obtain a sexual assault evidence exam at a facility that can provide the service.

WSHA Position

WSHA supports requiring all hospitals to have a clear process for notifying patients seeking sexual assault forensic evidence examinations if the hospital cannot provide the service. This process should include helping patients access forensic exams at another facility. Costs associated with a sexual assault evidence exam, including any transportation cost, should be covered by the Crime Victim's Compensation Fund. WSHA opposes penalties on hospitals.

Key Messages

- Trained staff to provide SANE services are a critical and limited resource in the state. Whether forensic exams are available at any given time depends on the availability of trained staff. If a hospital is not able to provide SANE services to a patient, the patient is screened, stabilized and then may be transferred or referred to a different hospital that provides this service.
- All hospitals should have a policy to assist individuals with obtaining sexual assault evidence kit collection at a facility that provides such collection. These policies should be developed in consultation with the local community sexual assault agency and establish a process to assist patients if a hospital does not provide sexual assault forensic evidence kit collection at the time a patient requests the service.
- Forensic evidence kits should be collected by well trained, experienced health care providers. Because the work requires advanced skills, some SANE providers are also the best nurses to assist in the case of trauma or life-threatening illness. While a SANE may be at the hospital when a patient needs a kit collected, the SANE may not be available to provide the service immediately.
- There is significant cost and time associated with specialized SANE training. This can be prohibitive, especially for small, rural, and remote hospitals that already struggle to find sufficient staff members. In addition, this work requires specialized skill and aptitude, making it challenging to retain specially trained providers.

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Washington State Hospital Association

2019
POLICY BRIEF

Uninterrupted Meal and Rest Breaks & Restrictions to Prescheduled On-Call and Mandatory Overtime

Background

For years, nursing unions have proposed legislation that would limit the ability of hospitals to staff and schedule according to patient care needs, without addressing the real concern of nurse fatigue or improving patient safety. This proposal would:

- Require hospitals to provide completely uninterrupted meal and rest breaks for nurses and certain technicians and technologists, regardless of patient need.
- Place rigid constraints on a hospital's ability to use prescheduled on-call and overtime for nurses and certain types of technologists and technicians, which currently support hospital staffing needs and provide high quality care to patients.

WSHA Position

WSHA strongly opposes this proposal. Washington hospitals need the flexibility to determine staffing according to patient care needs. This legislation would add unnecessary costs to patient care, without increasing patient safety or improving access to services. It provides no proven solution to address the expressed concerns of nurse fatigue and patient safety.

Key Messages

- Adequate nurse and technologist/technician staffing is a complex process that changes on a shift-by-shift basis and requires close coordination between management and staff based on a variety of factors such as patient acuity, nurses' expertise, and day-to-day adjustments, such as sick or family leave. The one-size-fits-all approach in this bill to meal and rest breaks, overtime, and on-call, is too rigid to keep up with the current demands of a complex hospital environment.
- Washington hospitals support healthy work environments and meaningful breaks for health care providers. The concern is over the requirement that meal and rest breaks be uninterrupted, which would require hospitals to:
    1. Schedule breaks ahead of time to ensure the break is uninterrupted, which takes away a nurse's ability to use his/her own clinical judgement to address emerging patients' needs;
    2. Hire additional staff for break coverage; and
    3. Not be able to communicate critical patient information. Even informing the nurse of a change in a patient's condition, the arrival of the patient's family or physician, or completion of essential lab tests without the nurse taking action would constitute an "interrupted" break – violating the law.

- Based on data provided by the University of Washington, WSHA estimates that 1,740 new nurses and other members of the care team would need to be hired to comply with this meal and rest break provision alone. However, recent health workforce data for Washington shows staffing shortages across the state, with nursing shortages being the most severe. If hospitals can't hire break nurses due to shortages, traveling nurses will need to be used. Traveling nurses are very expensive and are less familiar with the complexities of each facility. These costs will be borne by patients and employers.
- Rural and small facilities would be hit especially hard by this proposal. In small facilities, the employees all collaborate across the departments to help each other meet patient needs on a shift-by-shift basis. This bill would eliminate this current flexibility and force these hospitals to hire additional staff, when small and rural hospitals already have difficulty recruiting and retaining staff.
- Prescheduled on-call is part of collective bargaining and is usually voluntary and at most times, selected by the nurse to work best for his/her schedule. The restrictions against the use of prescheduled on-call to fill "chronic or foreseeable staff shortages" would make it difficult for a hospital to comply while still providing the same access to care that exists today.
- Hospitals need the flexibility to have prescheduled on-call staff come to the hospital to perform important and life-changing surgeries or procedures, even if they are not deemed an emergency, such as placing a chemotherapy port for a patient who does not live near the hospital, and to ensure access to care to a range of clinicians 24 hours a day, 7 days a week.
- Prescheduled on-call is also used to ensure patient access to care in smaller or rural facilities, where there is not enough patient demand for a full-time, on-site position for certain types of clinical staff, such as radiologic technologists.
- Proposed restrictions on mandatory overtime would also lead to delays in nonemergency patient care – for example, surgeries for breast and colon cancers, or heart procedures that are not life-threatening at that moment but are critically important to a person's quality of life. The proposed language prohibits hospitals from scheduling nonemergency procedures that would require overtime. That means that nonemergent patients would get delayed and rescheduled when life-threatening patient emergencies arise, as overtime is often used to ensure care is provided to patients when schedules change quickly. Rescheduling would sometimes take several weeks, after the patient has already shown up at the hospital and done their pre-surgical preparation, planned time off work or arranged child care for the original surgery.
- For patients living in rural areas, these delays could be especially difficult, as they are often arranging travel and time off work to receive nonemergency care at a hospital away from home.
- Hospital demands fluctuate and staff planning cannot be done with precision. Hospitals cannot predict the number of women who will go into labor or when and how severely the flu will strike. On-call and overtime are important tools to ensure hospitals can meet these demands for critical services.
- The legislature is calling for reducing health care costs. This proposal undoubtedly would increase costs.

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2019
POLICY BRIEF

Protect the Quality and Safety of Care Provided at Hospitals

Background

Legislation proposes to prohibit hospitals and health care facilities from appropriately managing the types and quality of services provided by health care providers. Hospitals are committed to providing patients with the right care at the right place and time. This includes both lifesaving emergency treatment and accurate, comprehensive information. The proposed legislation would negatively impact the quality, safety, and cost of care.

WSHA Position

WSHA strongly supports health care providers giving patients medically accurate and comprehensive information about care options. WSHA opposes attempts to drastically limit the ability of health care facilities to plan health care services and standardize care. WSHA cannot support state law mandates that could lead to violations of other laws or compromising the quality and safety of care.

Key Messages

- Hospitals and health care facilities require health care providers to abide by an array of standards in order to provide high quality, safe care in accordance with state and federal laws. Standards for appropriate referrals, scope of practice, and adherence to best practices improves health care delivery and makes care better and safer for everyone.
- Credentialing and privileging are the responsibility of the hospital and medical staff and crucial to establishing parameters of safe, quality care at the hospital. Credentialing establishes which providers are admitted to a hospital's medical staff. The privileging process establishes the scope and capabilities of the provider. Legislation that limits the ability to require providers to comply with credentialing and privileging requirements jeopardizes patient safety.
- Existing federal law protects a patient's right to receive emergency care in every hospital. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires all hospitals to screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies. These obligations are strictly enforced by the federal government and individuals may sue a hospital for EMTALA violations.
- A facility may not be able to provide all aspects of care for every patient. In those cases, health care providers give patients information about locations that provide care and a referral, where possible and appropriate.

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Washington State Hospital Association

2019
POLICY BRIEF

Balance Billing Limitations

Background

WSHA has been engaged in ongoing discussions about out-of-network billing for several years. In particular, there is concern about the ability for non-contracted providers to bill patients for the difference between the insurance payment and charges for out-of-network services ("balance billing").

The Office of the Insurance Commissioner (OIC) and legislators are proposing legislation to 1) prohibit in certain circumstances balance billing of the patient for out-of-network service by a provider or hospital; 2) provide a dispute/arbitration process for cases where the carrier and provider do not agree on the payment level; 3) enable self-funded groups to "opt-in" to the patient protections and payor requirements; and 4) require the OIC to ensure carriers have enough contracted emergency and ancillary providers to provide in-network benefits at contracted hospitals.

WSHA Position

WSHA supports efforts to protect patients from unforeseeable, unexpected billings. While we are pleased the proposed bill is improved compared to earlier versions, there are items that need to be addressed to avoid confusion to patients, greater administrative cost, and destabilization of the insurance market. They include:

- A robust mechanism for patient insurance cards and provider payment statements to accurately identify services that are subject to the legislation; and
- Removal of Medicare payment rate as a factor for the arbitrator to determine a reasonable commercial rate.

We prefer an alternative approach that would create a reporting of out-of- network claims by carrier, facility, and provider group.

Key Messages

- WSHA supports efforts to protect patients from unforeseeable, unexpected billings.
- WSHA believes the bulk of balance billing issues could be addressed though more rigorous network adequacy requirements and transparency. If facilities and physicians are prohibited from balance billing, there must be a clear mechanism via patient insurance cards and payment statements to identify the relevant carrier groups and self-funded groups.
- Any process with an arbitrator to determine "commercially reasonable" payment should not include Medicare payment rates as the bill does not apply to Medicare products.

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Washington State Hospital Association

2019
POLICY BRIEF

Noncompete Agreements: Maintain Flexibility in Clinician Contracts

Background

Hospitals, health systems and physician groups in Washington State may use noncompete clauses in contracting with physicians and certain other staff. Significant investments bring these health care professionals to the community, as well as support practices and advances in care. For the past several years, WSHA has been actively engaged in legislative discussions about the appropriate use of these clauses.

The current proposal would make these clauses unenforceable against all employees making less than $185,000 and independent contractors making less than $250,000—capturing many physicians and advance practice clinicians, such as nurse practitioners, particularly those in smaller and more rural communities. The proposed bill would also prohibit employers from restricting workers' moonlighting elsewhere, capturing scheduling and conflicts of interest policies that address workforce shortage and patient safety concerns.

WSHA Position

WSHA supports the use of reasonable noncompete clauses in contracts with physicians and certain other health care professionals, such as nurse practitioners.

Key Messages

- Hospitals big and small, urban and rural, may use noncompete clauses for physicians and other advance practice clinicians. These clauses are an important tool to protect hospital resources.
- Hospitals invest substantial funds to bring health care professionals to the community, often reaching hundreds of thousands of dollars. Investments include student debt relief, income guarantees, moving expenses, licensure and certification costs, administrative support and marketing.
- Reasonable and well-bargained noncompete clauses protect this investment in a highly competitive, workforce-challenged environment.
- Noncompete clauses fortify hospital workforces and enable continuity of care for patients.

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Washington State Hospital Association

2019
POLICY BRIEF

Consumer Data Privacy Alignment with Existing Health Privacy Protections

Background

Several bills proposing to regulate how businesses process an individual's personal data, including their personal health information (PHI), would apply to hospitals.

- "Consumer privacy" bills aim to increase consumers' access and control of their personal data and would require several measures toward that end. For instance, the bills would give consumers the ability to "opt-in" or "opt-out" to the processing of their data, as well as impose security and compliance obligations on businesses.
- A "breach notification" bill would amend existing state law, demanding more information while significantly shortening the timeframe for reporting, as well as expanding the circumstances triggering reporting obligations.

WSHA Position

WSHA supports increasing people's access and control of their personal data, but we need to ensure that state law does not create competing compliance obligations or add burdensome requirements over and above the high standards hospitals already meet as "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA), among other state and federal privacy laws and regulations.

Key Messages

- Hospitals currently protect PHI according to HIPAA standards, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). These standards address the confidentiality, security and transmissibility of a person's PHI. Patient consent, access and control are central tenets of the law. These are stringent standards, and they should be.
- Hospitals also protect health care related information pursuant to several other state and federal laws and regulations.
- Washington's existing privacy breach notification law appropriately aligns state breach notification standards to those under HIPAA/HITECH.
- These "same but different" laws would introduce competing requirements, making compliance extremely difficult and draining limited time and resources away from hospitals' existing efforts to protect people's personal data.

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Washington State Hospital Association

2019
BUDGET BRIEF

Increase Access to Memory Care for Medicaid Patients

The Problem

Patients should not be stuck in hospitals. Yet some patients stay in hospitals unnecessarily because they cannot be discharged to more appropriate post-acute care settings. The very low Medicaid rate for memory care services for Medicaid patients living with dementia is a significant barrier to getting patients the right care at the right place.

Patients with dementia often need residential care because they can no longer live at home due to a loss of cognitive function. The state's specialized dementia care program though the Department of Social and Health Services offers long-term care services for Medicaid patients. However, the rate paid under the specialized dementia program is inadequate and only a small number of post-acute care facilities accept patients with specialized dementia needs.

According to data from hospitals in Washington State, dementia is one of the top barriers that keep patients in acute care hospitals - on average these patients spent 90 unnecessary days in the hospital per hospitalization.

The need for increased access to specialized dementia care is included in the Governor's budget as part of the statewide behavioral health reform package. The Governor's budget includes $22.2 million total ($11.1 million general fund state) for a specialized dementia rate increase from approximately $120 to $325 and projecting increased capacity of 200 slots. WSHA has a similar request that is targeted to patients who are living in community hospitals.

Proposed Solution

WSHA supports increasing Medicaid long-term care payment rates for patients living with dementia and capital funding to support increased community capacity to care for Medicaid patients needing specialized dementia care.

Budget Ask

$10 million general fund state ($20 million total) to increase rates for Medicaid patients being discharged from acute care hospitals to specialized dementia facilities, including enhanced adult residential care settings.

$30 million in capital funding to support increased community capacity and increase access to specialized dementia care for Medicaid patients.

Funding assumptions: Increase specialized dementia rate from approximately $120 to $325 per day for patients being discharged from acute care hospitals. This increase would cover approximately 175 slots.

Updated: 1/15/2019

Key Messages

- Based on recent data from Washington State hospitals, the need for memory care was one of the top five barriers preventing patients from leaving an acute care hospital. Patients needing memory care often had additional barriers of combativeness, low or inadequate funding, and the need for a guardian. Patients needing memory care had an average of 90 avoidable days (day the patient was in an acute care hospital but did not need to be there).
- Acute care beds are a finite, expensive resource. Patients who need acute care need access to these beds. Patients who need post-acute care should be discharged to appropriate settings.

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Washington State Hospital Association

2019 **BUDGET** BRIEF

Increase Access to Long-Term Care for Noncitizens

The Problem

Patients should not be stuck living in hospitals. Yet hospitals are unable to discharge some patients to more appropriate post-acute care settings. Noncitizen patients who need post-acute care are often stuck in hospitals for months or years waiting for state funded long-term care slots. Due to citizenship status, these patients are not eligible for Medicaid. Patients may be undocumented or documented immigrants who do not meet the five-year residency threshold required under the Affordable Care Act expansion.

Washington State has a state-funded long-term care program for noncitizens. The program, which is part of the state's commitment to caring for vulnerable populations, involves funding from the Health Care Authority (HCA) for medical care and Department of Social and Health Services (DSHS) for residential services. However, the program only has 45 funded slots. There are regularly 80 or more patients on a waitlist to access the 45 slots. At least half of the patients on the waitlist are waiting in hospitals.

The hospital environment provides essential care for those who need immediate, intensive care. Hospitals are not set up to provide support for long term care, such as common rooms and outside space. In addition, acute care hospital beds are a finite resource. When hospital beds are occupied by patients who don't need to be in a hospital, fewer beds are available for other patients with acute care needs.

Additional funding for long-term care for noncitizens will provide patients with the right care at the right place and help maintain access to acute care facilities for other appropriate patients.

Proposed Solution

WSHA supports funding to increase the number of long-term care slots available for noncitizen residents who do not qualify for Medicaid. Adding 60 funded slots is appropriate to add capacity for patients waiting in hospitals and elsewhere. Based on conversations with hospitals and post-acute care providers, capacity exists in the community to care for these noncitizen patients, but funding is needed for patients to access this care.

Budget Ask

$20.8 million general fund state to add 60 slots to the long-term care program for eligible noncitizens. This funding is for the biennium which includes funding for the Health Care Authority for medical care and the Department of Social and Health Services for residential care.

Funding assumptions: $87,000 (HCA) and $87,000 (DSHS) per slot, totaling $174,000 per slot. $10.4 million to add funding for 60 slots, $20.8 million over the biennium.

Updated: 1/15/19

Key Messages

- Noncitizen patients waiting for a state-funded long-term care slot are essentially stuck in limbo. These patients could be safely discharged to a post-acute setting like skilled nursing facilities or adult family homes but cannot be accepted into these settings without funding. Here are just a few patient stories:
    - A Mexican citizen who suffered severe trauma as a result of day labor work stayed in a Pierce County hospital for over a year on the waitlist for a long-term care slot.
    - A patient from Cambodia suffered a stroke. The patient was stabilized and appropriate to transfer to a skilled nursing facility within four days. Instead, he waited in a hospital for over six months before eventually returning to Cambodia.
- The noncitizen long-term care program is funded for only 45 slots. There are regularly more than 80 or more patients on the waitlist – at least half are those living in hospitals waiting for a slot.
- In May 2018, 32 patients were stuck in acute care hospitals while on the long-term care waitlist.
- Acute care beds are a finite, expensive resource. Patients who need acute care need access to these beds. Patients who need post-acute care should be discharged to appropriate settings.

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Washington State Hospital Association

2019
BUDGET BRIEF

Expand Access to Outpatient Mental Health Services

(Partial Hospitalization and Intensive Outpatient Programs)

The Problem

Medicaid does not currently pay for partial hospitalization and intensive outpatient services – these services are not funded nor included in the Medicaid state plan. For both adults and children, partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs) bridge the gap between acute inpatient and outpatient treatment by providing intensive mental health services, and sometimes co-occurring chemical dependency services, without an overnight stay in the hospital. These services expand the available mental health continuum of care to patients and allow hospitals to utilize the beds and clinical resources more efficiently.

For hospitals, PHPs and IOPs are key tools to avoid some inpatient hospitalizations and help discharge certain patients from inpatient psychiatric units in a more timely manner. PHPs and IOPs focus on giving patients effective coping skills to improve self-management of care and enabling them to continue treatment in a community setting, surrounded by family and other supports.

Individuals with Medicare or commercial health insurance coverage can access PHPs and IOPs. While Medicaid enrollees in 29 states can also access these services, Washington Medicaid enrollees cannot.

Proposed Solution

Low-income Washingtonians on Medicaid with mental health needs should be able to access a wide array of treatment options. WSHA recommends that the legislature provide new, dedicated funding at a sustainable rate to support adding PHPs and IOPs to the Medicaid state plan.

Admissions Criteria

PHPs and IOPs are designed for adults and children with mental illnesses who would benefit from short-term, intensive treatment programs, structured around the individual's psychiatric needs. Clinical experts provide evidence-based treatments for a multitude of mental health illnesses including anxiety, depression, suicidality, trauma, and obsessive-compulsive disorder. These services are appropriate for individuals who:

- Experience acute psychiatric symptoms that require intensive treatment, but not necessarily hospitalization;
- Experience significant difficulty functioning on a day-to-day basis, such as inability to go to work, attend school, or take care of themselves day-to-day; and
- Are receptive to group-oriented treatment.

Program Services

PHPs and IOPs focus on teaching and building effective coping skills to improve self-management of care, enabling participants to continue treatment in a family and community setting.

- *PHPs are usually full-day programs* (anywhere from 3 to 8 hours a day, up to 5 days a week).
- *IOPs are usually part-day programs* (up to 3 hours a day, 2 to 3 days a week).

PHPs and IOPs are distinct from and more intensive than "day support services" that are offered by community mental health clinics. PHPs and IOPs focus more directly on reducing mental health symptoms so that a patient may be more effectively treated in a day support program.

Program participants generally meet several times a week and work with a multidisciplinary team of professionals such as psychiatrists, psychiatric nurse practitioners, master's level licensed therapists and mental health technicians. Each follow treatment regimens tailored to the patient's specific needs. Participants also engage in motivational group and individual therapy sessions, develop cognitive and dialectical behavior therapy skills, and receive medication management consultations. PHPs and IOPs are similar programs, the key difference being the duration of the program.

Broad Support

Governor Inslee's 2019-21 proposed budget recognized the importance of PHPs and IOPs by providing funding for this program. His budget appropriates $13.9 million general fund-state ($37.4 million total) to ensure that Medicaid enrollees can access these important services. The *Children's Mental Health Workgroup* and the *Health Coalition for Children and Youth* have also adopted expanding PHPs and IOPs to children who are enrolled in Medicaid as one of their 2019 legislative priorities.

Budget Ask

$13.9 million general fund-state ($37.4 million total) to add PHPs and IOPs as a Medicaid mental health benefit, starting on January 1, 2020.

Estimated Total Cost for 12 Months for PHPs and IOPs (Federal and State)	Estimated Total Cost for 18 Months for PHPs and IOPs (Federal and State)	Estimated Total Cost for 18 Months for PHPs and IOPs (State Only – Using Federal Match Rate of 63%)	Estimated Go Forward Cost for PHPs and IOPs (State Only Cost: Maintenance Level)
A	B = A x 1.5	C = B x 0.37	D = (A x 2) x 0.37
$24,955,000	**$37,432,000**	**$13,850,000**	**$18,467,000**

- The above figures are cost estimates that include seven hospitals (across the state) interested in expanding PHPs and IOPs to Medicaid enrollees. There may be other hospitals that may be interested in providing these mental health services at some point after June 30, 2021.
- The cost includes an estimated per diem rate. Participating hospitals will require a review of their cost reports after operations commence to determine if rebasing is necessary so rates accurately reflect costs of operations.
    - Request that the Health Care Authority (HCA) set an interim rate for PHP and IOP services based on the greater of hospital costs or the statewide average, depending on the type of hospital.
- Assume a federal match rate of 63%, based on federal match of FFS psych related DRGs for SFY18. Federal match rate calculation provided by the HCA.
- Hospitals' PHP and IOP per diem rates include costs such as staffing, facilities and incidentals.

Key Messages

- For adults and children, PHPs and IOPs are critical services in the continuum of mental health care.
    - It is "step up" care for adults and children who have mental health illnesses that are too severe for community providers but not severe enough to meet admissions criteria for inpatient psychiatric care.
    - It is also "step down" care for patients who are discharged from inpatient psychiatric care but still need intensive mental health services.

- For low-income Washingtonians on Medicaid, accessing PHPs and IOPs is about health equity. Washingtonians who have Medicare or commercial coverage can access these programs. Individuals who have Medicaid coverage should be able to access the same mental health care.
    - Currently, there are seven Washington hospitals (located across the state) interested in offering PHPs and IOPs to Medicaid enrollees.
    - We estimate they can provide almost 21,000 PHP patient days of care and almost 20,000 IOP patient days of care (*patient days may change depending on funding).
- For hospitals, broader patient access to PHPs and IOPs will likely:
    - Reduce hospitalizations by helping stabilize patients outside of inpatient care settings;
    - Ease discharge issues if patients can continue their mental health care by transitioning to an intensive outpatient care program once they no longer meet inpatient admissions criteria;
    - Help reduce psychiatric readmissions because patients can access medication management and therapies;
    - Provide options for individuals who come to the emergency room in psychiatric distress but do not meet inpatient admissions criteria; and
    - Allow hospitals to utilize their inpatient psychiatric beds and resources in the most efficient manner.

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Washington State Hospital Association

2019
BUDGET BRIEF

Appropriately Fund Hospitals that Expand Inpatient Psychiatric Services

(Operating and Capital Funding for 90- and 180-Day Beds in Community Hospitals)

The Problem

Concentrating all long-term mental health placements and resources at Eastern and Western State Hospitals is not working. For patients, they could be better served not in state hospitals, but when they are closer to their homes, communities and families. Patients may be less likely to be readmitted to care and have shorter durations of stay.

To help address this problem, some acute care and freestanding psychiatric community hospitals are willing to provide long-term, court-ordered mental health services to help expand inpatient psychiatric capacity in the state. While hospitals are increasing their capacity to serve civilly committed patients, key challenges hospitals are facing are the Medicaid payments rates – they fail to cover the cost of care, which is usually at 75 percent the cost of care for those hospitals currently treating short-term psychiatric patients.

Proposed Solution

Some community hospitals would like to treat 90- and 180- day mental health patients. This decision is complex and differs for each individual hospital since psychiatric care is a specialty service that comes with a variety of challenges stemming from an underfunded system.

For acute care and freestanding psychiatric community hospitals to provide long-term care to civilly committed patients, they will need assurances that financial reimbursements will be adequate to address the costs of caring for these complex cases. The state must appropriate adequate funding to ensure that managed care organizations (MCOs) and behavioral health – administrative service organizations (BH-ASOs) reimburse these hospitals at a sufficient rate. This will help assure these hospitals will have sufficient and predictable revenue streams to support this care.

The state should also appropriate the necessary capital funding to support community hospitals serving individuals on 90- and 180-day commitment orders. Facilities that accommodate involuntary civil commitment patients require additional infrastructure, including enhanced security features and recreational space. These features are not present at facilities that hospitals currently use to provide care for short-term psychiatric patients.

The Governor's 2019-21 Proposed Budget

A key focus of Governor Inslee's 2019-21 proposed budget is increasing investments in behavioral health, including moving long-term civil commitment patients out of state hospitals and into community settings. To help achieve this, the capacity at community hospitals needs to increase.

The **Office of Financial Management (OFM)** estimates the following increase in long-term 90- and 180-day inpatient beds in acute care and freestanding psychiatric community hospitals (rolling total):

OFM Estimate: New 90- and 180-Day Bed Capacity in Community Hospitals

	2019-21 Biennium		2021-23 Biennium		2023-25 Biennium		2025-27 Biennium	
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Acute	8	8	12	37	37	37	37	37
Freestanding	0	0	8	38	38	38	38	38

- Bed capacity assumptions are cumulative each fiscal year. Ultimately, assumes a total of 37 long-term beds in acute care hospitals and 38 long-term beds in freestanding psychiatric hospitals by 2027.

For the 2019-21 biennium, OFM estimates the following in necessary appropriations (for the eight 90- and 180-day beds in community hospitals):

OFM Estimate: Cost of New 90- and 180-Day Bed Capacity in Community Hospitals for 2019-21 Biennium

	FY 2020	FY 2021	2019-21 Biennium
General Fund – State	$1,606,930	$1,606,930	$3,213,860
Total	$3,419,000	$3,419,000	$6,838,000

- Assumes an inpatient psychiatric care rate of $1,170 (for both acute care and freestanding psychiatric community hospitals).
- Assumes an occupancy rate of 100 percent for each bed.
- Assumes federal match rate of 53 percent.

Budget Ask

Operating funding to expand services for individuals on 90- and 180- day civil commitment orders by adding inpatient beds in acute care and freestanding psychiatric community hospitals. The legislature must ensure that these hospitals are paid a rate that covers at least the cost of providing the care with an annual update for inflation.

$19.2 million in capital funding to assist hospitals to expand inpatient psychiatric units to accommodate more patient rooms, create additional common space, as well as repurposing existing areas. Capital funding will also help efforts to incorporate a mixture of indoor and outdoor recreational areas, gym space, and therapeutic activities to meet the needs of individuals on 90- and 180- day civil commitment orders.

A summary of the additional capacity these hospitals could provide is below:

WSHA Estimate: Acute Care Hospitals with Psychiatric Units Under RCW 70.41 (Qualifying for Federal Match)*

Hospital	County	Number of Additional ITA Beds	Patient Days at 85% Occupancy	Capital Funding Needed
Providence Everett (*new operations – need interim rate)	Snohomish	6	1,861.5	Yes - $4.2 million
Astria Toppenish (*new operations – need interim rate)	Yakima	8	2,482.0	Not at this time
Virginia Mason Memorial	Yakima	6	1,861.5	Yes - $4.5 million
TOTAL		**20**	**6,205**	**$8.7 million**

*NOTE: MultiCare is interested in expanding their capacity to serve both acute involuntary patients (those on 72 hour and 14-day holds) and long-term civilly committed patients (those on 90- and 180-day commitment orders). MultiCare estimates that for $100 million in capital funding, they will be able to expand the Navos campus in West Seattle and build a new site in South King County – site to be determined. Each site would require $50 million in capital funding. MultiCare estimates that this investment will result in an additional 90 to 120 beds to serve long-term patients on 90- and 180-day commitment orders. These beds would be divided among the two facilities.

WSHA Estimate: Freestanding Psychiatric Hospitals Under RCW 71.12 (Not Qualifying for Federal Match)

Hospital	County	Number of Additional ITA Beds	Patient Days at 85% Occupancy	Capital Funding Needed
Navos	King	8	2,482.0	Yes - $10.5 million
Cascade	King	18	5,584.5	Not at this time
Fairfax	King	20	6,205.0	Not at this time
TOTAL		**46**	**14,272**	**$10.5 million**

- Patient days are estimated at an occupancy rate of 85 percent.
- Hospitals with new operations will need an interim rate. From the beginning of operations until the hospital has reached 200 Medicaid days and produced a cost report, hospitals shall be paid an interim rate for inpatient psychiatric care of $1,170.
- The rate should be adjusted annually for inflation.
- Not all costs are reimbursed by Medicaid. For example, the physician group/hospital will be unable to cover psychiatrist salaries under the current payment system and staff time spent attending court proceedings is not captured by CMS on the cost report.

Key Messages

- Patients will be better served when they are closer to their home, communities and families. They may be less likely to be readmitted to care and have shorter durations of stay.
- Washington hospitals stand ready to help the state address the growing demand for long-term civil commitment services. There are three acute care hospitals in Snohomish and Yakima counties able and willing to provide 20 long-term psychiatric beds and three freestanding psychiatric hospitals in King County able and willing to provide 46 more.
- In order to effectively provide this much needed care, hospitals need to be paid a rate that is sufficient to meet the cost of care. For too many years, the Medicaid inpatient psychiatric rates for community hospitals have been a fraction of the total cost of patient care.
- The legislature should fund an interim rate for new facilities providing 90- and 180- day treatment.
- Hospital units for patients on 90- and 180- day commitments will be entirely Medicaid, meaning there will be no other payer source to help offset the losses from the under-funding of government payments.

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Washington State Hospital Association

2019
BUDGET BRIEF

Enable WRHAP Hospitals to Receive the Amounts Originally Appropriated

The Problem

The Washington Rural Health Access Preservation (WRHAP) project was created to protect Washington's smallest and most remote communities, where Critical Access Hospitals (CAHs) are at risk of closing, threatening access to care. WRHAP was created to design, test and implement improvements in payment and delivery of health care for our smallest communities. These 13 hospitals, all operated by Public Hospital Districts, generally serve as the platform for a broad range of health care services in the community, including primary, acute and long-term care. These hospitals' financial problems jeopardize both the health of the residents through the reduction of offered services, as well as the economies of the community.

HB 1520 (2017) authorized an alternative payment methodology to stabilize WRHAP hospitals and provided needed funding for care transformation until a new system was in place. Transition funds were intended to offset emergency department losses and invest in care improvements. The legislature's appropriation was based on additional support for the WRHAP hospitals as well as anticipated savings to the Medicaid budget with a new alternative payment system. The Health Care Authority (HCA) was never able to enact the new system, however. In September 2018, HCA began distributing additional funds under the current payment system to WRHAP hospitals that met quality performance benchmarks. The funds distributed to the hospitals were not the full amounts originally intended. Hospitals received reduced amounts, lowered by the savings anticipated to Medicaid from reduced emergency room visits under a new payment system. Because the underlying payment change was not enacted, HCA has not been tracking the overall savings to the Medicaid program associated with care improvements.

Proposed Solution

HB 1520 was intended to provide transitional funding to WRHAP hospitals that would allow them to pursue new care models while transforming to a new, more sustainable payment model. Funding has been helpful in making critical care improvements. While HCA continues to develop the multi-payer model for rural hospitals, WRHAP hospitals need full funding to stabilize their services and continue to capitalize care improvements as the state prepares for a broader transformation effort.

To date, WRHAP hospitals have used the transition funding to add necessary staff, pursue multi-hospital collaborations and improve care. Eight of the WRHAP hospitals have now hired staff to help with improved care coordination. A care coordinator makes follow up contact with patients who visit the emergency room or are discharged from an acute care hospital. This helps ensure the patients are following up with care needs and have appropriate visits scheduled with their primary care physician. In the first three months of this program, 1,200 Medicaid patients were contacted. Five hospitals are receiving funds to hire staff to help with behavioral health integration. They have initiated depression screens and are developing care plans for

patients diagnosed with clinical depression during their primary care visit. In the first three months, 700 patients were screened.

While helpful, these payments do not fundamentally change how rural hospitals are being paid or provide the stability sought by the original bill.

Budget Ask

While HCA has included a maintenance funding level of $1.5 million per year for the next biennium, WSHA believes funding at the original appropriation level of $4.4 million over the next biennium is needed.

Key Messages

- Until an alternative payment methodology is available, continued assistance is needed.
- Funding should continue at $4.4 million over the next biennium. This is the original level approved for hospital payments under HB 1520.
- Funding under HB 1520 has provided investment to WRHAP hospitals.
- Funding has been used to make significant advancements in care coordination and behavioral health integration, but have not provided the fundamental payment model reform sought by WRHAP hospitals.

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