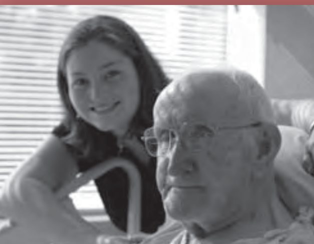
Washington State Hospital Association

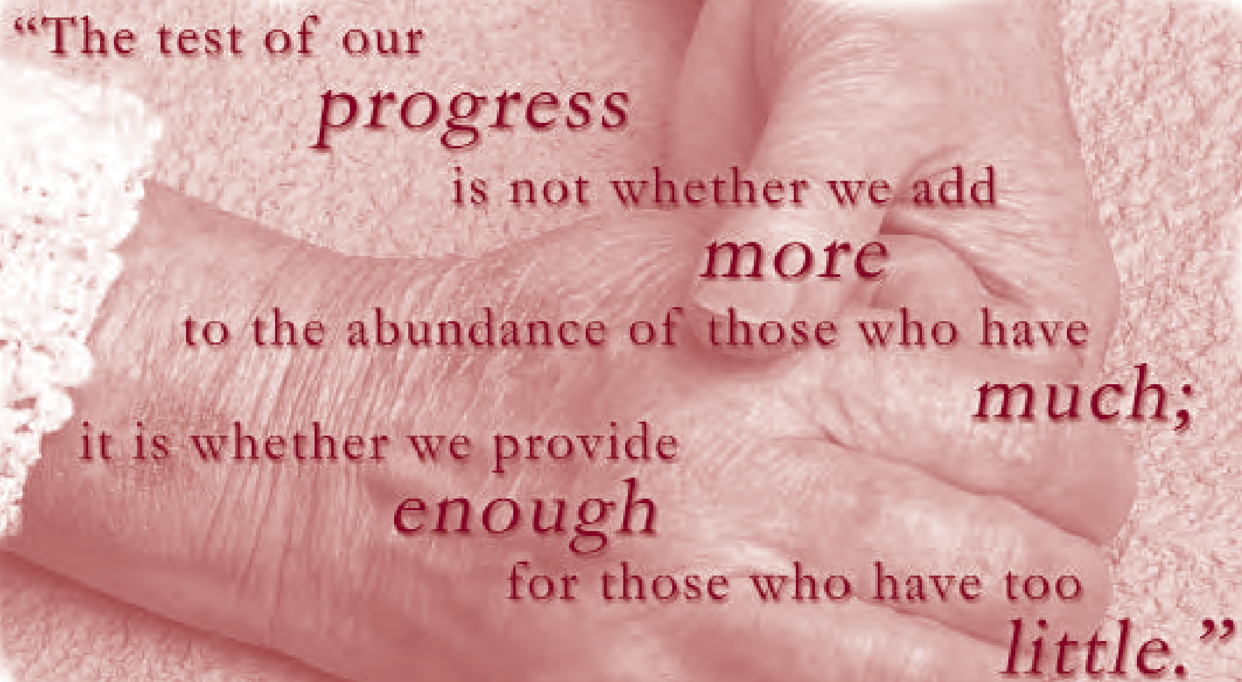
2010 Legislative Summary

May 2010



safety net *n.*
something that provides protection or security

Association of Washington Public Hospital Districts


"The test of our
progress
is not whether we add
more
to the abundance of those who have
much;
it is whether we provide
enough
for those who have too
little."
- Franklin Delano Roosevelt,
Second inaugural address, January 20, 1937

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INTRODUCTION

We are pleased to provide you with our annual legislative summary. As always, it is an honor to represent you before the Washington State Legislature.

This was a legislative session that seemed like it would never end. It was difficult, exhausting, and stressful. Somehow through it all, it turned out to be one of the most successful sessions in WSHA's history.

In the midst of some terrible economic times and a very complicated political environment, we were able prevent significant cuts to hospitals and health care, ensure hospitals were not taxed, and bring in almost $200 million in new funding for hospitals.

We were able to get a number of good policy bills enacted that will be very helpful to hospitals. We also stopped a number of very bad policy bills, most notably the meal and rest breaks bill.

I credit this success to outstanding teamwork by you, our WSHA members, and the WSHA staff. We truly appreciate your participation in our policy and advocacy work. It is the heart of what we do at the hospital association, and we could not do it without your help.

I hope this summary will provide you with useful information about key changes in the state budget and state law that will affect your hospital. We look forward to working with you to implement the new laws and to prepare for the 2011 legislative session.

Warm regards,

Leo Greenawalt
President
Washington State Hospital Association

BUDGET SUMMARY

The Budget Context

This year, as in all even-numbered years, the Governor and the Washington State Legislature were charged with creating a supplemental budget. A supplemental budget makes adjustments to the biennial budget enacted the previous year.

This year's supplemental budget was unusual because of the substantial deficit the legislature had to address. Typically, supplemental budget changes are minor. In contrast, the changes made to the 2010 supplemental budget are major as a result of the national recession.

Washington State's budget deficit this legislative session was ***$2.8 billion;*** on a $31 billion base budget. Fully 70 percent of the budget is protected from budget cuts by the state constitution, federal requirements, and union contracts. This deficit was in addition to last year's $9 billion deficit, making the total biennial budget deficit ***$11.8 billion***. The state budget is on a two-year cycle. Now, halfway through the budget for the biennium, much of that $31 billion is already spent.

Unlike the federal budget, the state budget must be balanced. Any budget shortfalls must be addressed by cuts or new revenues.

On April 13, 2010, the Washington State Senate and House of Representatives agreed on a budget and adjourned. The Governor approved the vast majority of the budget enacted by the legislature. The biennial and supplemental budgets enacted in 2009 and 2010 will be in effect through June 30, 2011.

Impact of the Recession

As the state legislature grappled with how to balance the budget, only some areas of the budget were on the table to be cut. Any part of K-12 education defined as "basic education" – a definition expanded by the 2009 legislature – enjoys Constitutional protection. State receipt of federal stimulus funding also required the state to maintain its funding in some new areas, particularly higher education. Other areas unlikely to be cut include public safety and interest on Washington State's debt.

One of the most significant sources of income for the state is the sales tax. With the recession and decline in business and sales, Washington is experiencing a significant loss of revenue. The impact on the budget is then magnified because as the economy sours, demand for state services – such as Medicaid, public schools, and unemployment compensation – continues to grow. Increasing demand for state services widens the gap and puts ever-growing pressure on the state budget.

BUDGET SUMMARY (continued)

WSHA Budget Priorities

Discussed below is how the enacted budget addresses the Washington State Hospital Association's (WSHA's) top budget priorities.

Hospital Safety Net Assessment: WSHA successfully lobbied to restore a portion of the hospital Medicaid budget cuts enacted last session through a hospital safety net assessment. The hospital assessment will bring about ***$200 million*** in increased federal matching funds this biennium for improved Medicaid hospital payment rates. The assessment will also shore up high-quality hospital services for Medicaid and Apple Health for Kids enrollees. A full description of the hospital safety net assessment is included in the bill summary section of this report.

Cuts to Hospital Services: Both the Senate and the House proposed elimination of the rural and urban Indigent Assistance Disproportionate Share Hospital (DSH) programs, which would have been a ***$21.9 million cut***. These programs provide vital funding for hospitals to care for low-income uninsured people. WSHA argued that enacting the hospital safety net assessment did not mean hospitals could absorb new cuts, as some legislators seemed to believe. Fortunately, the cut was not enacted.

Taxes on Hospitals: As the legislature devised its revenue package, one source of revenue considered and included in revenue bills was a Business and Occupation (B&O) tax increase on public, nonprofit, and for-profit hospitals. These proposals would have meant about ***$65 million*** in new taxes over the next three years. WSHA successfully lobbied against these new taxes. All hospitals (with one exception) were exempt from the B&O tax increases in the final revenue package.

Preparing for Health Reform

The enacted budget provides a framework for state actions needed to implement federal health care reform. The budget calls for the creation of a Joint Legislative Select Committee on Health Reform Implementation made up of state legislators. The committee is designed to prepare the state for creating statutory, regulatory, and budgetary changes needed to implement health care reform as quickly and efficiently as possible. The committee may form advisory committees and may invite interested stakeholders and experts to advise the committee. WSHA will be actively involved with the committee's work.

Eligibility for the Uninsured: Washington State has been a leader in providing health care to its residents through innovative public insurance programs. WSHA lobbied to maintain full eligibility for these programs. People enrolled have no other health insurance and cannot afford commercial coverage.

- ***Basic Health Program:*** The final budget fully funds the Basic Health Program at its current level of about 65,000 enrollees. The program was reduced significantly in 2009, and was targeted for elimination this year. WSHA and a broad coalition of supporters lobbied successfully for its continuation. The state has applied for new federal funding for the Basic Health Program as part of the federal health reform law. This money could go to fund an additional 4,000 slots. There are currently 100,000 people on the waiting list for the program.

- ***Apple Health for Kids:*** The enacted budget fully funds the Apple Health for Kids program (Medicaid/Children's Health Insurance Program), thanks in part to a $7.5 million bonus the state received from the federal government for outstanding performance in administering the Children's Health Insurance Program. The program was slated for significant reductions. Continuing the program means the state will keep working toward its goal of covering all kids by 2010. Unfortunately, the final budget suspends the outreach program for Apple Health that has been critical for helping hard-to-reach families enroll in and use health care for their children.

- ***General Assistance-Unemployable or "Disability Lifeline":*** This program, which is often a target for elimination, will continue but with significant new rules. There is now a 24- out of 60-month time limit for enrollees. There are also new conditions for receiving assistance, including participating in chemical dependency treatment or vocational rehabilitation if needed and securing stable housing. These changes are projected to immediately reduce the program's current enrollment of more than 20,000 people by 3,500 people. The state also plans to move participants off the state program and into federal disability aid more quickly. The state projects ***$25 million in savings*** from these changes. The program has also been renamed "Disability Lifeline." Changes to the program are detailed in House Bill (HB) 2782.

BUDGET SUMMARY (continued)

Mental Health System: WSHA lobbied to reduce the level of cuts the Governor proposed to community mental health programs. These programs help people living with mental illnesses get the services they need. These programs have already been cut significantly and should not be further reduced. The Governor proposed a $6 million cut to Regional Support Networks and a $3.2 million cut to the Program for Adaptive Living Skills, both of which provide community mental health treatment. In the final budget, fortunately, funding for both the Regional Support Networks and the Program for Adaptive Living Skills was preserved.

Work Force Shortages: In partnership with SEIU Healthcare 1199NW, WSHA successfully maintained the ***$4.5 million*** in state funding for training existing low-wage hospital workers as a means of supporting health care career advancement and reducing critical health care work force shortages.

Other Budget Issues: The following tables show other issues in the state budget that will affect hospitals:

Budget Item Added or Preserved	Funding (All Sources)
Nursing home rate cut restoration (due to lawsuit)	$101 million added
Federally Qualified Health Center payments	$95 million added
Professional services supplemental payment (increased federal funding for University of Washington Medicine, Valley Medical Center, and Olympic Medical Center professional providers)	$60 million added
Adult day health funding restoration (due to lawsuit)	$20 million added
ProviderOne Medicaid Management Information System implementation	$19 million added
Disciplining unsafe nurses and other health providers (funding to Department of Health)	$4 million added
Primary care pilot projects (Spokane and Whatcom Counties)	$2.5 million added
Funding for interpreters for medical services	Funding preserved (Governor had proposed eliminating this funding)

Budget Item Cut or Fee Increased	Funding (All Sources)
Nursing home rate cut	$26 million cut
Health Professional Scholarship and Loan Repayment Program	$4 million cut (funding for 100 new applicants)
Newborn screening fee increase (from $3.50 to $8.40 per birth)	$412,000 per year fee increase

Revenue Sources

Washington legislators faced budget shortfalls totaling $11.8 billion in the 2009-2011 biennium. The biennial budget was balanced overwhelmingly with cuts. In order to avoid even deeper cuts to vital state services — including education, health care, and services to seniors — the enacted state budget includes about ***$800 million*** in new state revenues. ***New state revenues make up less than 10 percent of the total budget-balancing actions over the two year biennium.***

The primary sources of new revenue in the enacted budget are:

- Increasing taxes on the portion of business done in Washington State by some out-of-state companies, mainly banks and credit-card companies;
- Increasing taxes on non-essential items, including candy, gum, and bottled water (with an exemption for in-state candy makers);
- Temporarily increasing taxes on beer and soda pop (with an exemption for microbrews) through June 2013;
- Temporarily increasing the B&O tax for most service businesses (with an exemption for hospitals) through June 2013;
- Increasing the cigarette tax by $1 per pack to fund the Basic Health Program and increasing taxes on other tobacco products.

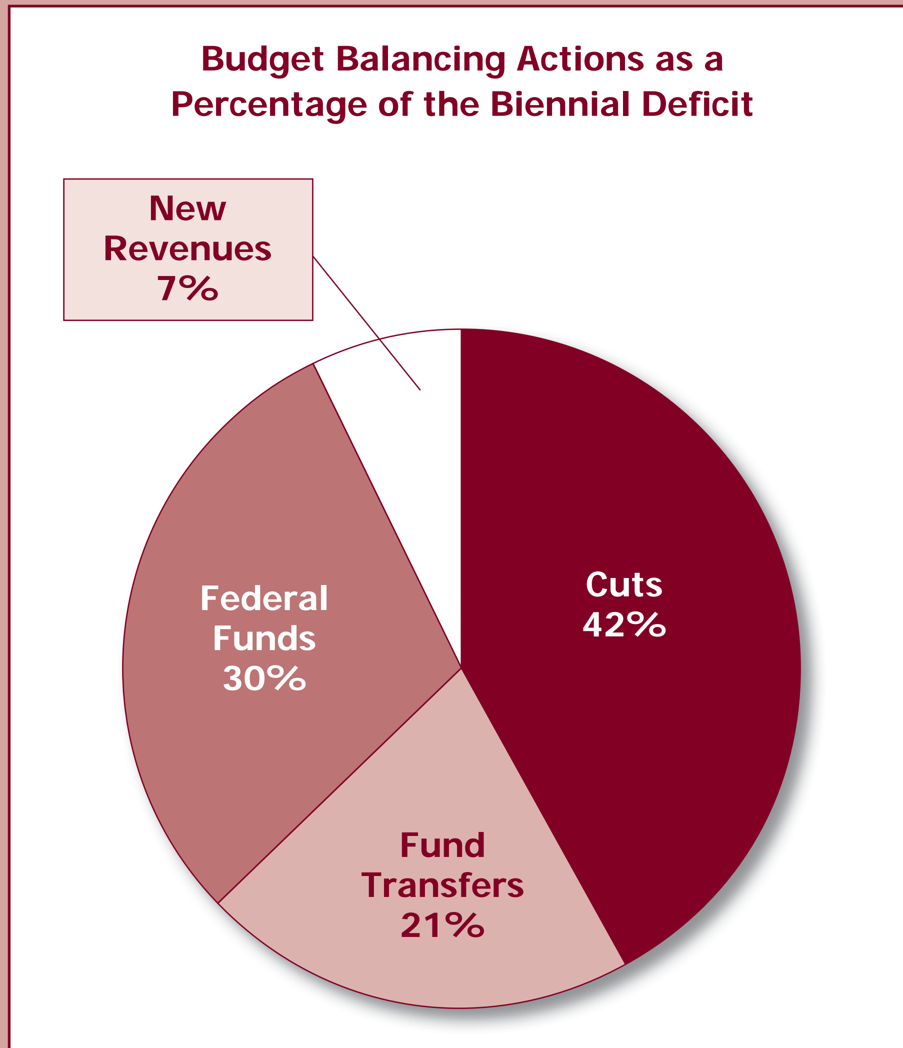
The legislature did not enact an income tax or a general sales tax increase. The revenue package does not include a B&O tax increase on public, nonprofit, or for-profit hospitals (with one exception), something that was included in earlier revenue proposals. WSHA successfully lobbied against these hospital tax increases.

WSHA staff and members worked hard for the enactment of the revenue package. It provides funding for vital state services, including Basic Health and Apple Health for Kids — programs in serious jeopardy without new funding. Without the revenue package, hospitals would likely have been subject to the increased B&O tax. Already, ballot initiatives have been filed in an attempt to overturn the revenue increases and eliminate funding for these programs.

The enacted budget uses significant fund transfers (moving money into the general fund from other sources) to help balance the budget, including the state's "rainy day fund." The budget also relies on ***$618 million*** in anticipated increased federal funding, particularly an extension of the enhanced federal Medicaid matching rate.

Balancing the 2009-2011 Budget

The chart below shows how the Governor and legislature addressed an $11.8 billion deficit for the 2009-2011 biennium. Whether the legislature and Governor would increase taxes certainly dominated the debate, but as this chart shows, those new revenues were only a small piece of the puzzle.



WSHA BILL SUMMARY: POSITIVE RESULTS

Bills Enacted

WSHA successfully lobbied to ***support*** or ***amend*** the following important bills enacted by the legislature, listed in rough order of WSHA priority and effort:

Hospital Safety Net Assessment: A top legislative priority for WSHA was enactment of HB 2956, which establishes the hospital safety net assessment fund. The assessment increases federal Medicaid matching funds; supports critical hospital safety net services; ensures ongoing high quality hospital services for Medicaid and Apple Health for Kids enrollees; and mitigates a significant portion of the severe budget cuts made to hospitals during the 2009 state legislative session.

WSHA estimates the cuts enacted by the 2009 legislature will reduce hospital Medicaid payments by more than $400 million in the current and next biennia, along with a large loss in additional revenues from Basic Health Program reductions. Every hospital in the state will be affected. The hospital safety net, access to care for enrollees in Medicaid and Apple Health for Kids, hospital programs for low-income people, community outreach/community benefits programs, and the Critical Access Hospital program are all at risk from these cuts. While these cuts may violate federal law, the legislature was in no position to mitigate them through its general fund given the current budget situation.

Hospital leaders came to the legislature with a feasible solution to this problem. They successfully lobbied for a hospital safety net assessment to bring in more federal Medicaid money for Washington hospitals. At least 26 other states have instituted a similar program, and at least another 6 states are in the process of developing one.

Under the new law, Washington hospitals will be assessed a fee on all non-Medicare patient days. The hospital assessment is the sole source of state funds used to draw down increased Medicaid matching funds. The assessment will flow into a new dedicated account administered by the state. In aggregate, hospitals will receive increased Medicaid rates to cover the assessments they paid, restore a portion of the cuts enacted during the 2009 legislative session, and avoid further Medicaid rate cuts proposed by the Governor and legislature. Hospital Medicaid rates are currently well below the cost of delivering care.

A number of key conditions to protect hospitals are included in the bill: the state may not cut Medicaid rates; federal approval and matching funds are required; managed care plans must pass on the rate increases to hospitals; annual adjustments

WSHA BILL SUMMARY (continued)

may be made to assessment levels; and the fund may not be used to supplant other funds. If federal approval is not obtained or the state violates key conditions, the entire legislation is invalid. The assessment and rate increases will sunset by June 30, 2013, which gives hospital leaders the chance to renegotiate the assessment or end it. Hospitals are also prohibited from billing patients for the cost of the assessment. The assessment must be part of the hospitals' operating overhead.

The hospital safety net assessment provides significant economic benefits for communities statewide. The economic vitality of a community often rests on the well-being of its hospital; in many areas, the hospital is the largest employer. Maintaining funding for hospitals will support good jobs statewide. In addition, since increased Medicaid funds are being returned to hospitals, the assessment reduces the cost shift and enables hospitals to lessen the amount of Medicaid underpayments that must be covered by privately insured patients and their employers.

Enacting the assessment was a difficult task. Because hospital leaders enlisted broad legislative support for the bill, and because it had money attached to it, many groups and legislators sought to amend their issues to the bill or sought to divert money from the fund. WSHA made some compromises along the way, but the ultimate bill is a good one.

Now that HB 2956 has been enacted, WSHA's work is not over. WSHA staff will be actively involved in securing the federal Centers for Medicare & Medicaid Services (CMS) approval of the program and working with the state Health and Recovery Services Administration (HRSA) on program implementation.

ASSESSMENT TIMELINE

Event	Timing
Hospital safety net assessment law (HB 2956) enacted by the legislature and signed by the Governor	April 2010
HRSA submits the state Medicaid plan to CMS for restoration of 2009 cuts	April 2010
HRSA submits a waiver to CMS to put assessment in place	April 2010
HRSA submits new state Medicaid plan to CMS for increasing hospital Medicaid rates	April 2010
HRSA writes the rules, regulations, and/or policy memoranda to implement the assessment	2010
CMS approves restoration of the 2009 Medicaid cuts	Unclear
HRSA implements initial assessment and restores Medicaid rates (retroactive and prospective)	Unclear; dependent on CMS approval
CMS approves the full assessment and increased Medicaid rates	Unclear
HRSA implements the full assessment and increased rates	Unclear; dependent on CMS approval
HRSA submits annual reports to WSHA	Annually in November
HRSA submits fund balance data to WSHA	Annually in November
HRSA may recalculate assessment rates	Annually in July
HRSA designs a quality program	Fall 2010
HRSA conducts measurement for the quality program	2011
HRSA implements payment increases for quality care	2012
Assessment and rate increases sunset	June 30, 2013
WSHA likely renegotiates the assessment and rate increases with the Governor and legislature	2013 state legislative session

WSHA BILL SUMMARY (continued)

ASSESSMENT RATES
(Per non-Medicare inpatient day)

Dates	Prospective Payment System Hospitals*	Psychiatric Hospitals	Rehabilitation Hospitals	Certified Public Expenditure Hospitals	Harborview and UWMC	Critical Access Hospitals
July 2009 to January 2010	$30	$0	$0	$0	$0	$10
February to December 2010	$151	$31	$31	$0	$0	$10
January to June 2011	$190	$39	$39	$0	$0	$10
July 2011 to June 2013	$200	$39	$39	$0	$0	$10

* For prospective payment system hospitals, days over 60,000 per year are assessed at a lower rate. These rates, by time period, are: $1, $5, $6, and $6.

PAYMENT INCREASES

Dates	Prospective Payment System Hospitals	Psychiatric Hospitals	Rehabilitation Hospitals	Certified Public Expenditure Hospitals	Harborview and UWMC	Critical Access Hospitals
July 2009 to January 2010	4.17%**	n/a	4.17%**	4.17%**	4.17%**	Small Rural DSH at 120% or $50 per day
February 2010 to June 2013	4.17%** +13% inpatient; 36.83% outpatient	13% inpatient	4.17%** +13% inpatient	4.17%**	4.17%** +3% inpatient; 21% outpatient	
July 2010 to June 2013	Maintenance of Indigent Assistance Disproportionate Share Hospital payments					

** 4.17% is needed to restore the four percent cut.

Infection Rate Reporting: HB 2828 changes the state's infection rate reporting law so hospitals will report surgical site infections to WSHA instead of to the Centers for Disease Control. Hospitals are currently submitting data on central line infections and ventilator associated pneumonia rates to the Centers for Disease Control's National Health Safety Network (NHSN). The Washington State Department of Health then posts the rates on its public web site. While reporting to NHSN for these two types of infections was challenging, hospitals overcame the administrative barriers and made it work. Unfortunately, reporting on surgical site infections is much more complicated to administer and would have overwhelmed hospitals.

Representative Tom Campbell, sponsor of the original infection rate reporting legislation, helped WSHA amend the legislation. Hospitals can now report in a streamlined fashion to WSHA's Quality Benchmarking System until the NHSN reporting system is made more compatible with hospital computer systems or three years, whichever comes first. WSHA must publicly post a report containing the infection rates on its website by December 1, 2010.

Cardiac and Stroke Care: HB 2396 seeks to make Washington State's system for treating cardiac and stroke events as fast and effective as the trauma system. The faster someone is treated for a heart attack or stroke, the less likely he or she will die or become disabled. This is complicated by the fact that many stroke or cardiac patients arrive at the hospital emergency department with no emergency medical services contact.

The legislation is the result of two years of study by a Department of Health work group related to emergency medical services and trauma care. According to the new law, hospitals will self-identify cardiac and stroke capabilities and the level of services provided by the hospital. Hospitals are provided "deemed status" if certified by the Joint Commission or other accrediting bodies. The department is required to adopt cardiac and stroke pre-hospital care protocols consistent with the recommendations of the work group.

Participating hospitals must: (1) participate in internal and regional quality improvement activities; and (2) participate in national, state, or local data collection to ensure system performance meets nationally recognized consensus measures for stroke. Hospitals may advertise their participation, but may not claim certification unless verified by an external, nationally-recognized certifying body.

WSHA BILL SUMMARY (continued)

Nursing Assistant Credentialing: SB 6582 creates a career pathway for home care aides and medical assistants to become certified nursing assistants. The bill allows alternative and relevant training as well as current experience to be applied towards becoming a certified nursing assistant. The bill also creates a commission to adopt criteria for evaluating alternative training in order to determine eligibility to take qualifying exams. As a result of lobbying by WSHA and other groups, the legislature added employers to those advising the commission. Also as a result of lobbying, the legislation clarifies that federal requirements for training of certified nursing assistants working in long-term care settings must be followed.

Cardiovascular Invasive Specialists: HB 2430 adds cardiovascular invasive specialists to the list of professions recognized under Revised Code of Washington (RCW) 18.84. Washington State is home to one of the few schools in the nation for cardiovascular invasive specialists, but until now the profession has not been recognized here. Cardiovascular invasive specialists are a new type of radiologic technologist. These technologists work under the personal supervision of a physician. Work includes all anatomic or physiological studies of intervention in which the heart, coronary arteries, or vascular system are entered via a systemic vein or artery using a catheter that is manipulated under fluoroscopic visualization. Until July 1, 2012 the state Department of Health must also issue a credential to any other type of health professional with a department credential who has at least five years of experience in cardiac or vascular catheterization.

Accountable Care Organization (ACO) Pilot Projects: SB 6522 requires the Washington State Health Care Authority to appoint a lead organization by January 1, 2011 to support at least two accountable care organization pilot projects that will be implemented no later than January 1, 2012. ACOs establish a spending benchmark for health care providers in an organization based on an expected level of spending. They offer provider organizations such as medical homes or primary care practices the opportunity to share savings from payers when the savings are achieved through care coordination, wellness, chronic care management, and effective referral patterns. This model attempts to shift emphasis from volume and intensity of services to incentives for efficiency and quality.

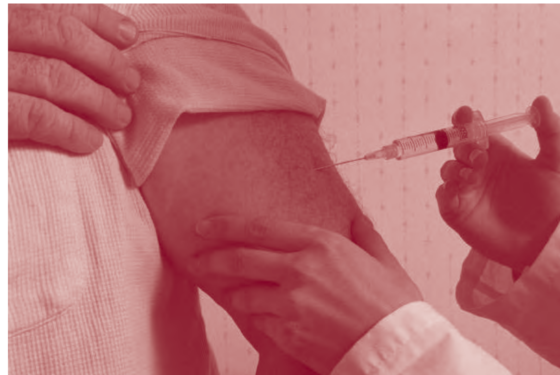
The lead organization will provide support for the pilot projects without using state funding. It may seek federal funds and solicit grants, donations, and other sources of funding. The accountable care organizations participating in the pilot projects must use spending benchmarks and report health outcomes. Coordination

with existing medical home pilot projects is also required. Washington State's pilot program is a good training ground for the accountable care organizations envisioned in federal health reform law.

Dissolution of Nonprofit Assets: HB 3046 clarifies the authority of superior courts to handle the dissolution and disposal of assets of a nonprofit corporation when the board is at an impasse. The initial legislation was problematic because it was so far reaching. WSHA worked with other stakeholders to identify acceptable language from the American Bar Association's Model Nonprofit Corporation Act. A substitute bill was introduced and enacted.

Under the new law, a superior court may dissolve a nonprofit corporation in a proceeding brought by the attorney general, a creditor, certain persons with voting power of the corporation, or by one or more directors if certain criteria are met. The court may issue injunctions, appoint a general or custodial receiver with all powers and duties as directed by the court, take other action required to preserve the corporate assets, and carry on the activities of the nonprofit corporation until a full hearing can be held. If a court determines that grounds for dissolution exist, the court may enter a decree dissolving the nonprofit corporation and direct the winding up and liquidation of the nonprofit corporation's affairs. The act is prospective and only applies to actions or proceedings commenced on or after the effective date of the act.

Washington Vaccine Association: HB 2551 establishes the Washington Vaccine Association as a nonprofit corporation to ensure cost-effective purchase and distribution of children's vaccines. Historically, the state had a universal vaccine purchasing system that gave all children access to the Centers for Disease Control contract pricing. Last year, the legislature cut funding for vaccine programs for privately insured children. The association will assess health carriers and third-party administrators for the cost of vaccines for children. The vaccine association will ensure low-cost vaccines are available to all children through a more efficient system than uncoordinated purchase by health care providers.



Eliminating Boards and Commissions: HB 2617 and SB 5995 eliminate many state boards, committees, and commissions in an attempt to save the state money. WSHA and others worked successfully to ensure continuation of several boards and commissions important to hospitals. These include the Emergency Medical Services and Trauma Care Steering

WSHA BILL SUMMARY (continued)

Committee, which works to sustain and improve Washington's much-praised trauma system; the Workforce Training Customer Advisory Committee, which does critical planning for health care education in community colleges; and the Advisory Council on Adult Education, which has been helpful in meeting the education needs of the adult work force in hospitals.

Tax Exemption for Air Ambulances: Under current Washington law, aircraft are subject to either the property tax or the aircraft excise tax, depending on the type of aircraft. SB 6737 creates an exemption from both types of taxes for aircraft used exclusively to provide emergency medical transportation services. To qualify for the tax exemption, the aircraft must be owned by a nonprofit organization.

Health Plan Eligibility: Under current law, people who lose group health insurance have 31 days to secure individual insurance without experiencing a lapse in coverage or being subject to pre-existing condition requirements. HB 2521 clarifies that the 31 days begins on the date the health plan's coverage ends, or 31 days from the date the person is notified of the loss of coverage, whichever is later. The bill ensures people can continue coverage even if their employer does not provide adequate notice about the policy's cancellation.

Bills *Not* Enacted

WSHA successfully lobbied to ***defeat*** or significantly ***amend*** the following bills that ultimately were ***not enacted*** by the legislature, in rough order of WSHA priority and effort:

Meal and Rest Breaks: HB 3024 would have required hospitals to provide uninterrupted meal and rest breaks for their employees, with very narrow exceptions that did not adequately provide for patient needs. Although WSHA and hospital leaders support hospital staff meal and rest breaks, this bill would have led to arbitrary and rigid assignments of break times, with little flexibility for staff. Hospitals vehemently opposed the bill as it was drafted.

The bill was amended through the process, including limiting the bill's applicability to nurses and technicians and broadening the exceptions for patient care. Even with these amendments, the bill created significant patient safety concerns for WSHA, hospitals, physicians, and many direct caregivers who would have been affected by the bill.

WSHA successfully partnered with concerned direct care providers to defeat the bill. Nurses and technologists testified in opposition; repeatedly met with legislators; worked with WSHA to produce a video explaining their opposition; and even aired their concerns on The Dave Ross Show and the nightly news. Other organizations opposing the legislation included the Washington State Medical Association, the Northwest Organization of Nurse Executives, and the Washington State Society of Radiologic Technologists.

Three nursing unions — SEIU Healthcare 1199NW, the Washington State Nurses Association, and United Staff Nurses Union, Local 141 UFCW — lobbied the legislation nearly all the way through the legislature. They ran television advertisements claiming hospitals were opposed to safe patient care and set up a "Rest Breaks for Safety" web site.

At one point during the session, a legislator described the bill as a "freight train." This was an apt description as there was overwhelming momentum driving it towards enactment. Both the Senate and the House have overwhelming majorities of Democrats, many of whom have strong ties to labor unions. The bill passed the House 63 to 34, largely on a party line vote. WSHA and other opposing parties successfully stopped the bill at the last possible moment – just before the bill was brought to a final vote on the floor of the Senate. The bill was then revived again as legislators sought to amend it onto the Hospital Safety Net Assessment legislation. Fortunately, that effort was also defeated.

Interstate Sale of Health Insurance: HB 3015 and SB 6781 had the goal of allowing Washington State to enter into an agreement with other states to permit the sale of health insurance across state lines. The bills would have applied to the small group market. WSHA strongly opposed the bills because out-of-state health insurance could have been sold in Washington State without complying with our state's mandated benefits laws. A number of these mandated benefits are important to hospitals. The bills threatened Washington's mental health parity law, as well as other mandated benefits such as diabetes coverage and reconstructive breast surgery. WSHA, the Washington Coalition for Insurance Parity and many other groups worked successfully to defeat the bills and prevent them from being amended to other bills.

WSHA BILL SUMMARY (continued)

Patient Safety Implications of Meal and Rest Breaks Legislation

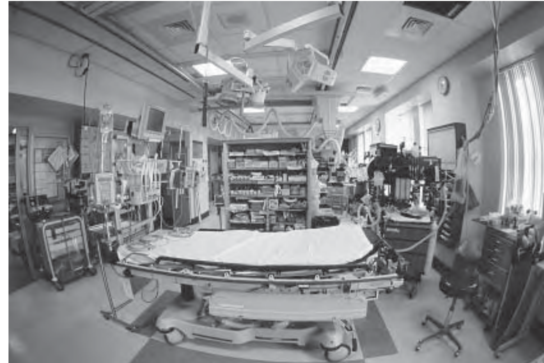
Proponents of HB 3024 claimed the bill would improve patient safety by ensuring health care workers were better rested and able to focus on providing patient care. Opponents, including many direct caregivers, believe the legislation instead created an unsafe practice environment. Here is why.

- Once a nurse or other health care provider covered by the legislation was on break, he or she could not be interrupted except in very narrow circumstances prescribed by the bill. These exceptions included: (1) an unforeseeable emergent circumstance (defined to mean a natural disaster or other large scale emergency); or (2) a clinical circumstance that could lead to patient harm without the specific skill or expertise of the employee on break. The second exception did not provide for interruption based on the most important factor an individual health care provider usually has to contribute to a patient care situation — ***knowledge*** of the patient's clinical situation. As a result, the exception as written would have been used infrequently — to the detriment of patients.
- Another reason the bill created patient safety concerns is it removed the professional judgment of the nurse or other care provider about when it would be safe to interrupt a break. While the goal is always to have an uninterrupted break, health care workers want to know when something significant is happening with a patient. If critical laboratory values come back or an important physician or family consultation occurs, the health care provider wants to know what is happening and make sure critical information is shared. This bill would have eliminated that professional judgment about when to return to the bedside.
- The bill would have also created communication barriers among health care providers. Patient safety experts cite communication breakdown as one of the most significant contributors to medical errors. Once a nurse was on break, it would be a rare instance when he or she could be consulted on a patient concern. Currently, it is possible to consult with health care providers on break without violating state law. A quick question, posed and answered in the break room, could save a patient's life.

Adverse Event Penalties: SB 6247 would have required the state Department of Health to fine a medical facility that has failed to provide notification or to report an adverse event $1,000 per violation per day. The Senate Health and Long Term Care Committee was concerned that some hospitals were not reporting adverse events and some were not reporting events frequently enough. WSHA staff explained how adverse event reporting currently takes place. Hospitals not reporting or reporting infrequently are almost exclusively small rural hospitals. In these hospitals, the number and complexity of the patients and types of procedures performed makes the probability of an adverse event much lower than in larger facilities.

WSHA and department staff also explained the check-in survey developed jointly by the two organizations to remind hospitals regularly of the adverse event reporting requirement. The department is sending each hospital a quarterly on-line survey that prompts hospitals to respond whether or not the hospital confirmed an adverse event in the previous quarter.

Payment for Emergency Services: HB 2779, SB 6400, and SB 6532 all sought to change the definition of emergency services and limit charges for emergency services provided by non-contracted providers. The bills would have required the benefit level provided to a person with insurance to be the same for covered emergency services provided in a participating hospital, whether provided by a participating provider or a non-participating provider. Providers would have been prohibited from balance billing the patient for the difference between the plan payment and the provider charges.



WSHA worked with the Washington State Medical Association to defeat the bills. Our state is experiencing a shortage of emergency medicine providers, and these bills would have made it more difficult to attract highly qualified physicians to emergency departments in Washington. They would also have made it harder for hospitals to provide adequate staffing of emergency providers and on-call specialists. The bills ultimately would have had a detrimental effect on emergency care for patients.

Adverse Employment Actions Due to Influenza: HB 2764 would not have allowed any employer to fire or discipline an employee because of absence due to influenza-like illness. A complaint from an employee would have triggered an extensive review by the Washington State Department of Labor and Industries and potentially court action. WSHA advocated that this type of policy only made sense when employees were vaccinated for influenza and proposed making the protections contingent upon employees being vaccinated. This bill and the proposal to require vaccines both died.

Freestanding Emergency Rooms: SB 6671 would have made free-standing emergency departments subject to the Certificate of Need process. Current Certificate of Need requirements for hospitals include: construction of a new hospital; sale, lease, or purchase of a hospital; reallocation of beds between major categories; new beds; and new tertiary services. WSHA's position on the Certificate of Need program is that it should not be expanded until Washington State has an adequately funded and staffed state health resources plan.

Wrongful Death: SB 6508 proposed to expand liability under the state's wrongful death statute. The bill would have eliminated the decades-old age limit of 18 for making a wrongful death claim for a child. It also would have allowed parents of adult children to recover unlimited non-economic damages. The legislation allowed

WSHA BILL SUMMARY (continued)

for possible punitive damages against government entities, which are not allowed under current law. The Attorney General's Office estimated an $18 million per biennium impact for the state. The Association of Washington Cities estimated an additional $2 million added to every local government payout on wrongful death claims. This would have been a major concern for Washington's public hospital districts. The Liability Reform Coalition (WSHA is a member) led the opposition to this legislation. The bill was not enacted after a long standoff between the House and the Senate regarding amendments eliminating joint and several liability for local government entities in wrongful death cases.

Street Maintenance Utility Charge: HB 2618 would have allowed for the creation of local option street maintenance utilities to raise revenues for street maintenance. Street maintenance utility rates would apply to residents, businesses, governmental entities, and other users. For businesses, the rate would have been expressed as dollar amounts per trip or based on types and volume of trips generated. Hospitals are major employers and generate high traffic due to the nature of the services they provide. Because the bill provided no safeguards to prevent hospitals from bearing a disproportionate cost of a city's road maintenance, WSHA and other groups worked successfully to defeat it.

Informed Consent: HB 2544 would have changed the state's medical liability law to require that patients with drug allergies provide written "informed consent" before receiving a drug or a drug within a family of drugs to which the patient has a known allergy. While Washington hospitals are strong supporters of patient safety, the approach of this legislation threatened to slow hospital operations dramatically — especially in places such as the operating room — as a formal informed consent process occurred with each patient. WSHA is interested in reducing medication errors in ways that allow for less disruption to patient care and that do not create entirely new liability theories upon which hospitals can be sued. Fortunately, this bill died early in the session without a hearing.

False Claims: SB 5144 died early in the session. The bill would have created a state law about false claims, redundant to federal law. The law would have been the first in the state where individuals who sue can personally recover large amounts of money. These "qui tam" suits increase state expenses with uncertain potential for recoveries. The state must review each qui tam complaint, investigate, and decide whether to take over the suit or decline. In Washington, enforcement laws for the Medicaid program already exist. It is not clear that the expense of granting individuals the right to sue would have been offset by amounts gained in recoveries.

Nonprofit Hospital Acquisitions: SB 6698 would have required ten annual reports following the acquisition of a nonprofit hospital. It would also have given the state Department of Health quicker authority to punish new owners who are not fulfilling commitments to the affected community. It would have created an additional community study paid for by the acquiring organization for future acquisitions. WSHA offered constructive amendments, including removal of the financial penalties and adding due process provisions, but the bill died in the House.

WSHA BILL SUMMARY: DISAPPOINTING RESULTS

The following bills were not enacted by the legislature, despite WSHA's lobbying in support of them, listed in rough order of WSHA priority and effort:

Protecting Patients from Influenza: SB 6486 would have required hospital workers to be immunized for influenza or follow hospital infection control guidelines for working with patients during the influenza season. In many cases, hospitals would likely have determined that hospital infection control guidelines should include wearing a surgical mask. The bill also would have required education for workers who declined to be vaccinated about the impact of that decision on patients, families, and co-workers.

Despite strong nursing union opposition, the bill received a highly favorable hearing in the Senate Health and Long Term Care Committee. Legislators recognized workers would be given a choice about immunization, and the bill was designed to promote patient safety. The unions successfully lobbied that the bill never be brought up for a vote, and it died in committee. WSHA is not giving up on this important strategy to prevent hospital-acquired infections, and will work with hospitals to determine the next practical steps in protecting patients from the flu.

Respiratory Care Practitioners: HB 2989 would have expanded the types of practitioners who could supervise respiratory care practitioners. Currently, only physicians may provide supervision. The bill would have allowed supervision to be provided by: osteopathic physicians, physician assistants, osteopathic assistants, and nurse practitioners. This would have made it easier for hospitals to offer respiratory care services. The bill was not enacted.

WSHA BILL SUMMARY (continued)

Exemptions from Immunizations: Immunizations are theoretically required for school attendance in Washington State, but our state offers one of the easiest procedures in the nation for parents to exempt their children from needed vaccines. Consequently, our childhood vaccine rate consistently lags behind the rest of the country. Parents may currently exempt their children from vaccines without consulting a health care provider. HB 2706 would have modified the vaccine exemption form to require a statement signed by the child's health care provider that the individual requesting the exemption was counseled by the provider on the benefits and risks of immunizations. Unfortunately, the bill died in the final days of the legislative session.

The following bill was enacted by the legislature, despite WSHA's opposition:

Tort Judgment Interest Rate: SB 6764 unravels a bipartisan standard set by the legislature in 2004 and increases the interest rate on tort judgments for non-governmental entities. The "tort judgment interest rate" is the amount of interest a defendant pays on an award while the case is on appeal. The legislation increases the tort judgment interest rate for non-governmental defendants to two points above the prime rate. (The current prime rate is 3.25 percent.) The result is rates significantly above market rates. For governmental entities the current structure, which requires defendants to pay interest at two points above the 26 week average Treasury Bill rate, remains in place. (The current treasury rate is 0.21 percent.) This discrepancy results in the private sector paying significantly higher rates. The Liability Reform Coalition (WSHA is a member) led the opposition to the bill, but ultimately it was enacted.

Your Advocacy Makes a Difference!

Hospital contacts with legislators made an important difference in the outcome of many of the bills and budget items WSHA lobbied. Hospital staff and leaders provided excellent testimony about how certain proposed legislation or budget items would positively or negatively affect hospital operations and patient care. Hospital leaders, board members, and staff made phone calls, sent e-mails, wrote letters, and met with legislators. Thank you to those who provided excellent advocacy this session – we could not have been so successful without you!

WSHA BILL SUMMARY: OTHER BILLS

WSHA was ***neutral*** on the following bills, but they affect hospitals and WSHA will be involved in their implementation:

Pain Management Education: HB 2876 requires that by June 30, 2011 the Medical Quality Assurance Commission, the Board of Osteopathic Medicine and Surgery, the Podiatric Medical Board, the Dental Quality Assurance Commission, and the Nursing Care Quality Assurance Commission adopt new rules on chronic, non-cancer pain management. The rules must contain dosing criteria, including a dose limit triggering consultation with a pain specialist, guidance on using pain specialty consultation, guidance on tracking clinical progress, and tracking use of some opioids.

The boards and commissions must adopt rules in consultation with several groups, including the largest associations representing the professions the boards and commissions regulate. The rules do not apply to palliative, hospice, or other end-of-life care. The rules also do not apply to the management of acute pain caused by injury or a surgical procedure. The bill was widely supported across health disciplines.

Penalties for Vulnerable Adult Abuse: SB 6202 creates new penalties for people who physically abuse or take financial advantage of vulnerable adults. The bill includes additional reporting requirements for health professionals and facilities, including hospitals.

A vulnerable adult is a person 60 years of age or older who has the functional, mental, or physical inability to care for himself or herself; is incapacitated; has a developmental disability; is admitted to a licensed facility; or receives services from home health, hospice, or home care agencies. Certain persons who are "mandated reporters" under state law have a duty to report suspected assault, financial exploitation, abandonment, abuse, or neglect of a vulnerable adult to the Washington State Department of Social and Health Services. Mandated reporters include social service and health care providers, social workers, and law enforcement.

Under the new law, mandated reporters must now also report the death of a vulnerable adult to a medical examiner or coroner and law enforcement when the mandated reporter suspects the death was caused by abuse, neglect, or abandonment.

WSHA BILL SUMMARY (continued)

Involuntary Treatment Act Changes: HB 3076 modifies the definition of "likelihood of serious harm" within the Involuntary Treatment Act to include an additional basis for commitment. The new law allows designated mental health professionals making a determination of initial detainment to consider information provided by family members or others with significant contact with the individual or who are familiar with the individual's history. These two changes will take place in January 2012.

The bill also requires the state hospitals and evaluation and treatment facilities to provide a packet of information about the person to the designated mental health professional office responsible for the initial commitment and the designated mental health professional office that services the county in which the person is expected to reside. Also, before imposing legal financial obligations on a defendant who suffers from a mental health condition, other than restitution or the victim penalty assessment, a judge must first determine the defendant has the means to pay such additional funds.

Restraints on Pregnant Women or Pregnant Youth: HB 2747 prohibits the use of restraints of any kind on pregnant women or pregnant youth incarcerated in a correctional or detention facility while the woman is in labor, during childbirth, or in postpartum recovery. The new law does not affect the use of hospital restraints requested for the medical safety of the patient by treating physicians. If a doctor, nurse, or other health professional treating the pregnant woman or youth requests that restraints not be used, the corrections officer accompanying the pregnant woman or youth must immediately remove all restraints. Any time restraints are used on a pregnant woman or youth, they must be the least restrictive available and the most reasonable under the circumstances; leg irons or waist chains may not be used. No correctional personnel can be present during the pregnant woman's or youth's labor or childbirth while she is being attended to by medical personnel, unless specifically requested by the medical personnel. If the employee's presence is requested by medical personnel, the employee should be female if practicable.

Prescriptions from Nurse Practitioners: SB 6627 authorizes Washington pharmacies to fill prescriptions written by advanced registered nurse practitioners in other states or in certain provinces of Canada. Current law authorizes pharmacists to accept prescriptions from physicians, osteopaths, dentists, podiatrists, and veterinarians licensed in any state or province of Canada that shares a common border with Washington State. Current law does not allow prescriptions written by advanced registered nurse practitioners to be filled by pharmacists. The new law authorizes pharmacists to accept prescriptions written by a licensed advanced registered nurse practitioner in any province of Canada or state of the United States that shares a common border with Washington State.

Medical Interpreters: SB 6726 adds language access providers (Medicaid or medical assistance interpreters) to the list of workers who will collectively bargain with the state. The bill as passed by the legislature, would also have established a work group, with a WSHA representative as a member, to explore a more responsive and cost effective alternative to the current language brokerage system; the Governor vetoed that section.

Related to SB 6726, there are no cuts to interpreter services funding in the enacted budget. Prior to the session, it was assumed the state would no longer pay for interpreters for medical services and the costs would be absorbed by the hospitals and providers. This was a concern to many clinics and hospitals and would have impacted access to care.

AWPHD BILL SUMMARY: POSITIVE RESULTS

The Association of Washington Public Hospital Districts (AWPHD) successfully lobbied in ***support*** of the following bills enacted by the Washington State Legislature:

Mortgage Authority for Public Hospital Districts (PHDs): Enacting HB 2510 was AWPHD's top legislative priority. With this new law, effective June 10, 2010, PHDs gained an additional option for financing facilities and equipment. HB 2510 enables a PHD issuing bonds in connection with a federal program providing mortgage insurance, including Federal Housing Administration (FHA) mortgage insurance programs, to grant a lien on its property pursuant to a mortgage, deed of trust, security agreement, or any other security instrument allowed under applicable law. The FHA is authorized to insure mortgage loans for the construction, rehabilitation, replacement, and equipping of hospital facilities, as well as the refinancing of existing debt. In some situations, mortgage insurance obtained from the FHA or another federal agency will result in reduced financing costs for participating hospitals, and will make possible financing options that would otherwise not be available. The bill made it through the legislative process with no negative testimony offered, and was approved unanimously by both the Senate and the House.

Responding to Public Records Requests: With the enactment of SB 6367, PHDs and other agencies will be able to direct requesters of public records to the agency's web site in some circumstances to access the requested records. Under the current Public Records Act, an agency must respond to a request for records within five days by either: (1) providing the record; (2) acknowledging that the agency has received the request and providing a reasonable estimate of the time the agency will need to respond to the request; or (3) denying the request. SB 6367 now gives agencies another option. In addition to the above three options, an agency can provide an Internet address and link on the agency's web site to the specific records requested. However, if the requester notifies the agency that he/she cannot access the records through the Internet, the agency must provide copies of the record or allow the requester to view copies using an agency computer.

Local Option Capital Asset Lending Program: With the enactment of SB 6218, effective June 10, 2010, PHDs will be able to participate in the local option capital asset lending program through the State Treasurer's Office, including with respect to voter approved bonds payable from excess property tax levies. Under current law, PHDs and other local governments that receive voter approval to issue bonds

payable from excess property tax levies are ineligible to use the State Treasurer's Office financing program. SB 6218 changes this to allow PHDs and other local governments to use the State Treasurer's Office pooled financing program for voter approved bonds payable from excess property tax levies.

New Resource for AWPHD Members

AWPHD has completed its first legislative session working with the Municipal Research and Services Center (MRSC) of Washington, with excellent results. The MRSC has extensive experience working with local governments on legal issues. We encourage AWPHD members to contact Joe Levan, Legal Consultant, with legal questions, including questions about implementing these newly enacted laws. Joe can be reached at jlevan@mrsc.org or (206) 625-1300.

Joe Levan, Legal Consultant
Municipal Research and Services Center of Washington

AWPHD BILL SUMMARY: OTHER BILL

Changes to Campaign Contribution and Disclosure Laws: HB 2016 is a very lengthy bill that changes several provisions related to campaign contribution and disclosure requirements. Some of the changes were effective March 25, 2010, and others go into effect January 1, 2012. Given the complexity of the legislation, AWPHD will be seeking guidance from the Public Disclosure Commission and others and will provide additional information on this topic in the coming months.

Cultivate Relationships with Your Legislators!

The summer and fall are ideal times to cultivate relationships with your legislators, so when you contact them during the legislative session, you already have a solid connection. Some ideas:

- Arrange a meeting with your legislators in their offices, or for lunch or coffee somewhere in your community.
- Invite legislators to visit your hospital. While they are there, give them a tour. Tours are a great way to inform legislators about the work of your hospital, nursing home, or clinic. Tours give legislators a first-hand view of how government investments are working in hospitals and health care.
- Educate legislators about your patient safety work or your work with nurse staffing committees, and the gains you are making in these areas.
- Invite legislators to make a presentation to your hospital's governing board about their goals and priorities, as well as a discussion about the hospital's needs. Legislators always love an opportunity to address a smart, well-connected group!

For assistance, please contact Cassie Sauer at cassies@wsha.org or 206/216-2538.

FOR MORE INFORMATION

All of us on the WSHA staff continue to be grateful for your effective support of our policy and advocacy efforts and your relationships with your legislators. Your involvement in our advocacy agenda, your legislative relationships, and your legislators' understanding of your hospitals are critical to our work. We hope each of you will make strengthening these legislative relationships a priority this summer and fall. If we can help you create or improve these relationships, please let us know.

Please do not hesitate to contact us with questions or comments about the 2010 legislative session or with your suggestions as we prepare for the 2011 session. We work for you, and we want to make sure we are doing all we can to support your hospital or health system!

Sincerely,

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Educating Hospital Boards

WSHA's Hospital Governing Boards Committee continues to encourage trustees and commissioners to increase their involvement in policy and advocacy. Contacting legislators on behalf of hospitals and their patients is an important role of hospital trustees and commissioners. WSHA works to give board members the tools they need to be effective advocates.

One great way for trustees and commissioners to increase their advocacy on behalf of their hospitals is to learn about the legislative process, the issues at stake, who represents them, and how the state legislature affects their local hospitals. WSHA staff will be pleased to come to your hospital's board (or staff) meeting and lead a discussion of these topics. Please contact Jo Chavira at 206/577-1838 or joc@wsha.org to schedule a presentation.

Political Action Committees

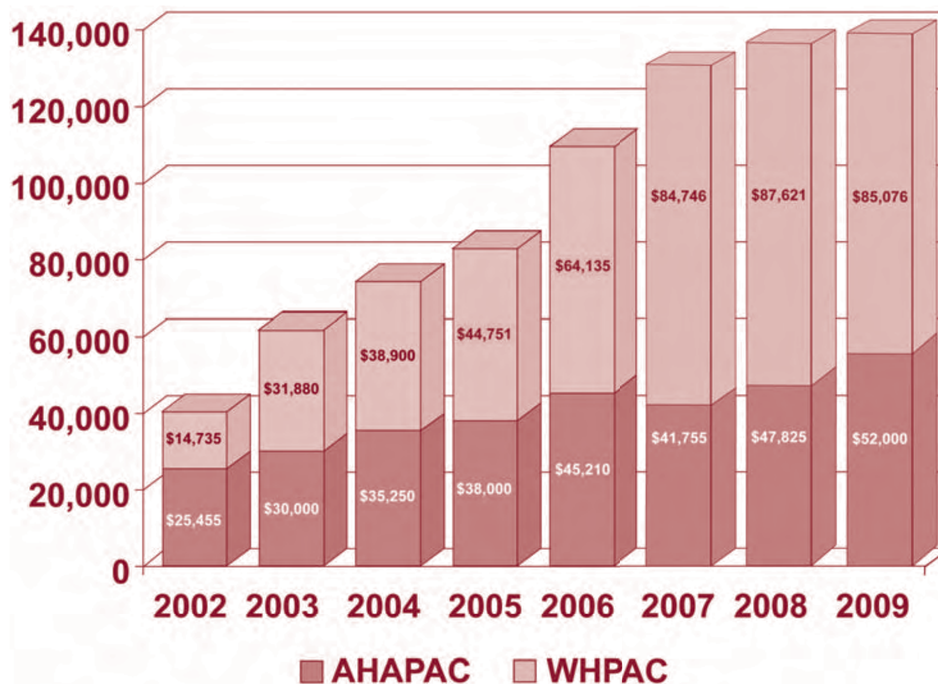
In 2001, WSHA members directed the Washington Hospital Political Action Committee (PAC) to expand and increase its political influence through greater involvement in federal and state elections. They also asked for increased contributions to the American Hospital Association PAC.

As a result, both PACs are making significantly more and larger contributions to federal and state elected officials from Washington State who have been helpful on hospital issues and deserve our support as they seek election. In particular, the Washington Hospital PAC has been instrumental in electing numerous state legislators who have become great supporters of hospitals and health care.

The main reason for the success of both PACs is the participation of individual hospital management staff and trustees/commissioners. As shown in the chart below, contributions have grown significantly since 2002. In 2009, 475 individual contributors from 91 hospitals and health systems contributed more than $137,000! ***The goal for 2010 is $150,000.***

The legislative decisions affecting hospitals are significant, and both PACs need your support to be effective. Please contact Jo Chavira at 206/577-1838 or joc@wsha.org for more information or to make a personal contribution.

We look forward to receiving your generous PAC contribution in 2010!



POLICY/ADVOCACY TEAM*

The 24 members of the Policy/Advocacy Team represent hospital interests before federal, state, and local governments. Team members work with hospital leaders and elected officials to support priorities of the Washington State Hospital Association (WSHA) and the Association of Washington Public Hospital Districts (AWPHD). Team members also work with federal, state, and local agencies to help ensure appropriate enforcement and administration of hospital-related policies, rules, and laws.

For more information about the Policy/Advocacy Team, see www.wsha.org or contact Randy Revelle at 206/216-2515 or randyr@wsha.org.

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* *Everyone works for WSHA only, except where indicated otherwise.*

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