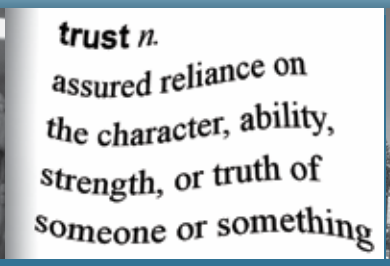
Washington State Hospital Association

# 2011 Legislative Summary

*July 2011*




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

# INTRODUCTION

We are pleased to provide you with our 2011 Legislative Summary. It is an honor to represent you before the Washington State Legislature.

This, my first legislative session as your hospital association president, was extraordinarily difficult. The state's deep budget deficit on top of significant budget cuts made in 2009 and 2010 created a crisis in funding essential state services unequaled in recent memory. We have serious concerns that the cuts the legislature enacted – not just to health care, but to all the services the state provides for its residents and their quality of life – could negatively impact Washington State and the people who live here for years to come.

Unfortunately, hospitals and health systems were not spared the pain of the state's deficit and budget cutting. The state budget cuts the safety net and will cause real pain for vulnerable people and the health care providers who serve them. Hospitals and health systems will experience increases in demand for charity care and emergency room services, while enduring significant cuts in payments. The burden of these cuts will fall on poor children, seniors, people with disabilities, and low-income workers. Workers with private insurance will be affected as hospitals are forced to shift the cost of state underpayments to them. In particular, we are dismayed by the raiding of the Hospital Safety Net Assessment funds we worked so hard to establish last year.

We had much greater success with policy issues, where we focused our energy on stopping a number of bad policy bills that would have added more regulatory burdens to each of your facilities and operations. We stopped bills that would have interfered with hospital and health systems trustees' ability to recruit and retain talented hospital executives, politicized hospital financing, shared detailed root cause analysis from adverse event reporting with payers, and allowed whistle blowers to bring frivolous Medicaid fraud lawsuits against hospitals, health systems, and other health care providers. On a positive note, the hospital association worked hard with legislators and other stakeholders to help enact some of the enabling legislation required to implement health care reform in Washington State, including laws creating Washington's health insurance exchange and establishing primary care health homes.

As always, we are grateful for your outstanding help. 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 partnership.

I hope this summary provides you with useful information about key changes in the state budget and state laws that will affect your hospital and health system. We look forward to working with you to sort out the results of what happened in 2011 and to prepare for the 2012 legislative session.

Warm regards,

**Scott Bond**
President and CEO
Washington State Hospital Association

**Shifting Responsibility**

Members of the Washington State Legislature and the Governor clearly hope non-profit and community-based organizations, including hospitals, will be able to pick up the pieces from the deep cuts they made. Hospitals – as well as churches, food banks, higher education institutions, and others – will have a difficult time absorbing the impact of these cuts. These cuts will hurt the people who rely on these services, and the stability of local health systems may be threatened in some parts of the state.

# BUDGET SUMMARY

## The Budget Context


This year, as in all odd-numbered years, the Governor and the Washington State Legislature were charged with creating a budget to govern the 2011 to 2013 biennium. In addition to the biennial budget, they also had to create a significantly revised supplemental budget that adjusted the current (2009 to 2011) biennial budget.

This year's supplemental and biennial budgets were unusual because of the crippling deficits facing the legislature. The state's budget deficit is a result of the national recession combined with increased demand for state services. Changes made in the biennial budget are severe and may have consequences for years to come. The changes made in the 2011 supplemental budget are also major; typically, supplemental budget changes are minor.

Washington State's budget deficit for the 2011 to 2013 biennium was ***$5.1 billion***. This deficit was in addition to the large budget deficit in the 2009 to 2011 biennium and the deep cuts made to eliminate that deficit. Total state spending for the 2011 to 2013 biennium will be about ***$32 billion***. Achieving a balanced budget is difficult in times of deficit because more than 60 percent of the budget is protected from being cut by the state constitution, federal law, or debt requirements. Unlike the federal budget, the state budget must be balanced. Any budget shortfalls must be addressed by cuts or new revenues.

On May 25, 2011, after a special session of the legislature, 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 budget will be in effect through June 30, 2013.

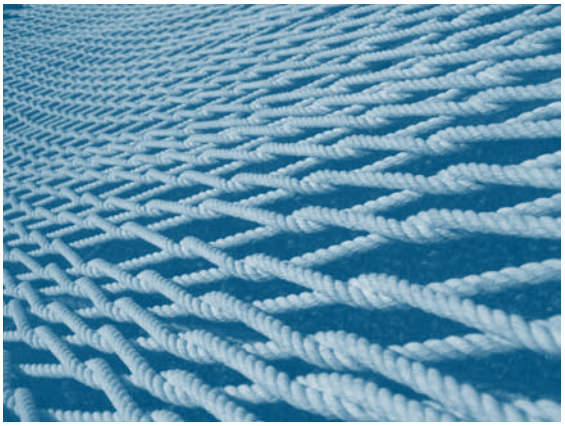
### Impact of the Recession

As the Washington State Legislature grappled with how to balance the budget, only some areas were eligible to be cut. Any part of K-12 education defined as "basic education" enjoys constitutional protection. Every year, Washington State also fully pays its debt obligations. Receipt of federal stimulus funding required the state to maintain its funding in some new areas, particularly higher education.

The sales tax is the most significant source of income for the state. 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. The amount cut for each item reflects state and federal funds; many health care programs receive substantial federal match.

**Hospital Safety Net Assessment:** The 2011 Washington State Legislature raided the Hospital Safety Net Assessment fund created in 2010. This fund was intended to restore prior Medicaid cuts, help keep hospital and health system Medicaid payment rates high enough to pay for the costs of care delivered, and reimburse hospitals for the cost of the assessment.

Under the assessment, the state collects a per-day fee from hospitals, uses that assessment to draw down new federal funds, and returns the money to hospitals to help pay for poor and vulnerable Medicaid patients. Unfortunately, the 2011 legislature broke the agreement made last year and raided the assessment fund. The enacted budget takes a total of ***$261 million*** that should be used to fund a reasonable level of hospital Medicaid payments and diverts the money to the state general fund. The $261 million includes ***$221 million*** in cuts to hospital Medicaid rates at larger, non-governmental hospitals and takes for the state the current ***$40 million*** surplus in the assessment account.

### Hospitals and Health Systems Sue to Stop Raid on the Assessment

By raiding the Hospital Safety Net Assessment, the legislature broke its word to hospitals, and health systems, violating both the Washington State Constitution and the assessment law. In 2010, hospitals and health systems reached an agreement with the legislature to make sure essential hospital Medicaid services could be preserved without creating a crisis in the state budget. The agreement used the assessment to restore cuts made in July 2009. In 2011, the legislature reneged on the agreement.

WSHA recently filed a lawsuit to overturn the legislature's action on House Bill 2069, which cuts hospital payments to prospective payment hospitals and diverts funds from patient services into the state's general fund.

WSHA and its member hospitals and health systems are convinced they had no choice but to file the lawsuit. A large grassroots effort by hospitals and their supporters failed to stop the bill during the legislative session. Hospitals needed to act to keep services to patients intact and ensure patients get the care they need.

The goal of the lawsuit is to maintain the assessment in its original form. We have great confidence in the merits of our lawsuit, and know it is the right strategy to protect hospital services for vulnerable patients.

**Emergency Room Visits:** The enacted budget limits payments for so-called "non-emergency" emergency room visits for Medicaid patients to three per year, projecting a savings of ***$72 million***. According to some legislative leaders, the intent of these cuts was not simply to save money, but to force hospitals to ensure patients receive care in the most appropriate settings. While no one should be using the emergency room as an alternative to primary care, many Medicaid patients lack access to care in their communities. Ironically, the cuts state legislators made to places where Medicaid patients receive primary care, such as community health clinics, will further exacerbate access and place greater demand on hospital emergency rooms. Federal laws require hospitals to screen and treat all patients who seek help at the emergency room, ensuring this abrogation of state responsibility is transferred to hospitals.

*"While no one should be using the emergency room as an alternative to primary care, many Medicaid patients lack access to care in their communities."*

In addition, WSHA has major concerns with the list of non-emergency conditions we believe will be included. Many of these could in fact be life threatening or lead to permanent disability. Some others may easily be determined to be non-emergent after screening, but the patient could not have known that prior to seeking help. As an example, someone with chest pain – a diagnosis included on the preliminary list of conditions – may or may not be having a heart attack, but this will not be clear until after the patient is screened.

**Basic Health:** This program currently insures about 40,000 low-income people, with many more on the wait list. Washington has been a leader in providing health care to its residents through this innovative program. Program enrollees, many with incomes below the poverty level, are not eligible for Medicaid, have no other health insurance, and cannot afford commercial coverage. While the program had previously been funded entirely by the state, the state was able to obtain a waiver from the federal government to allow for federal matching funds. Even with the additional funding, however, the legislature was unable to preserve the program in its original form.

The state's supplemental budget made major changes to Basic Health, such as disenrolling immigrants. The enacted budget further reduces Basic Health by 5,000 people each year, covering only 33,000 people in 2013, generating a savings of ***$202 million***.

# BUDGET SUMMARY (continued)

## SUMMARY OF BUDGET REDUCTIONS

| Budget Item Cut | Funding Cuts (All Sources) |
|---|---|
| Hospital Safety Net Assessment | $261 million |
| Emergency Room Visits | $72 million |
| Basic Health | $202 million |
| Disability Lifeline | Medical benefit preserved, but cash grant changed to a housing assistance program |
| Apple Health for Kids | $1.6 million |
| Mental Health Funding | $25.7 million |
| Disproportionate Share Hospital Payments | $29 million |
| Community Health Clinics | $86 million, with a $6 million offset for rural health clinics |
| Maternity Support Services | $24 million |
| Payment for Hospital Services | $8.7 million |

**Disability Lifeline:** This program currently covers 14,000 disabled poor people and provides health care to the state's most vulnerable residents. Most enrollees have mental health problems. Recent changes to the program promote more efficient care by creating a system of managed care with a mental health benefit. As with Basic Health, the state has been able to obtain federal matching funds for enrollees in this program. The enacted budget continues the medical portion of this temporary safety net, but changes the cash grant program into a housing assistance program.

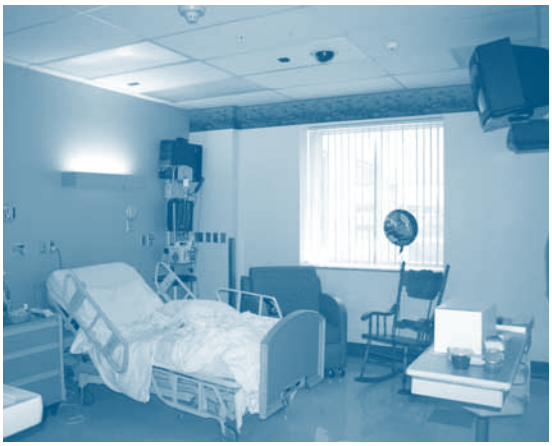
**Apple Health for Kids:** This is the state's program to provide health care to low income children. The Governor and state legislature made a commitment to cover all children by 2010. Early preventive care reduces future health care expenses; investments in child health care keep children ready to learn. The final state budget continues current eligibility for children covered through Apple Health for Kids, but requires immigrant children with family incomes above 200 percent of poverty to pay the full cost of their premiums, for a savings of ***$1.6 million***. House Bill (HB) 2003 implements this policy change, but also allows for financial sponsorship of these children. The budget also establishes a new Disproportionate Share Hospital program to provide ***$2.8 million*** for inpatient and outpatient services for children not eligible for Medicaid or the Children's Health Insurance Program.

**Mental Health Funding:** Through contracts with community mental health agencies, Regional Support Networks administer publicly funded mental health services in their region, including outpatient treatment, crisis and involuntary detention, residential mental health services, and authorization for inpatient services for Medicaid and non-Medicaid patients. Previous cuts have resulted in a system that does not provide adequate services to meet the current need for care. The final state budget makes further cuts that jeopardize essential services for people needing on-going mental health treatment. The budget reduces funding for state patients receiving mental health services through a ***$17 million*** cut for Medicaid services and an ***$8.7 million*** cut for non-Medicaid services.

> *"Previous cuts have resulted in a system that does not provide adequate services to meet the current need for care."*

**Disproportionate Share Hospital (DSH) Payments:** Many of our state's hospitals receive DSH payments, intended to provide additional funds to hospitals that are treating a significant number of uninsured patients. The state's supplemental budget suspended one DSH program (indigent assistance). The final budget maintains this DSH program, but reduces it and another DSH program (low income) by 40 percent. This action cuts ***$29 million***.

**Community Health Clinics:** A significant portion of our state's primary care safety net services is provided by community health clinics – including Federally Qualified Health Clinics and rural clinics. These clinics provide primary care and other critical services in underserved areas on a sliding scale regardless of a patient's ability to pay. WSHA strongly supported adequate funding to ensure clinics can remain viable and able to meet the increasing need for primary care in their communities. The Governor's budget proposed to cut clinics by $172 million. Hard work on the part of WSHA and its partners resulted in a better outcome for



# BUDGET SUMMARY (continued)

clinics, but the enacted budget still cuts clinic payment rates by ***$86 million with an offset of $6 million for rural clinics***. This will have a serious detrimental impact on access to primary care in communities across the state.

**Maternity Support Services:** Washington State currently invests in promoting positive birth and parenting outcomes through a program to provide assistance during pregnancy to Medicaid mothers-to-be. Services include assessment, education, intervention, and counseling. The enacted budget cuts this program by ***$24 million***, or 30 percent, which could leave vulnerable mothers-to-be without needed services.

**Payment for Hospital Services:** The enacted budget requires prior authorization for advanced imaging services, requires prior authorization for some surgical procedures, and seeks to reduce unnecessary Cesarean sections. While WSHA supports promoting evidenced-based care, we need to make sure the implementation of these changes does not create unwarranted administrative hurdles. The total projected savings from these three initiatives is projected to be ***$8.7 million***.

**Other Budget Issues:** Other health system-related budget cuts enacted by the legislature include: discontinued dental services for non-pregnant, non-disabled adults (***$29 million***); eliminated prescription drug assistance for dually eligible Medicare/Medicaid clients (***$14 million***); reduced services for children with intense behavioral and emotional needs (***$1.1 million***); and limited services for hearing, vision, and occupational/physical/speech therapies (***$8.7 million***).

### No New State Funding

Enactment of Initiative 1053 in November 2010 requires a two-thirds supermajority vote of the Washington State Legislature or a vote of the people to raise revenue. Unlike the 2009 to 2011 biennial budget, the 2011 to 2013 budget is balanced entirely with cuts. No new state revenues were generated. Looking at only one side of the equation – what the state spends – and leaving out the other side – not increasing revenues – makes for an unbalanced approach to our state's deep deficit.

# WSHA BILL SUMMARY

## Positive Results

This section summarizes bills that WSHA lobbied to either enact or defeat. It also includes bills on which WSHA had no position, but closely monitored throughout the legislative process to ensure they were not amended to impact hospitals or health systems. The bills are listed in order of importance to hospitals and health systems. An index is included on page 30 for a quick reference.

### Meal and Rest Breaks

On February 16, 2011, the Ruckelshaus Center Nurse Staffing Steering Committee came to an agreement on issues relating to nurse and technologist/technician meal and rest breaks. First, all participating organizations agreed not to pursue legislation or regulation on this issue, pre-scheduled calls, or mandatory overtime during the 2011 legislative session. In lieu of legislation or regulation, the Committee agreed to:

- An education and dialogue initiative from February to May 2011 to increase the knowledge and understanding among hospital and health sytems leadership of the effect of fatigue among nurses and other health care workers on patient safety, including the problems of meal and rest breaks.
- At the conclusion of the education and dialogue initiative, the participating members of the committee will begin policy development discussions. These discussions began in May of 2011 and will conclude by September to assure adequate preparation time before the 2012 legislative session.

Current regulations regarding meal and rest breaks remain in effect. Given this, hospitals and health systems are encouraged to review their policies and procedures with regard to their practices to assure staff receive adequate breaks.

### Bills Enacted

WSHA successfully lobbied to ***support*** or ***amend*** the following important bills enacted by the legislature:

**Health Insurance Exchange: Senate Bill (SB) 5445.** This bill creates the governing body of Washington State's soon to be formed health insurance exchange. In the 2012 legislative session, the legislature will develop legislation that describes how Washington's exchange will operate. Exchanges are a key component of the federal Affordable Care Act (the health care reform law);

# WSHA BILL SUMMARY (continued)

they are intended to assist individuals and small businesses in obtaining insurance. The exchange will be an important vehicle to maintain and improve access to health care coverage in our state.

The health insurance exchange will offer government subsidies for health insurance to anyone not on Medicaid with income up to 400 percent of the federal poverty level. It is difficult to predict how many people will participate in the exchange, but the expectation is the exchange could provide health insurance for 400,000 to 500,000 people in Washington State. Medicaid and the existing employer-based market will continue to operate outside the exchange.

There were competing versions of the health insurance exchange bill, which sets up the structure to create an exchange in our state. WSHA is pleased with the final result. The bill calls for the creation of a public-private governing board by mid-December 2011.

While we sought to have providers on the governing board, the legislature intends the board to be comprised of those individuals and businesses that will be using the exchange services. The bill does direct the Health Care Authority to seek advice from outside health care stakeholders. WSHA successfully obtained an amendment to include facilities and providers of health care on the list of "groups to consult with" on development and implementation work.

The bill also directs the state to work to avoid administrative duplication in the regulation of insurers. WSHA plans to be very involved as the exchange is developed.

### Health Exchange Influence on Washington's Health Care System

Enactment of SB 5445 is just the first step to implementing an insurance exchange. Once the new governing board of the exchange is formed, it will need to address the issues listed below. WSHA will closely monitor these discussions and decisions.

- How many insurers will be allowed to participate in the exchange? Will any insurer that meets the requirements be allowed, or will the board select only certain ones based on criteria?
- Will insurance plans want to participate in the individual and small group market?
- How will the Office of the Insurance Commissioner interact with the exchange?
- How will the state use federal subsidies for qualified low income residents? Will the subsidies be used to continue the state's Basic Health program or instead to help individuals buy insurance through the exchange?
- What are the administrative costs for running the exchange and how will they be paid?

**Basic Health/Disability Lifeline waiver: HB 1312.** This bill modifies eligibility requirements for the Basic Health and Disability Lifeline programs so they may qualify for federal match under Washington State's early Medicaid expansion waiver. Enrollment under these programs is contingent on meeting Medicaid citizenship and income requirements. The bill also removes the coverage time limits previously in place under the Disability Lifeline program.

*"The legislature considered several bills aimed at fixing some of the problems with the state's workers' compensation system."*

**Medicaid reform: SB 5596.** This bill, which received strong bipartisan support, is intended to give the state greater flexibility in the provision and payment for health services. The bill requires the Washington State Department of Social and Health Services to submit a request to the federal government to waive some of the current rules on Medicaid and to provide a specific amount of federal funding per enrollee rather than federal match based on services provided.

**Workers' compensation: HB 2123.** The legislature considered several bills aimed at fixing some of the problems with the state's workers' compensation system. The state Department of Labor and Industries estimates the cost savings from all the major reforms will total $519 million next year and more than $1.2 billion between 2012 and 2015.

HB 2123 was the compromise bill passed during the special session. The new bill:

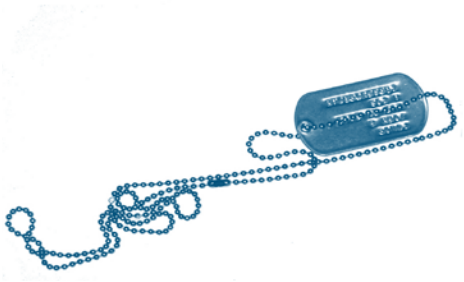
- Creates a claim resolution option that allows for the settlement of all aspects of an allowed claim excluding medical benefits;
- Requires that settlements be approved by the Board of Industrial Insurance Appeals;
- Subsidizes employers for up to 50 percent of wages for up to 66 days when they bring injured workers back for light duty or transitional work;
- Calls for a study of the frequency and severity of occupational disease claims with a report due by December 1, 2012; and

# WSHA BILL SUMMARY (continued)

- Requires that the Joint Legislative Audit and Review Committee conduct a performance audit of the Washington State Department of Labor and Industry claims system by June 30, 2015.

Other bills addressed administrative efficiencies, vocational rehabilitation, and transparency in rate notices.

**Mental health information: SB 5187.** This bill requires hospital emergency departments and mental health units to provide treatment information to parents seeking mental health care for their children. The Washington State Department of Social and Health Services is tasked with creating an informational document for hospitals to give to parents. WSHA worked hard to improve this bill. One version of the bill would have fined hospitals and exposed staff to findings of unprofessional conduct for not providing the information.



**Medical homes: SB 5393.** This bill puts several structures in place to help promote and form medical homes (called primary care health homes by the legislature). The bill directs the Health Care Authority and the Department of Social and Health Services to encourage adoption of primary care medical homes through contracts with managed care plans and providers. The bill also directs the Authority to coordinate discussions with commercial health plans regarding successful chronic care management models. These discussions should result in further developing effective reimbursement methods that align incentives supporting chronic care health homes. To support chronic disease management, the bill establishes a state training program for primary care providers to learn strategies that will improve care for people living with chronic conditions.

**Medical licensing requirements: SB 5307.** Currently, Washington State does not recognize most military health care training when granting licenses in health care professions. This not only contributes to the high unemployment rate of veterans, but also exacerbates future work force shortages. This bill requires the state Department of Health to evaluate military training and experience toward meeting state health professions licensing requirements for 12 different health care occupations, including physician assistants, nurses, and dentists. Once the evaluations are complete, colleges and universities will still need funding to develop bridge programs for each occupation.

*"This bill requires the state Department of Health to evaluate military training and experience toward meeting state health professions licensing requirements for 12 different health care occupations, ..."*

**Long-term care service delivery: SB 5708.** To meet increasing expectations to control health care spending, providers will need more flexibility in how health services are provided. This bill allows post-acute services to be provided in the most appropriate and cost effective setting, creating opportunities for communities to develop the best mix and venues for services. This bill expands the scope for boarding homes and expands the ability of skilled nursing facilities to provide in-home monitoring and care. The bill also provides a mechanism to study ways to provide incentives to reduce excess skilled nursing facility capacity.

**Immunization exemptions: SB 5005.** Childhood immunizations are one of the most effective ways to prevent disease. Through immunizations, we have eliminated or drastically reduced childhood diseases that used to sicken or kill thousands of children. While immunizations are theoretically required for school admission, Washington State has one of the least restrictive laws in the country. Washington's school and child care immunization entry requirements allow exemptions with just a parent's signature. As a result, more than three times the children in Washington are exempted from immunizations than in other states.

*"More than three times the children in Washington are exempted from immunizations than in other states."*

SB 5005 requires that parents talk to their health care provider about the risks and benefits of immunization before they can exempt a child from the immunization requirements. This policy will lead to more of our children getting the immunizations they need. Ensuring timely immunization of our children is critical to protecting not only their health, but the health of our communities and the health care workers who care for them.

**Physician work force data: SB 5480.** This bill begins to improve the state's ability to accurately describe its current health care work force and make plans for future shortfalls. Current demographics in Washington State are projected to increase demand for health services right around the time when the Baby Boom generation begins retiring in large numbers. With this bill, physicians and physician's assistants will submit current practice, specialty, certification, and other information to the Medicaid Quality Assurance Commission at the time of their license renewal.

# WSHA BILL SUMMARY (continued)

**Pharmacy technician standards: HB 1353.** Health care reform is likely to create incentives for hospitals to want mid-level technicians to work at the top of their scope of practice. Continuing education will ensure the work force has the skills to respond. This bill would allow the state board of pharmacy to create continuing education requirements for pharmacy technicians by rule.

**Centers for occupational health: SB 5801.** This bill requires the Washington State Department of Labor and Industries to establish a health care provider network to treat injured workers. Providers who meet minimum standards are accepted into the network and must agree to follow evidence-based coverage decisions, treatment guidelines, and policies. Providers who follow established best practice standards can qualify for a second tier within the network. Financial and non-financial incentives may be provided to second tier providers. The department will convene an advisory group to seek advice from various health care provider groups and associations concerning implementation of the network. The bill also requires statewide expansion of the Centers of Occupational Health and Education.

**Affordable Care Act implementation: SB 5122.** This bill made a number of technical changes to bring Washington's insurance laws into compliance with specific provisions of the federal Affordable Care Act, including extending dependent eligibility to age 26.

### Your Advocacy Makes a Difference

Hospital and health systems contacts with legislators made an important difference in the outcome of many of the bills and budget items WSHA lobbied. Hospital and health system 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 and health system leaders, board members, and staff made phone calls, sent emails, 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!

**Organ donation work group: SB 5386.** Each year, thousands of Washington State patients die in need of an organ transplant. This bill creates a privately funded work group to study strategies to promote organ donation. The work group will include a representative from WSHA.

## Bills Not Enacted

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

**Hospital executive compensation: SB 5666.** For hospitals to receive a property tax exemption, the original form of this bill required that hospitals pay their officers "at levels comparable to the salary or compensation of like positions with the public services of the state;" annually conduct salary surveys for the five highest paid hospital employees; and ensure that all management contracts and third-party vendors are obtained at no greater than market value. The bill also required WSHA to post the full salary detail of the five highest paid hospital executives for every non-profit hospital in the state. The bill threatened about $55 million in property tax exemptions.

*"The market for recruiting senior executives is a national market; Washington's hospitals need to be able to recruit top level candidates to run their organizations."*

The original form of this legislation could have complicated the hiring process for hospital governing boards as they perform one of their most critical responsibilities – recruiting and retaining top-notch leadership. The market for recruiting senior executives is a national market; Washington's hospitals need to be able to recruit top level candidates to run their organizations. Thanks to excellent testimony from hospital trustees, the bill was amended and improved. Even after amendment, however, several problematic provisions remained, including carving out free-standing emergency rooms from property tax exemptions and burdensome new rules on hospital contracting. We are pleased the bill died in committee, but a similar bill has already been introduced to be heard in the next legislative session.

**Health Care Facilities Authority: SB 5514.** The original version of this bill would have changed the composition and duties of the Washington Health Care Facilities Authority in a way that would make it much more difficult and time-consuming

# WSHA BILL SUMMARY (continued)

for hospitals to secure financing through tax exempt bonding. The bill also would have created a structure within the Authority duplicating the state Department of Health's certificate of need process – government duplication not needed given our state's budget crisis. The bill was later amended to add to the board two members of the public representing consumer advocacy groups. The bill also would have restricted current public members to those having no fiduciary interest or responsibility to any health care facility within seven years prior to appointment. Because these changes threatened to turn financing for the state's non-profit hospitals into a political process rather than a rational economic evaluation, WSHA opposed the bill and was pleased when it failed.

**Adverse events: SB 5370.** Since June 2006, hospitals have been required to report adverse events as defined by the National Quality Forum to the state Department of Health. The list of 28 events includes occurrences hospitals continually work to prevent, such as wrong site surgeries, medication errors, and late stage pressure ulcers.

The intent of the adverse event reporting system is to create a system where all hospitals can learn from mistakes made at other hospitals in a non-punitive environment. In addition to reporting an adverse event, hospitals must submit a report to the department outlining the cause of the event and steps the hospital will take to prevent it from happening in the future.

*"The intent of the adverse event reporting system is to create a system where all hospitals can learn from mistakes made at other hospitals in a non-punitive environment."*

SB 5370 would have made several changes to the adverse event reporting system. Hospitals would be required to share with payers the adverse events notifications and the root cause analysis they perform after an adverse event. The ability of hospital quality improvement programs to keep the root cause analysis confidential is critical to a thorough examination of what happened, ensuring hospital improvement and preventing future adverse events. Other provisions would have required hospitals and others to pay a facility fee to fund the system and would have required disciplinary authorities governed by the Uniform Disciplinary Act to provide a copy of complaints to the adverse events reporting system. WSHA supports a robust adverse event reporting system, but the proposals contained in SB 5370 do not further this goal.

**Reporting to law enforcement: SB 5671.** The original version of this bill would have put significant new reporting requirements on hospitals. Specifically, hospitals would have had to report to law enforcement: (1) patients with blunt force injury; (2) bullet, gunshot, or stab wounds in conscious patients (reporting is already required for unconscious patients); and (3) death of a patient from a drug overdose or a patient brought in dead from a drug overdose. Even though the bill was amended to require only reporting of drug overdoses resulting in death or patients brought in dead from drug overdoses, WSHA still opposed it. WSHA believes medical examiners, not hospital personnel, are responsible for determining cause of death. Enacting this bill would have created a duplicative process that would be problematic for hospitals.

**False claims act: SB 5310, SB 5458, and SB 5960.** Because of the tight budget situation, legislative leaders in Olympia looked every place they could to save money. Medicaid is a large part of the state budget. Despite rigorous enforcement against fraud by the Washington State Attorney General, many policymakers suspect significant Medicaid fraud is going undetected. These bills would have changed the state's false claims laws to provide a significant new incentive to individuals who successfully bring claims for fraud, allowing them to collect 15 to 25 percent of the award and have their legal fees paid for by the defendant.

SB 5310 would have created a comprehensive state false claims act, but the bill died in committee. SB 5458 specifically targeted health care providers and Medicaid fraud, and created incentives for frivolous lawsuits by individuals; in the past, more than 70 percent of whistle blower lawsuits have been found to be without merit. Defending these frivolous claims would reduce money available for patient care. WSHA worked with the Liability Reform Coalition to remove the whistle blower provisions, and the bill eventually died.

**Free-standing emergency rooms: SB 5515.** This bill, which would have put new requirements on free-standing emergency rooms, was supported by some WSHA members and opposed by others. WSHA was neutral on the provisions of the bill that would have instituted a two-year

# WSHA BILL SUMMARY (continued)

moratorium on construction of new free-standing emergency rooms. The original bill included provisions that could have been problematic for all hospitals and health systems, such as requiring them to pay the costs of transporting patients to the nearest available hospital and expensive new reporting requirements.

A substitute bill was introduced that addressed WSHA's concerns about the new data requirements. The substitute bill's definition of "free-standing emergency room" would have captured hospitals operating under the same license; but not on the "main hospital campus" and applied those requirements to existing emergency rooms that are part of a hospital. The bill died in the Senate Rules Committee.

*"...the bill could have limited hospitals' ability to use their own internal interpreter staff or created a new bureaucracy for certifying interpreters."*

**Interpreter services: SB 5807.** Federal law requires Medicaid providers to ensure access to health care for individuals who have limited English-speaking ability. Washington's medical assistance program has for many years paid interpreters to assist with medical visits. SB 5807 would have stated that medical interpretive services purchased through state medical assistance programs may only be provided by interpreters who have been certified by Washington State. WSHA was concerned the bill could have limited hospitals' ability to use their own internal interpreter staff or created a new bureaucracy for certifying interpreters. We sought amendments to the bill, but the bill was defeated. The amendments we sought were included in the budget, which also preserved interpreter services.

**Breast reconstruction information: HB 1101.** This bill would have required a hospital or ambulatory surgery center in which mastectomy, lymph node dissection, or lumpectomy is performed to provide the patient with information on the option of post procedure reconstructive breast surgery. Hospitals would also have to provide information about state law regarding insurance coverage for breast reconstruction. WSHA opposed the bill because it would have placed hospitals in the role of practicing medicine – clearly the purview of physicians. We were also concerned it would open the door to codifying medical practice in the hospital licensing statute. The bill was amended to address WSHA's concerns and give the responsibility to physicians, but the bill ultimately died.

**Street utility fees: HB 1929.** This bill would have granted cities the ability to propose and implement a street maintenance utility. WSHA opposed the bill as hospitals and other high traffic destinations could be required to bear a disproportionate portion of the cost of street maintenance. The bill died in the House Rules Committee.

## Disappointing Results

The following bills were enacted by the legislature, despite WSHA's opposition:

**Hospital rate cuts: HB 2069.** In 2010, the state enacted the Hospital Safety Net Assessment to restore prior Medicaid cuts. Under the assessment, the state assesses hospitals a per-day fee, uses that assessment to draw down federal funds, and returns this new money to hospitals. This bill enacts the raid on the assessment and cuts hospital payments by $261 million.

*"The cuts to the assessment program undermine the safety net and threaten the stability of all our hospital systems."*

Of this total, $221 million would have provided payment increases for prospective payment system hospitals to restore Medicaid cuts made in 2009 and pay back the assessment the state used to draw federal matching funds. Both inpatient and outpatient rates are reduced by about ten percent. Without the higher rates, prospective payment system hospitals end up paying the state more in assessment dollars than they receive in increased payments. In addition, the bill takes $40 million in surplus from the 2009 to 2011 biennium that should have been used to reduce assessment rates for the 2011 to 2013 biennium. These dollars are instead transferred to the general fund.

WSHA believes the transfer of funds violates the Washington State Constitution. In addition, the 2010 assessment law contained specific provisions, such as not allowing the state to supplant funds, which we believe have now been violated. In July 2011, WSHA filed a complaint in King County challenging the state's implementation of HB 2069.

The cuts to the assessment program undermine the safety net and threaten the stability of all our hospital and health systems.

# WSHA BILL SUMMARY (continued)

**Payments to providers: SB 5927.** When a provider does not have a contract with an insurer, the standard practice is to bill the insurer the full charges for the services provided. This bill limits payments to providers who do not have contracts with Medicaid and Basic Health managed care plans to "about" Medicaid payment amounts ("no more than the lowest amount paid for that service under the managed health care system's contracts with similar providers in the state"). WSHA opposed the bill. Hospitals and health systems are concerned this limitation would undermine their ability to reach acceptable contracts with managed care plans if the plans know that, even without a contract, they are only required to pay Medicaid rates. WSHA was unsuccessful in efforts to have hospitals excluded, but was able to strengthen the bill's network adequacy language.

**Notifying law enforcement: HB 5452.** The bill requires that in cases where law enforcement officers deliver persons to a crisis stabilization unit, evaluation and treatment facility, or hospital emergency department for mental health evaluation, the facility or provider must notify a requesting law enforcement officer if the patient is released from detention to enable the officer to return and take the individual back into custody. Under the previous law, facilities were required to detain patients for a limited time period, but were not responsible for communication and the return to law enforcement. WSHA strongly disagrees with expanding the hospital's responsibility and believes law enforcement should bear the burden of security for individuals they bring for evaluation.

WSHA did not lobby this bill since it slipped under our bill tracking radar. We will be following the implementation of this bill. We will also be reviewing and improving our bill tracking process for next year. WSHA requests information from hospitals regarding the impact of the bill. Depending upon this information, WSHA may seek a modification to the bill in the next legislative session beginning in January 2012.

## Other Bills

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

**Evidence-based care: HB 1311.** This bill establishes a collaborative to identify evidence-based best practices to reduce unnecessary use of costly health services. The collaborative is tasked with identifying up to three health services it will address each year. The participants on the collaborative include state payers (Medicaid and the State Department of Labor and Industries), commercial payers, and providers. Based on the recommendations of the collaborative, all state and commercial payers must implement the evidence-based guidelines or protocols. If a consensus on the evidenced-based guidelines or strategies is not reached by the collaborative, state payers may proceed with the recommendations without the commercial payers. WSHA worked to ensure hospital executives and hospital-based physician leaders are represented on the collaborative.

*"This bill establishes a collaborative to identify evidence-based best practices to reduce unnecessary use of costly health services."*

**Handling hazardous drugs: SB 5594.** This bill requires the state Department of Labor and Industries to regulate the handling of chemotherapy, antineoplastic, and other hazardous drugs to ensure worker safety. An early version of the bill was broad, poorly defined, and required the department to develop regulations despite excellent standards already developed by the Centers for Disease Control's National Institute on Occupational Safety and Health. WSHA was successful at amending the bill to narrow its impact and restrict rule making to adopting the existing standards. WSHA will participate in the rule making process to ensure the rules are adopted as the legislature intended.

**Clinical rotations for medical students: HB 1183.** The bill prohibits osteopathic or allopathic medical schools from developing exclusive arrangements for medical student rotations. An earlier version of the bill was broad and would have impacted hospitals' ability to control the number and type of medical students in their facilities. WSHA was successful in amending the bill to limit its impact to medical schools.

# 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:

> *"...AWPHD submitted this bill to allow public hospital districts to solicit, accept, invest and distribute gifts."*

**Fundraising by public hospital districts: SB 5116.** The bill was developed in response to the Washington State Auditor's concern that public hospital districts did not have the express statutory authority to engage in fundraising activities. To address the situation, AWPHD submitted this bill to allow public hospital districts to solicit, accept, invest, and distribute gifts. Also, recognizing that many public hospital districts raise funds through a separately incorporated foundation, SB 5116 allows districts to contract with foundations to conduct these fundraising activities. Both the state Auditor's Office and the Attorney General's Office supported the bill. AWPHD will be working with the Auditor's Office and with member hospital districts to implement the provisions of the bill.

**Expanding the definition of "rural public hospital district": SB 5117.** This bill allows rural public hospital districts to continue collaborating with one another.

Under current law, a "rural hospital district" cannot contain cities with more than 30,000 residents. The law allows these rural districts to develop cooperative agreements with other rural public hospital districts in order to increase access to care and provide greater efficiencies. In northwest Washington, the collaborative relationships in one rural district were threatened because the 2010 census revealed the district contains a city of more than 30,000 people. SB 5117 allows hospital districts with cities of populations up to 50,000 to meet the definition of a rural public hospital district and to engage in cooperative relationships with other rural public hospital districts.

**Open government bills: HB 1899.** Each session sees a number of bills related to transparency in government; since public hospital districts are units of government, they would be impacted by most of the bills. One such bill, HB 1899, related to

the penalties a judge can charge when an agency is found not to have produced requested records. Current law requires the judge to impose a penalty of between $5 and $100 per day. HB 1899, actively supported by AWPHD, removed the lower threshold so judges would have the discretion to charge no penalty if that would more accurately respond to the situation before them. HB 1899 was enacted by the legislature and signed by the Governor.

### Municipal Research Services Center

Municipal Research Services Center of Washington is an invaluable resource when AWPHD members have questions about laws and regulations. The center has vast experience working with local governments and, through a contract with AWPHD, is available to answer members' questions. Your contact at the center is Joe Levan, legal consultant. Joe can be reached at 206/625-1300 or jlevan@mrsc.org.

## Other Results

**Public records: SB 5049.** This omnibus bill would have implemented several recommendations of the Attorney General's Public Records Exemptions Accountability Committee (the Sunshine Committee). Among other provisions, the bill would have required that local governments make public all applications for top management jobs. Such a mandate would make it very difficult for public hospital districts to recruit top leadership. AWPHD worked with others to amend the bill so only the applications of the finalists would be made public. In the end, however, because of our concerns and the concerns others had with different aspects of the bill, it died.

## 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 firsthand 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 or health system'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 Chelene Whiteaker at chelenew@wsha.org or 206/216-2545.

# 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 and health systems 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 contact us with questions or comments about the 2011 legislative session or with your suggestions as we prepare for the 2012 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,

**Randy Revelle**

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**Hospital Governing Board Connections**

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 or health system 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 let WSHA know about personal connections they may have with elected or appointed officials. Through these personal relationships, key decision makers can be informed about issues that are important to hospitals and health systems. If you have a personal relationship with a state or federal elected or appointed official, please contact Chelene Whiteaker at 206/216-2545 or chelenew@wsha.org.

# POLICY/ADVOCACY TEAM*

The 23 members of the Policy/Advocacy Team represent hospital and health systems interests before federal, state, and local governments. Team members work with hospital and health systems 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-and health system-related policies, rules, and laws.

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

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**Taya Briley**
General Legal Counsel

**Jessica Burkard**
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**Andrew Busz**
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Chief Nurse Executive & Senior Leader for Clinical Strategy, WSHA

**Jane Feldman**
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**Maria Harwood**
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**Melissa Waddell**
Executive Assistant

**Chelene Whiteaker**
Director
Advocacy and Policy

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

## Political Action Committees

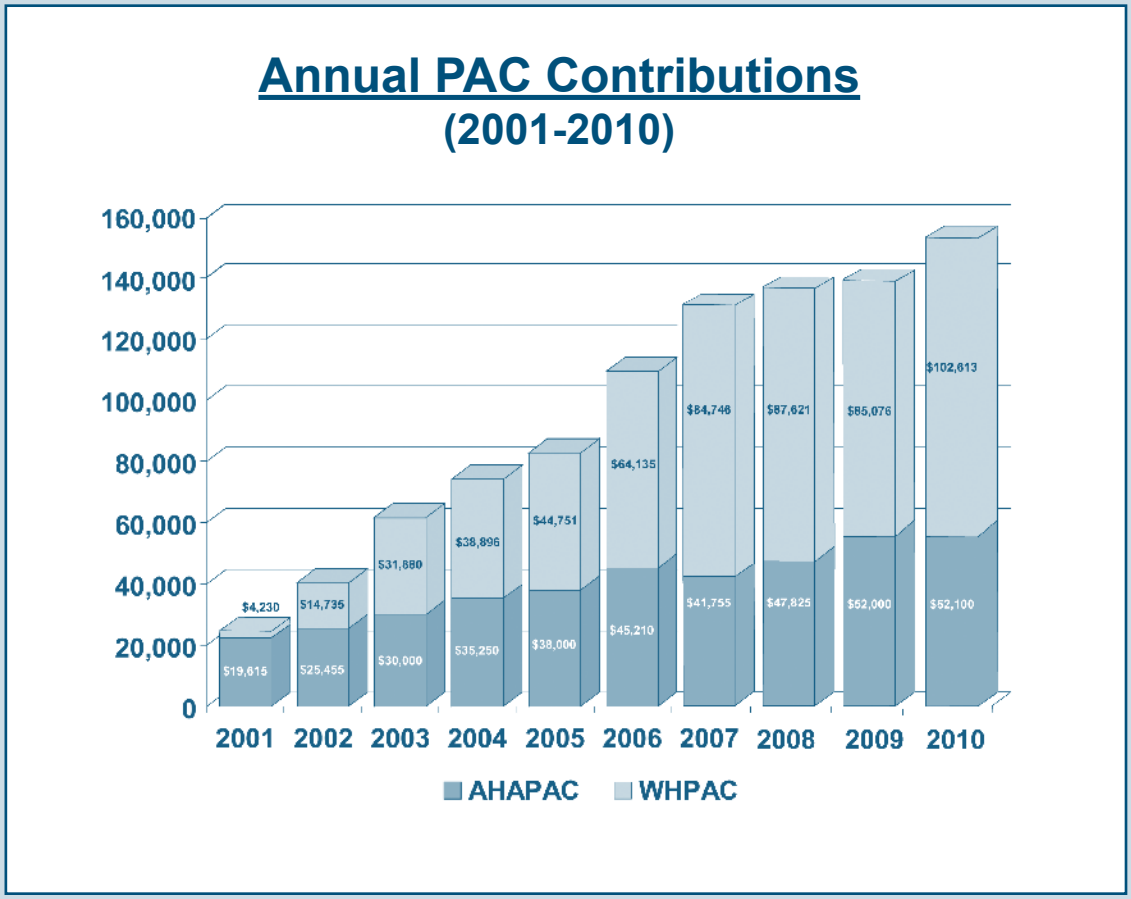
In 2001, WSHA members directed the Washington Hospital Political Action Committee (PAC) to expand and increase its political influence through greater involvement in federal and state elections. They also asked for increased contributions to the American Hospital Association PAC.

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 and health system 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 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 2001. During 2010, the PAC campaign raised a record ***$154,713*** from ***531*** donors. These donors represent ***92*** hospitals and health systems and eight other organizations. From 2001 to 2010, the Washington Hospital PAC raised a total of ***$945,897***.

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

***We look forward to receiving your generous PAC contribution in 2011!***



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