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Hospital Assessment and MA Rate Increase (DHFS -- Health Care Quality Fund)

Bill Section

[LFB 2007-09 Budget Summary: Page 238, #2]

CURRENT LAW

MA and BadgerCare Reimbursement to Hospitals. The state's medical assistance (MA) and BadgerCare programs pay hospitals for inpatient and outpatient services they provide to MA and BadgerCare recipients. The Department of Health and Family Services (DHFS) pays hospitals directly for inpatient and outpatient services they provide to recipients who are not enrolled in managed care organizations. DHFS pays health maintenance organizations (HMOs) monthly capitation payments for each MA and BadgerCare recipient enrolled in the HMO. HMOs use revenue from the capitation payments to pay providers, including hospitals, for services they render to their enrollees.

Under MA and BadgerCare, hospitals are not fully reimbursed for their costs of providing care to MA and BadgerCare recipients, nor are they reimbursed at rates equal to their "usual and customary charges."

Most inpatient services are reimbursed under the diagnosis related groups (DRG) system, under which the hospital determines the patient diagnosis and then bills MA for the hospital-specific DRG rate related to that condition and treatment. DHFS includes a number of adjustments to a hospital's DRG rate to reflect differences in costs among hospitals. The DRG includes all covered services except professional services provided at the hospital, including physicians, dentists, anesthesia assistants, pharmacy, specialized medical vehicle transportation and durable medical equipment and supplies for non-hospital use. The certified provider bills these services separately.

Each hospital receives a single, predetermined rate for each outpatient visit the hospital provides. The rate is not based on the services a patient receives, or the conditions that resulted in the hospital visit. Instead, the outpatient rate per visit is based on a hospital's outpatient cost per visit, as documented in an audited cost report, which is inflated to the current fiscal year and adjusted to reflect the amount of funding available and other limits on outpatient hospital payments.

DHFS reimburses hospitals that are certified as critical access hospitals (CAHs) for their reasonable costs for both inpatient and outpatient services. A CAH is a rural hospital that: (a) has no more than 25 beds used for acute inpatient care and "swing beds," which are beds used for skilled nursing facility-level care; (b) provides inpatient care for no more than an average annual stay of 96 hours per patient; and (c) provides emergency care 24 hours per day. A hospital is considered a rural hospital for purposes of CAH designation if it is: (a) located outside of a metropolitan statistical area, or is in a rural area of an urban county; (b) located more than a 35 mile drive from another hospital or certified by DHFS as a necessary provider of health care services to residents in the area; (c) is designated as a CAH under Medicare; and (d) is not designated as an urban hospital for purposes of reimbursement under either Medicare or MA.

Provider Taxes. Federal MA rules have been established to limit states' ability to tax health care providers. In general, if a state wishes to implement a health care-related tax for the purpose of providing a source of state funding for MA payments, it must ensure that the tax is broad-based and applied uniformly to classes of providers. States may not pay back providers, dollar for dollar, the assessments that they pay the state. Under federal law, the provider tax must create "winners" and "losers."

If a provider tax does not meet the standards established in rule for being "broad-based" or "uniformly imposed," a state may seek a waiver from these requirements. However, if a state applies for such a waiver, it must demonstrate that the net effect of the tax and associated expenditures is redistributive in nature, and the amount of the tax is not directly correlated with MA payments. Further, a state may seek a waiver to exempt rural and sole-community providers from a provider tax.

Current Hospital Assessment. DHFS currently assesses hospitals, within 90 days of the beginning of each fiscal year, a total of $1,500,000, in proportion to each hospital's respective gross private-pay revenues during the hospital's most recently concluded entire fiscal year. Each hospital is required to pay its assessment on or before December 1, for the fiscal year. Funding from the assessment is used to partially support the state's share of MA benefits costs.

GOVERNOR

Provide $344,467,500 (-$57,909,700 GPR, $198,344,400 FED, -$1,500,000 PR, and $205,532,800 SEG) in 2007-08 and $357,256,900 (-$61,750,200 GPR, $207,780,600 FED, -$1,500,000 PR, and $212,726,500 SEG) in 2008-09 to reflect the net fiscal effect of the

Governor's proposal to: (a) create an assessment on the gross revenues of hospitals; (b) deposit all revenue from the assessment to the health care quality fund (HCQF) to increase MA rates for hospital services; and (c) to replace base GPR funding for MA benefits with SEG revenues from the HCQF.

Statutory Provisions

Impose on each hospital, for the privilege of doing business in the state, an annual assessment, based on the hospital's gross revenue, which each hospital would be required to pay before December 1. Specify that all revenue from the assessment would be deposited into the health care quality fund (HCQF), which would be created in the bill.

Require DHFS to verify the amount of each hospital's gross revenue and determine the amount of each hospital's assessment, based on claims information that is currently provided to DHFS by an entity with which DHFS contracts that compiles state hospital information (currently, the Wisconsin Hospital Association). Specify that, although DHFS may consider the MA revenue received by a hospital in the calculation of the assessment, the assessment must be based on a rate not to exceed 1% of the hospital's gross revenue, as adjusted by DHFS.

Specify that certain current law provisions in Chapter 77 of the statutes relating to tax deficiency and refund determinations, interest and penalties for late taxes, refunds of less than $2, testimony and disclosure, timely mailings, and the collection of delinquent sales and use taxes, apply to the hospital assessment, except that the revenue would be deposited to the HCQF. Direct DHFS to levy, enforce, and collect the assessment and develop and distribute forms necessary for levying and collection.

Permit an affected hospital to contest an action relating to the assessment by DHFS by submitting a written request for a hearing to the Division of Hearings and Appeals in the Department of Administration within 30 days after the date of the action by DHFS. Provide that any order or determination made by the Division would be subject to judicial review, as prescribed under Chapter 227 of the statutes.

Funding and Revenue

Assessment Revenue. Estimate that $205,532,800 in 2007-08 and $212,726,500 in 2008-09 would be collected in assessment revenue for deposit to the HCQF.

Rate Increase. Provide $345,967,600 ($147,623,200 SEG and $198,344,400 FED) in 2007-08 and $358,756,900 ($150,976,300 SEG and $207,780,600 FED) in 2008-09 to provide a rate increase for services provided to MA and BadgerCare recipients. This rate increase includes: (a) an increase in fee-for-service rates to approximately 100% of cost; (b) an increase in disproportionate share hospital payments to critical access hospitals; and (c) an increase in the managed care rate to approximately 80% of cost.

Replace Base GPR Funding with SEG. Provide $57,909,600 SEG in 2007-08 and $61,750,200 SEG in 2008-09 and decrease GPR funding by corresponding amounts to replace GPR funding currently budgeted for MA benefits with SEG revenues from the HCQF.

Repeal Current Hospital Assessment. Repeal the current hospital assessment and delete base MA benefits funding supported by the assessment (-$1,500,000 PR annually). Repeal the PR appropriation from this source and related references in the state's MA statutes.

DISCUSSION POINTS

1. The Governor's proposal provides a means by which the state would increase federal MA matching funds by creating a permissible provider tax on hospital gross revenue, using a portion of the combined tax and federal MA revenues to increase MA payment rates to hospitals, and replace base GPR funding for the MA program with additional revenues that would be deposited to the HCQF. By using this method, the state could effectively increase the amount of federal funding that would be available to support MA benefits without increasing GPR funding for the program. Further, hospitals would receive higher MA payments that would more than offset the amount the industry would pay, in the aggregate, in hospital assessments. However, not all hospitals would receive increased MA payments that were equal to, or greater than, the amount of their assessment.

2. DHFS estimates that, in 2004-05 (the last year for which information is available), total MA payments for hospital inpatient services equaled approximately 67.7% of hospitals' inpatient costs and MA payment for outpatient services equaled approximately 50.5% of hospitals' costs for outpatient services. In that year, the difference between inpatient and outpatient costs and MA payments for inpatient and outpatient services was approximately $157.1 million and $97.6 million, respectively.

Under the Governor's proposal, the MA reimbursement to hospitals would equal the maximum amount permitted under federal law, which is the amount of reimbursement hospitals would receive for the providing the same service to a Medicare recipient. This limit is commonly referred to as the "Medicare upper limit." DHFS estimates that hospitals would be reimbursed for approximately 98% and 88% of their costs for inpatient and outpatient hospital costs, respectively.

3. States commonly use provider taxes to generate state funding for their MA programs. At least 17 states administer federally-approved assessments on hospitals, including Illinois, Michigan, Iowa and Minnesota. Wisconsin currently has two provider taxes -- the nursing home bed assessment and the hospital assessment. However, it is believed that Wisconsin uses provider taxes as a means to support the state's share of its MA program to a lesser extent than most other states. For example, in the March, 23, 2007, *Federal Register,* CMS indicated that, based on a review of quarterly MA expenditures, states reported the collection of $2.2 billion in tax revenues from health care providers.

4. On May 17, 2007, the Secretary of the Department of Administration (DOA) sent a

letter to the Co-Chairs of the Joint Committee on Finance that identified changes the administration would like to make to its initial proposal. The administration did not request that the Committee modify the statutory or funding provisions in the bill, since the revised proposal would have approximately the same fiscal effect as the Governor's initial proposal. In addition, the letter indicates that the administration received advice from several national experts to address concerns expressed about DHFS' proposed method of increasing MA reimbursement to hospitals. Consequently, the administration believes that the revised plan addresses technical issues raised by the Wisconsin Hospital Association.

5. Under the administration's revised plan, all critical access hospitals and psychiatric hospitals would be excluded from the assessment and rate increase. The revised plan would still permit the state to assess up to 1% of each hospital's gross revenue, but assumes that in 2007-08, DHFS would assess approximately 0.8% of hospitals' gross revenue to maintain the revenue targets established in the bill. The current plan revises the rate increases, using a percentage of Medicare allowable cost as a target for both inpatient and outpatient rates.

6. The following table identifies the administration's current estimates of the fiscal effect of the proposal.

Estimated Fiscal Effect of Governor's Revised Proposal
($ in Millions)

	2007-08				2008-09			
	Revenue	Expenditures			Revenue	Expenditures		
	SEG-REV	SEG	FED	Total	SEG-REV	SEG	FED	Total
Hospital Assessment	$205.5				$212.7			
Reimbursement Increase								
Hospitals		$65.0	$88.3	$153.3		$54.9	$76.3	$131.3
HMOS		80.2	108.9	189.1		95.7	133.0	228.7
Total		$145.2	$197.2	$342.4		$150.6	$209.4	$360.0
Available for HCQF (Replace GPR Funding)		$60.3				$62.1		

The table shows that, while hospitals would be assessed $205.5 million in 2007-08 and $212.7 million in 2008-09, MA payments to hospitals and HMOs (to pass on to the hospitals) would increase by $342.4 million in 2007-08 and $360.0 million in 2008-09, resulting in a net gain for the hospital industry, in the aggregate, of approximately $136.9 million (all funds) in 2007-08 and $147.3 million (all funds) in 2008-09.

7. The administration's proposal is based on two key assumptions: (a) that DHFS could increase MA payments to hospitals by the amounts assumed by the administration, while complying with federal requirements; and (b) that CMS would determine the hospital assessment to

be a permissible provider tax.

8. Federal law specifies that a hospital assessment is only approvable if it is "broad-based," "uniformly imposed," "redistributive" in nature, and does not hold providers harmless.

9. According to federal law, a broad-based health-care related tax means a health care related tax which is applied to a class of providers, and does not exclude certain providers. For example, a tax on hospital revenue could not be applied only to revenue of hospitals that serve MA recipients. However, CMS may waive the "broad-based" requirement if a state can show that the net impact of the tax is generally redistributive in nature and that the amount of the tax is not directly correlated to payments that the provider receives for services with respect to which the tax is imposed. In this case, the state would need to show that the hospital tax proposal is generally redistributive in nature and that the amount of the hospital tax is not directly correlated to payments that the hospital will receive in the form of an increase to MA rates.

Under federal law, a tax is "uniformly imposed" if the amount of the tax is the same for all providers. Under the bill, all hospitals would be assessed an amount up to 1% of their gross revenue. Because all hospitals would be assessed at the same rate, the tax would be considered "uniformly imposed."

10. Under federal law, a payer of a tax is considered to be "held harmless" if any of the following condition applies: (a) the state provides directly or indirectly for a non-MA payment to those providers or others paying the tax and the amount of the payment is positively correlated to either the amount of the tax or to the difference between the MA payment and the total cost of the tax; (b) all or any portion of the MA payment to the taxpayer varies based on only the amount of the total tax payment; and (c) the state provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

11. It is possible that CMS could modify the administration's proposed method of increasing reimbursement to hospitals, which could reduce the MA reimbursement increases the administration assumes would be provided to hospitals. If this occurs, any reduction in MA payments to hospitals would result in net GPR savings to the MA program, since DHFS could expend authorized SEG funds from the HCQF to support general MA benefits costs, up to the amounts authorized in the bill.

12. It is also possible that DHFS would modify the current proposal in response to comments and recommendations the agency receives from CMS after submitting the required state plan amendment. For example, if CMS reduced the amount of funding DHFS could provide to hospitals as a reimbursement increase, DHFS may reduce the amount of the assessment on hospitals. Under the bill, the assessment could not exceed 1% of a hospital's gross revenue, as adjusted by DHFS. However, DHFS could assess hospitals less than 1% of their gross revenue.

13. The Wisconsin Hospital Association (WHA) opposes the proposal, arguing that the tax should not be used to offset GPR base funding for the MA program. WHA is also concerned

that the Legislature may increase the tax in the future to support future increases in the state costs of MA and BadgerCare benefits.

14. WHA is concerned that the bill would authorize DHFS to assess hospitals, but the plan to increase MA payments to hospitals may not be approved by CMS until after DHFS assesses hospitals. This may create a cash flow problem for some hospitals. To address this concern, the Committee could modify the bill to prohibit DHFS from making the assessment prior to obtaining CMS approval of a plan to increase MA payments to hospitals. The bill could authorize DHFS to make the assessment retroactive, if necessary, to ensure that the revenue assumed by the Governor would be realized in the 2007-09 biennium.

15. Another concern expressed by WHA is that there is currently no mechanism in the bill to ensure that HMOs use funding in the bill that would be provided to increase their capitation payments ($189.1 million in 2007-08 and $228.7 million in 2008-09) to increase reimbursement to the hospitals that provide services to their enrollees. To address this concern, the Committee could amend the bill to require DHFS to revise its contracts with HMOs to require each HMO to pay MA fee-for-service rates for hospital services.

16. Under the proposal, some hospitals would receive more money back in the form of MA rate increases for services provided to MA recipients than they would pay for the assessment on their gross revenue. Hospitals that serve more MA recipients would likely fare better under the assessment (depending on their current level of MA reimbursement), as they would receive the rate increase for all services they provide to MA recipients. Hospitals that serve fewer MA recipients would likely fare worse, as they would pay the assessment, but would be less likely to recover the assessment amounts they paid through higher MA reimbursement. As a result, this proposal would accomplish the administration's goal of rewarding hospitals that serve high numbers of MA recipients and helping to offset the losses they might incur as a result.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendations.

ALT 1	Change to Bill		Change to Base	
	Revenue	Funding	Revenue	Funding
GPR	$0	$0	$0	- $119,659,900
FED	0	0	0	- 406,125,000
PR	0	0	0	- 3,000,000
SEG	0	0	418,259,300	- 418,259,300
Total	$0	$0	$418,259,300	- $701,724,400

2. In addition to Alternative 1, prohibit DHFS from implementing the assessment prior to obtaining CMS approval of a plan to increase MA payments to hospitals. However, authorize DHFS to make the assessment retroactive, if necessary, to ensure that the revenue assumed by the

Governor is realized in the 2007-09 biennium.

3. In addition to Alternative 1, require DHFS to change HMO contracts for MA capitation payments to require that HMOs pay hospitals MA fee-for-service rates.

4. Delete provision.

ALT 4	Change to Bill		Change to Base	
	Revenue	Funding	Revenue	Funding
GPR	$0	$119,659,900	$0	$0
FED	0	406,125,000	0	0
PR	0	3,000,000	0	0
SEG	- 418,259,300	418,259,300	0	0
Total	- $418,259,300	$701,724,400	$0	$0

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