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Repeal Ambulatory Surgical Center Assessment (Health Services -- Medicaid Services)

[LFB 2017-19 Budget Summary: Page 212, #8]

CURRENT LAW

The Department of Revenue (DOR) collects an assessment on the gross patient revenues of ambulatory surgical centers (ASCs) located in Wisconsin, consistent with federal regulations. Of the revenue collected by DOR, 99.5% is deposited in the medical assistance trust fund (MATF). DOR retains 0.5% of ASC assessment revenue to support the administrative cost of collecting the assessment.

A portion of ASC assessment revenues, along with federal matching dollars, is used to fund ASC access payments for each patient served who is enrolled in the medical assistance (MA) program. The balance of the ASC assessment revenues not used for that purpose is used to support other MA benefit expenditures, offsetting some of the GPR needed to fund the program.

GOVERNOR

Repeal all statutory provisions relating to the ASC assessment, including a DOR appropriation that funds administration of the assessment. Reduce estimates of revenue the state collects from the assessment for deposit to the MA trust fund (SEG revenue) by $5,000,000 annually to reflect the elimination of the assessment. Reduce MA benefits funding by $6,024,100 ($2,616,300 GPR, -$5,000,000 SEG, and -$3,640,400 FED) in 2017-18 and $6,024,100 ($2,623,400 GPR, -$5,000,000 SEG, and -$3,647,500 FED) in 2018-19 to reflect the loss of MA trust fund revenue, the administration's intent to stop making ASC access payments for services ASCs provide to MA recipients following the elimination of the assessment, and to replace loss of SEG revenue DHS uses to fund general MA benefits costs with GPR.

DISCUSSION POINTS

1. Defined under federal regulations, an ASC is any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. An ASC must also have an agreement with the federal Centers for Medicare and Medicaid Services (CMS) to participate in Medicare as an ASC. There are currently 81 ASCs in the state.

2. According to the MA state plan, the ASC assessment is intended to promote Wisconsin Medicaid recipients' access to physician services in ASCs throughout Wisconsin. The assessment permits the state to do this by taxing ASCs and using the resulting revenue, along with corresponding federal matching funds, to make supplemental ASC access payments on Medicaid claims. This has the effect of increasing net revenue to the ASC industry as a whole, with the remaining revenue used to offset GPR payments for other MA benefits. In this way, it is similar to the hospital assessment and the nursing home bed assessment, both of which support supplemental payments to those service providers.

3. Since the inception of the program through 2015-16, DOR has collected approximately $16,700,000 annually in assessments. In 2015-16, the assessment paid by each ASC was set at 3.6% of its 2015 gross patient revenues.

4. A portion of the assessment revenue deposited into the MATF is paid out to ASCs in the form of access payments. This funding is divided by the estimated number of ASC visits for the fiscal year based on historical data. The ASC access payments are separate payments made in addition to the maximum fee payment for covered ASC services. As stipulated in Wisconsin's Medicaid state plan, the total funding pool for ASC access payments is set at $20,080,000. In 2015-16, ASC access payments were set at $964 per MA patient served for fee-for-service claims, with slightly different amounts paid for HMO claims.

5. In 2015-16, ASC access payments were paid with approximately $8.4 million in from assessment revenue and $11.7 million with federal matching funds. After making access payments, approximately $8.2 million in remaining assessment revenue was used to offset GPR expenditures in the MA program.

6. Access payments are made on behalf of three categories of MA recipients; (a) those receiving MA benefits on a fee-for-service basis; (b) those enrolled in HMOs; and (c) those dually eligible for Medicare and Medicaid. In 2015-16, approximately 5,800 MA fee-for-service claims received access payments, receiving a total of $5.6 million in supplemental payments. In addition, DHS provided $5.1 million to HMOs to make supplemental payments to ASCs, and paid ASCs a total of $9.4 million on approximately 10,700 claims for those dually eligible.

7. Beginning in 2016-17, DHS reduced ASC access payments, based on a determination that access payments at previous levels may not be in compliance with federal regulations regarding upper payment limits for provider reimbursement in the MA program. In response to this determination, DOR reduced the amount of assessment revenue it collects from ASCs to approximately $6.4 million. As part of the Medicaid base reestimate, DHS anticipates that

assessments will be further reduced to approximately $5 million in the 2017-19 biennium, allowing for ASC access payments of approximately $6 million and offsetting GPR savings of $2.6 million. The Department believes that the $6,024,000 in annual access payments anticipated in the base reestimate item would not exceed federal reimbursement limits. With this reduction to the total amount of the access payments, the per-patient access payment would be expected to decline to approximately $290.

8. In 2015-16, since the state collected $16.7 million in ASC assessment revenue, but paid $20.1 million in access payments, the ASC industry as a whole gained $3.4 million from the program. With the reduction in the assessment to $5.0 million and a reduction in access payments to $6.0 million, the net industrywide gain would decline to $1.0 million.

9. Because all ASCs are assessed at the same percentage of gross patient revenues, but ASCs only receive access payments for MA claims, the impact of the program is not evenly spread throughout the industry. Those ASCs with a higher proportion of MA claims will fare better under the program than those with a lower proportion of MA claims. In 2015-16, there were 41 ASCs that paid more in assessment than they received back in the form of access payments. Conversely, there were 40 ASCs which received more in access payments than they paid in assessments. The disparity between those ASCs that realize a net gain from the ASC assessment and access payments and those that experience a net loss is one of the primary arguments for eliminating the assessment entirely. Furthermore, the reduction in access payments necessitated by federal reimbursement limits significantly reduces the effect that the program can have on increasing access to ASC services to MA patients. For these reasons, the bill would eliminate both the ASC assessment and the associated access payments (Alternative 1).

10. To eliminate the disparity between those ASCs that realize a net gain from the ASC assessment and access payments and those that experience a net loss, while still providing an incentive to increase access to ASC services, the Committee could opt to eliminate the assessment, but to continue making supplemental access payments of $6,024,100 annually to ASCs. The state share of these payments would have to be funded with GPR, rather than assessment revenue. Relative to the bill, this would require funding increases of $2,383,700 GPR and $3,640,400 FED in 2017-18 and $2,376,600 GPR and $3,647,500 FED in 2018-19 (Alternative 2).

11. Although the ASC assessment and access payments together result in some ASCs that experience a net gain and some that experience a net loss, the elimination of the program would produce the opposite effect, and reduce total MA payments most to those ASCs that serve a higher proportion of MA patients. Since the intent of the ASC program is to increase access to ASC services and the elimination of the program would reduce payments to ASCs that serve the highest proportion of MA patients, the Committee could opt to continue with the assessment and associated access payments (Alternative 3).

ALTERNATIVES

1. Adopt the Governor's recommendation to eliminate the ambulatory surgical center (ASC) assessment, and to discontinue associated access payments to ASCs.

ALT 1	Change to Base		Change to Bill	
	Revenue	Funding	Revenue	Funding
GPR	$0	$5,239,700	$0	$0
FED	0	- 7,287,900	0	0
SEG	- 10,000,000	- 10,000,000	0	0
Total	- $10,000,000	- $12,048,200	$0	$0

2. Adopt the Governor's recommendation to eliminate the ambulatory surgical center assessment, but continue to provide access payments, using GPR, rather than assessment revenue to fund the payments, along with federal matching funds. Increase funding in the bill by $6,024,100 annually ($2,383,700 GPR and $3,640,400 FED in 2017-18 and $2,376,600 GPR and $3,647,500 FED in 2018-19) to continue access payments.

ALT 2	Change to Base		Change to Bill	
	Revenue	Funding	Revenue	Funding
GPR	$0	$10,000,000	$0	$4,760,300
FED	0	0	0	7,288,000
SEG	- 10,000,000	- 10,000,000	0	0
Total	- $10,000,000	$0	$0	$12,048,200

3. Delete provision.

ALT 3	Change to Base		Change to Bill	
	Revenue	Funding	Revenue	Funding
GPR	$0	$0	$0	- $5,239,700
FED	0	0	0	7,287,900
SEG	0	0	10,000,000	10,000,000
Total	$0	$0	$10,000,000	$12,048,200

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