Washington State Health Care Authority

Report to the Legislature

HOSPITAL SAFETY NET ASSESSMENT FUND

Engrossed Second Substitute House Bill 2956
Chapter 30, Laws of 2010, First Special Session
RCW 74.60.090(4)

December 1, 2012

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Overview & Summary

This report examines the amount of assessments that would be necessary to support hospital payments for Medicaid services during the fiscal biennium that begins on July 1, 2013. The report is required by RCW 74.60.090(4), which provides in its entirety as follows:

> *By December 1, 2012, the department will submit a study to the legislature with recommendations on the amount of the assessments necessary to continue to support hospital payments for the 2013-2015 biennium. The evaluation will assess medicaid hospital payments relative to medicaid hospital costs. The study should address current federal law, including any changes on scope of medicaid coverage, provisions related to provider taxes, and impacts of federal health care reform legislation. The study should also address the state's economic forecast. Based on the forecast, the department should recommend the amount of assessment needed to support future hospital payments and the departmental administrative expenses. Recommendations should be developed with the fiscal committees of the legislature, office of financial management, and the Washington state hospital association.*

Washington, like the national economy, is below the long term trend of a full employment economy. For the fiscal biennium that begins on July 1, 2013, the Economic and Revenue Forecast Council projects a revenue shortfall of more than $900 million.[1]

This report is presented in seven parts and was developed with input from the fiscal committees of the legislature, Office of Financial Management and the Washington State Hospital Association.

Part I: Hospital Safety Net Assessment Program History

The Hospital Safety Net Assessment program is authorized by federal law (42 U.S.C. § 1396b(w) and 42 C.F.R. § 433.68) and state law (RCW 74.60).

A. 2009 Legislative Reductions to Hospital Payments

In 2009, the Legislature reduced its level of appropriations to the Medicaid agency with the intent of reducing the rates paid to hospitals for both inpatient and outpatient services by four percent.[2] These reductions totaled approximately $64 million in anticipated general fund state savings over the 2009-2011 biennium.

B. 2010 HSNA Legislation

[1] State Budge Outlook Based on SSB 6636

[2] In 2009, the Department of Social and Health Services (DSHS) was the State's Medicaid agency. As of July 1, 2011, the Health Care Authority (HCA) is the State's Medicaid agency. *See* RCW 74.09.530(1); Laws of 2011, 1st Spec. Sess., ch. 15.

In 2010, the Legislature enacted House Bill (HB) 2956, which created the Hospital Safety Net Assessment program. The Legislature intended to (1) generate additional state and federal Medicaid funding and (2) increase Medicaid payment rates to hospitals. *See* RCW 74.60.005(2); RCW 74.60.030(1); RCW 74.60.080(1); RCW 74.60.090(1).

The Safety Net Assessment was created in cooperation among DSHS, the Washington State Hospital Association (WSHA), the Legislature, and the Governor's Office. This legislation established a new hospital assessment, levied on all in-state, non-governmental, prospective payment system hospitals.[3] Hospitals are assessed based on their non-Medicare patient bed days.

The legislation allowed for the restoration of the 2009 four percent rate reductions as well as rate increases to both inpatient and outpatient rates, restoration of and an increase to the small rural disproportionate share hospital program, and an access payment to critical access hospitals not able to participate in the small rural disproportionate share hospital program. The bill also specified that the State could use certain sums from the Safety Net Assessment Fund "in lieu of state general fund payments to hospitals[.]" *See* RCW 74.60.020(3)(e).

C. 2011 HSNA Legislation

In 2011, the Legislature enacted Engrossed House Bill (EHB) 2069, which increased the sum available to the State from the Safety Net Assessment Fund and adjusted the amount of scheduled future rate increases. *See* RCW 74.60.020(3)(e); RCW 74.60.090(2)(a).

Part II: Health Care Provider-Related Assessments[4]

Current federal law requires that health care provider-related taxes not exceed six percent of net patient revenues (see 42 CFR 433.68(f)(3)(i)(A)).

President Obama's proposed 2013 budget addresses reductions to health care provider-related taxes beginning in 2014 and continuing through 2017. The allowable percentage eventually reduces to 3.5% (see http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/health.pdf.)

Under Washington's current program, the assessment is approximately 1% of net patient revenue.

There is no guarantee of how Congress or the Obama Administration will treat health care provider-related taxes in the future.

[3] Critical access, rehabilitation, and specialty psychiatric hospitals are assessed at lower rates.
[4] Even though this is also called a provider-tax, the use of the term "tax" in this context is misleading under state law, because the federal definition of the term "health care-related tax" is broad and includes assessments, fees, and other payment obligations. *See* 42 C.F.R. § 433.55(a).

Part III: Medicaid Hospital Payments Relative to Medicare Payments and Medicaid Costs

In determining whether Medicaid payment rates are reasonable, HCA considers the interpretation given by the Ninth U.S. Circuit Court of Appeals to the meaning of 42 USC § 1396a(a)(30)(A) ("Section 30(A)"). In certain types of cases interpreting Section 30(A), the Ninth Circuit has held that Medicaid rates must "bear a reasonable relationship" to the costs that "efficient and economical" providers incur in furnishing "quality services." In those cases, CMS had not been asked to approve, or had not yet approved, any State Plan Amendment outlining the proposed changes in rates or methodologies. In those cases, the Ninth Circuit has held that, in order to establish the "reasonable relationship," the State "must rely on responsible cost studies" that provide "reliable data" as a basis for determining rates. On the one hand, there is no "prescribed method of analyzing and considering" the Section 30(A) factors. On the other hand, the State "must rely on something" to assure itself that a reasonable relationship would exist between costs and rates. We note that the Ninth Circuit issued another decision interpreting Section 30(A) on December 13, 2012, in a case known as Managed Pharmacy Care v. Sebelius, 2012 WL 6204214. In that decision, a three-judge panel held that the courts should defer to CMS approval of State Plan Amendments outlining changes in rates or methodologies. The December 13 decision, which still is subject to further appeal, could impact how states approach their determinations of Medicaid rates and methodologies.

In this section, we review Medicaid payments in comparison to the amounts that the Medicare program would have paid for similar services. We also compare Medicaid payments to the Medicaid allowable costs incurred by providers of inpatient and outpatient hospital services.

A. Analysis of Medicaid Payment Levels to Medicare Payment Levels

We compared Medicaid fee-for-service payments to simulated payments under the federal fiscal year (FFY) 2013 Medicare Inpatient Prospective Payment System (IPPS) methodology for the same claims. The table below shows total projected Medicaid inpatient acute care service payments as a percentage of projected payments under Medicare for the same claims. By applying the Section 30(A) standard, we assume Medicare rates "bear a reasonable relationship" to the costs that "efficient and economical" providers incur based on the assumption that the payments under the Medicare[5] program would be a reasonable proxy for the costs that "efficient and economical" providers incur as a benchmark for evaluating the "reasonable relationship" standard.

The 38 Critical Access Hospitals (CAH) are excluded. Medicaid inpatient services at CAHs are reimbursed 100 percent of their allowable cost by Medicaid and 101 percent of their allowable cost by Medicare. As such, Medicaid reimbursement for these CAHs is 99 percent of Medicare (calculated by dividing 100 percent by 101 percent).

[5] Hospitals do not pay an assessment associated with Medicare.

General Acute Hospitals	Estimated Inpatient Acute Service Payments Using SFY 2013 Medicaid Rates	Estimated Inpatient Acute Service Payments Using FFY 2013 Medicare Rates	Medicaid Payments as a Percentage of Medicare Payments
In-State Acute Hospitals	$791,639,956	$837,095,515	94.6%
Out-of-State Border Hospitals	$17,038,448	$18,531,879	91.9%
Total	**$808,678,404**	**$855,627,393**	**94.5%**

We performed a similar comparison on outpatient claims with the following results.

Hospital Type	Number of Hospitals	Percent of Hospitals	Medicaid Payments as a Percentage of CY 2012 Medicare Payments
University of Washington Medical Center and Harborview Medical Center	2	1.96%	90.75%
Other CPE/Government Hospitals	9	8.82%	75.00%
PPS Hospitals	40	39.22%	95.44%
CAHs	38	37.25%	99.00%
Out-of-State Border Hospitals Total	13	12.75%	75.00%

B. Analysis of Medicaid Payment Levels to Estimated Cost

This analysis shows that the projected SFY 2013 Medicaid fee-for-service (FFS) inpatient aggregate payment-to-cost percentage is 96.0 percent. For inpatient hospital services, payments under current FFS rates are projected to exceed estimated costs for 31 of the 56 total in-state, non-Critical Access Hospitals providing Medicaid inpatient services. There are also 38 in-state Critical Access Hospitals providing Medicaid inpatient services that are cost-settled at 100 percent of their costs, with the exception of detoxification and rehabilitation services.

	SFY 2013 Inpatient Medicaid FFS Estimated Cost Coverage		
Providers	**SFY 2013 Total Estimated Allowable Costs**	**SFY 2013 Total Projected Payments**	**SFY 2013 Estimated Cost Coverage**
In-State Hospitals	$893,818,591	$858,446,981	96.0%
Out-of-State Border Hospitals	$20,523,644	$19,677,955	95.9%
Total	**$914,342,235**	**$878,124,936**	**96.0%**

The outpatient analysis shows that the projected SFY 2013 Medicaid FFS outpatient aggregate payment-to-cost percentage is 58.8 percent. For outpatient hospital services, payments under the current Ambulatory Payment Classification (APC) system are projected to exceed estimated costs for one of the in-state 51 non-Critical Access Hospitals providing Medicaid outpatient services. However, there are an additional 38 in-state Critical Access Hospitals providing Medicaid outpatient services that are cost-settled at 100 percent of their costs.

	SFY 2013 Outpatient Medicaid FFS Estimated Cost Coverage		
Providers	**SFY 2013 Total Estimated Allowable Costs**	**SFY 2013 Total Projected Payments**	**SFY 2013 Estimated Cost Coverage**
In-State Hospitals	$489,187,705	$288,453,591	59.0%
Out-of-State Border Hospitals	$7,532,654	$3,651,380	48.5%
Total	**$496,720,359**	**$292,104,971**	**58.8%**

This analysis assumes only a portion of the cost of the assessment as a Medicaid expense. If the entire assessment is considered a Medicaid cost to hospitals, it would reduce the reported ratios and lower the percent of costs paid.

Part IV: Assessments Needed to Continue HSNA Program at Current Level

The HSNA model is updated on an annual basis. For the purpose of this report, HCA updated the most recent HSNA model to include:

- State Fiscal Year (SFY) 2011 inpatient and outpatient fee-for-service claims data.
- SFY 2011 managed care submitted encounter data.
- Inpatient and outpatient trend factors from the October 2012 HCA Forecast.
- Hospital cost report data from hospital fiscal years ending in 2011.
- Non-Medicare inpatient acute hospital inpatient days from 2011, adjusted as appropriate via hospital attestation.
- Assessments sufficient to maintain inpatient and outpatient rates at their current levels.
- Assessments sufficient to maintain administrative expenses incurred by HCA at the level currently allowed in RCW 74.60.020(3)(f).[6]
- Assessments sufficient to achieve $100 million to be expended in lieu of state general fund payments to hospital in both SFY 2014 and SFY 2015.

For the SFY 2014 – 2015 biennium, in the aggregate, the estimated payment increases are projected to exceed the assessments collected. The following table shows the breakdown of assessments paid and estimated payment increases by hospital type.

	SFY 2014-2015 Biennium		
Hospital Group Name	**Assessments**	**Estimated Payment Increases**	**Estimated Net Gain/Loss**
Prospective Payment System	$469,130,879	$396,989,287	($72,141,592)
Critical Access Hospital	$722,800	$8,195,244	$7,472,444
Harborview/University of WA	-	$53,213,488	$53,213,488
Other Certified Public Expenditure	-	$16,658,214	$16,658,214
Specialty Psych	$3,254,938	$3,708,809	$453,871
Border Cities	-	$3,392,789	$3,392,789
Total	**$473,108,617**	**$482,157,831**	**$9,049,214**

[6] Administrative expenses are currently funded at $1 million per biennium.

Assessment rates are set based on type of facility as well as a taxable day threshold. The following table illustrates the historical (2013) rates per type of hospital as well as the rates necessary to continue the assessment into the upcoming biennium at the current level of hospital payments and the day thresholds.

	SFY 2013			SFY 2014			SFY 2015		
Provider Group	***Assessment Rate***	***Taxable Days Threshold***	***Assessment Rate Above Threshold***	***Assessment Rate***	***Taxable Days Threshold***	***Assessment Rate Above Threshold***	***Assessment Rate***	***Taxable Days Threshold***	***Assessment Rate Above Threshold***
UWMC	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Harborview	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Other CPE Hospitals	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
District CAH	$10	N/A	N/A	$10	N/A	N/A	$10	N/A	N/A
PPS	$232	54,000	$7	$241	54,000	$7	$248	54,000	$7
Private CAH	$10	N/A	N/A	$10	N/A	N/A	$10	N/A	N/A
Specialty – Psych	$45	N/A	N/A	$46	N/A	N/A	$48	N/A	N/A
Specialty – Long-Term Acute Care	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Border Cities	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Rehab	$45	N/A	N/A	$45	N/A	N/A	$45	N/A	N/A

Part V: Affordable Care Act Changes

A. Welcome Mat

The Affordable Care Act impacts the HSNA in several ways. There are certain individuals who are currently eligible for Medicaid but are not currently enrolled. This population is commonly referred to as the "Welcome Mat" population. For services provided to the Welcome Mat population, Washington will receive fifty percent federal financial participation (FFP) based on the current Federal Medical Assistance Percentage (FMAP) rate.

The HSNA model was updated to reflect the impact of the Welcome Mat population for the 2014-2015 biennium. There are approximately 78,000 people in this group, and they are projected to enter Medicaid at various points throughout the 2014-2015 biennium.

For both SFY 2014 and 2015, the estimated payment increases are projected to exceed the projected assessments collected when the Welcome Mat population is included.

The following table is updated to reflect the assessments needed to support the phased in inclusion of the Welcome Mat population at the current level of inpatient and outpatient rates.

Hospital Group Name	SFY 2014-2015 Biennium		
	Assessments	Estimated Payment Increases	Estimated Net Gain/Loss
Prospective Payment System	$475,960,136	$406,538,826	($69,421,310)
Critical Access Hospitals	$722,800	$8,195,244	$7,472,444
Harborview/University of Washington	-	$54,646,767	$54,646,767
Other Certified Expenditure	-	$17,106,468	$17,106,468
Specialty Psych	$3,324,192	$3,735,557	$411,365
Border Cities	-	$3,481,628	$3,481,628
Total	**$480,007,128**	**$493,704,489**	**$13,697,361**

The following table is updated to reflect the assessments needed to support the phased in inclusion of the Welcome Mat population at the current level of inpatient and outpatient rates.

	SFY 2013			SFY 2014			SFY 2015		
Provider Group	***Assessment Rate***	***Taxable Days Threshold***	***Assessment Rate Above Threshold***	***Assessment Rate***	***Taxable Days Threshold***	***Assessment Rate Above Threshold***	***Assessment Rate***	***Taxable Days Threshold***	***Assessment Rate Above Threshold***
UWMC	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Harborview	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Other CPE Hospitals	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
District CAH	$10	N/A	N/A	$10	N/A	N/A	$10	N/A	N/A
PPS	$232	54,000	$7	$243	54,000	$7	$253	54,000	$8
Private CAH	$10	N/A	N/A	$10	N/A	N/A	$10	N/A	N/A
Specialty – Psych	$45	N/A	N/A	$47	N/A	N/A	$49	N/A	N/A
Specialty – Long-Term Acute Care	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Border Cities	0	N/A	N/A	0	N/A	N/A	0	N/A	N/A
Rehab	$45	N/A	N/A	$47	N/A	N/A	$49	N/A	N/A

B. Expansion Population

An expansion of the Medicaid program under the ACA would bring additional benefits to the HSNA program. HCA anticipates approximately 200,000 newly eligible people entering the Medicaid program over the 2014-2015 biennium. Like the Welcome Mat population, this population ramps up over time, fully entering the caseload by the end of 2015.

For services provided to the newly eligible population, the State will receive 100% FFP through 2016[7], so no further assessment will be required to support increased payments for this population. We estimate the gain associated with HSNA increases and this population to be approximately:

- 2014 = $14.7 million
- 2015 = $39.4 million

The gain is the amount attributable to the rate adjustments from HB 2956 and EHB 2069 for the expansion population. In subsequent years as the FMAP related to this population decreases, hospitals will need to contribute more through the HSNA program to support the increased rates for the expansion population. However, the greatly enhanced FMAP requires a lower level of assessment given the current FMAP is 50% and the FMAP for the expansion population never drops below 90%.

Part VI: Cost to Discontinue Program

Unless continued by the Legislature, RCW 74.60 expires on June 30, 2013. In accordance with RCW 74.60.902:

> *Upon expiration of chapter 74.60 RCW, inpatient and outpatient hospital reimbursement rates shall return to a rate structure as if the four percent medicaid inpatient and outpatient rate reductions did not occur on July 1, 2009, or as otherwise specified in the 2013-15 biennial operating appropriations act.*

HCA has calculated the cost[8] to return to a rate structure as if the four percent rate reductions did not occur to be approximately:

- SFY 2014 = $41.7 million general fund state
- SFY 2015 = $43.9 million general fund state

In addition to the cost to restore the four percent rate reductions, HCA would also need to compensate for the potential shortfall of $199,800,000 for the 2013-2015 biennium that is currently expended in lieu of state general fund payments to hospitals[9].

The total cost to discontinue the program for the 2013-2015 biennium is $285,400,000 in state general funds (under the assumption that re-enactment of the HSNA would continue to allow the

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[7] FMAP decreases over time beginning in 2017. Based on the calendar year, the FMAP is as follows:

- CY14-CY16: 100%
- CY17: 95.0%
- CY18: 94.0%
- CY19: 93.0%
- CY20 – forward 90%

[8] The amounts in this report differ from the HCA Forecast as they include non-forecasted items from Budget Unit X54, such as small rural disproportionate hospital (SR DSH) payments and certified public hospital expenditure (CPE) hold harmless grants, which are also included in the July 1, 2009 restoration model. The forecasted totals excluding X54 are:

- SFY 2014 = $36.7 million general fund state
- SFY 2015 = $39.2 million general fund state

[9] See RCW 74.60.020(3)(e).

State to use a certain amount from the HSNA "in lieu of" the General Fund for making payments to hospitals).

Part VII: Conclusion

The Hospital Safety Net Assessment Program is projected to provide payment increases to hospitals that exceed the assessments paid by the hospitals through the 2013-2015 biennium.

If the Legislature chooses to expand Medicaid under the Affordable Care Act, the payment increases to hospitals for newly eligible adults are 100% federally matched for the first three years.