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Hospital Supplement Payments (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 167, #4; Page 168, #5; Page 169, #6; Page 170, #7; Page 170, #8]

CURRENT LAW

Wisconsin's medical assistance (MA) program reimburses hospitals for services they provide to MA recipients through various mechanisms that vary depending upon the type of hospital that provides the service. For the purposes of MA reimbursement, there are two types of general medical/surgical (GMS) hospitals and several types of specialty hospitals. GMS hospitals include acute care hospitals (ACHs) that are not critical access hospitals and critical access hospitals (CAHs). Critical access hospitals have 25 or fewer inpatient beds and are typically in rural areas where there are few other general hospitals. In Wisconsin there are 71 ACHs and 58 CAHs. Specialty hospital categories include psychiatric hospitals, rehabilitation hospitals, and long-term acute care hospitals.

GMS and specialty hospitals receive a base payment for services, but may also receive supplemental payments. Base payments for ACHs and CAHs are generally based on the diagnosis and acuity of the patient for inpatient services and for the group or bundle of services provided for outpatient services. The base payment for specialty hospitals is based on a hospital-specific daily rate, tied to a percentage of the hospital's average costs.

Supplemental payments take several forms and can be either broadly or narrowly targeted. The two major supplements are hospital access payments and disproportionate share hospital (DSH) payments. The state share of access payments is funded with segregated revenue collected from assessments on hospitals, while the state share of DSH payments is funded with general purpose revenue (GPR). Several other smaller hospital supplemental payments are funded with assessment revenue.

Disproportionate Share Hospital Payments. The state makes DSH payments to hospitals for

which at least 6% of inpatient days are attributable to MA patients and which meet other criteria related to emergency and obstetrical services. DHS is required to allocate $27,500,000 GPR annually for these payments, which when matched with federal funds, will total $67,683,800 in 2018-19. All but one hospital receiving a payment is a GMS hospital.

For each qualifying hospital, the DSH payment is calculated using an add-on percentage, multiplied by the hospital's base inpatient payment. The add-on percentage is generally proportional to the hospital's MA patient days percentage, such that those hospitals with a higher proportion of MA patients have a higher percentage. However, the maximum payment that a hospital may receive in a year is $4.6 million.

Hospital Assessment and Hospital Access Payments. DHS collects an assessment on hospitals (excluding psychiatric hospitals), based on a percentage of patient revenues. There are two separate assessments--one collected on large acute care and rehabilitation hospitals (hereafter "ACH assessment"), and another collected on critical access hospitals ("CAH assessment").

For the ACH assessment, the rate is set each year so that the total amount collected from hospitals equals $414,507,300. In 2018-19 the rate is 0.92% of gross patient revenues.

ACH hospital assessment revenue is deposited in the hospital assessment fund and a portion is used, along with federal matching funds, to make hospital access payments and other hospital supplements. DHS is required, in accordance with a statutory formula, to make total annual supplemental payments equaling the total amount collected through the assessment divided by 61.68%, which is $672,028,700. Of this amount, $654,028,700 is used for hospital access payments, while the remaining $18,000,000 is used for other hospital supplemental payments. Hospital access payments are flat rate payments made in addition to the base reimbursement for inpatient and outpatient services. In 2018-19, the hospital access payment for inpatient services is set at $4,027 for inpatient services (paid upon discharge) and $318 for outpatient services (paid per visit), amounts that are recalculated each year to distribute the total amount of funding allocated for access payments. Access payments from this pool are paid to ACH hospitals but also to specialty hospitals other than psychiatric hospitals.

Any assessment revenue remaining in the hospital assessment fund after making the access payments is transferred to the medical assistance trust fund (MATF), where it is used for the state share of general MA benefits (including hospital base payments), offsetting what would otherwise be GPR expenditures. In 2018-19, an estimated $164.5 million of the total $414.5 million in assessment revenue will be transferred to the MATF.

The CAH assessment uses the same rate as the ACH assessment, but is applied to gross inpatient revenue, as opposed to total revenues. Unlike the ACH hospital assessment, which is a fixed total each year, the total amount collected under the CAH assessment changes. In 2018-19 CAH assessment collections will total $6,582,600. The assessment revenue is used primarily, along with federal matching funds to make CAH access payments, totaling an estimated $10,672,200 in 2018-19. CAH assessment revenue not used for access payments is used for a rural physician grant program and to offset GPR for general MA benefits.

Other Hospital Supplements. DHS makes several other targeted supplemental hospital

payments, two of which are affected by the bill. First, MA makes pediatric inpatient supplemental payments to hospitals that have more than 12,000 inpatient days in the hospital's acute care and intensive care pediatric unit, excluding neonatal intensive care. The UW Hospital and Clinics and Children's Hospital of Wisconsin each receive $1,000,000 annually under this provision.

Second, DHS makes payments to rural hospitals that meet all of the qualifications for a DSH payment except that they lack obstetrical services. DHS is required to distribute $250,000 GPR, plus associated federal matching funds for these payments. Payments are distributed under a formula similar to the one used for DSH payments. In 2018-19, DHS will make payments totaling $613,000 to seven hospitals.

GOVERNOR

This paper discusses five items related to supplemental hospital payments under MA:

Disproportionate Share Hospital Payments. Provide $71,428,600 ($29,000,000 GPR and $42,428,600 FED) annually to increase disproportionate share hospital (DSH) payments to hospitals under MA. Modify statutory provisions relating to the program by: (a) increasing, from $27,500,000 to $56,500,000 per year, the state share of payments, in addition to the federal matching funds, that DHS is required to pay to hospitals that serve a disproportionate share of low-income patients; (b) increasing, from $4,600,000 to $9,200,000 the maximum amount any single hospital can receive in each fiscal year; and (c) provide that a hospital that is a free-standing pediatric teaching hospital located in Wisconsin for which 50 percent or more of its total inpatient days are for MA recipients may receive up to $12,000,000 in each fiscal year.

Acute Care Hospital Access Payments. Provide $100,000,000 (-$7,400,000 GPR and $107,400,000 FED) annually to increase the total annual hospital access payments under MA. Require DHS to make total hospital supplement payments equal to the amount collected under the hospital assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%, which has the effect of increasing the annual total from $672,028,700 to $772,028,700.

Critical Access Hospital Access Payments. Provide $1,500,000 (-$300,000 GPR and $1,800,000 FED) annually to increase the total amount of critical access hospital (CAH) access payments under MA. Require DHS to make total supplemental payments to critical access hospitals equal to the amount collected under the CAH assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%.

Pediatric Inpatient Supplement. Increase MA benefits funding by $10,000,000 ($1,407,000 GPR and $8,593,000 FED) in 2019-20 and $10,000,000 ($2,557,000 GPR and $7,443,000 FED) in 2020-21 to fund a pediatric supplemental hospital payment. Authorize DHS, using a method determined by the Department, to distribute $10,000,000 in each fiscal year to hospitals that are free-standing pediatric teaching hospitals located in Wisconsin, and for which 45 percent or more of their total inpatient days are for MA recipients.

Require DHS, using a method determined by the Department, to distribute a total sum of

$2,000,000 each state fiscal year to acute care hospitals in Wisconsin that have inpatient days in the hospital's acute care and intensive care pediatric units that exceed 12,000 days in the second calendar year prior to the hospital's current fiscal year. Specify that, for the purposes of this calculation, days for neonatal intensive care units are not included.

Rural Critical Care Hospital Supplement. Provide $615,800 ($250,000 GPR and $365,800 FED) annually to increase funding for supplemental payments made to rural critical care access hospitals under the MA program. Increase, from $250,000 to $500,000, the total amount of the state share of payments for the supplement. Delete the current law eligibility criteria for receiving a supplemental payment under the program, which is any hospital that does not have obstetric services, but would otherwise meet all of the requirements for a payment under the disproportionate share hospital payment program.

Specify, instead, that payments be made to hospitals that meet the following criteria: (a) the hospital is located in Wisconsin and provides a wide array of services, including emergency department services; and (b) in the most recent year for which information is available, the hospital charged at least six percent of overall charges for services to the medical assistance program for MA recipients. Specify that DHS may determine the amount of the payment based on MA charges as a percentage of total charges rather than, under current law, MA inpatient days as a percentage of total inpatient days.

DISCUSSION POINTS

1. Hospital payments, including both base payments and supplements, account for one of the largest expenditures categories in MA. In 2017-18, MA paid a total of approximately $2 billion through the combination of base reimbursements and supplements. The following table shows total projected hospital payments broken down by base rate reimbursements, access payments, DSH payments, and other supplements.

Total 2017-18 MA Hospital Payments ($ in Millions)

Base Rate Reimbursement*	$1,279.2
Access Payments	642.9
DSH Payments	66.8
Other Supplements	30.8
Total	$2,019.7

* Includes data on HMO payments to hospitals on a calendar year basis rather than fiscal year basis.

2. There are two commonly used measures of the adequacy of MA hospital payments. One is the ratio of the reimbursement rates paid to hospitals by commercial insurers to the reimbursement rates paid by MA (including base rates and supplements). The second is the relationship between total amount of MA reimbursement payments and total hospital costs attributable to MA patients. Both measures can be used to demonstrate that MA payments are comparatively low and to justify payment increases.

3. On an aggregate basis, DHS estimates that commercial insurance payment rates are two to three times higher than rates paid by MA. Because the prices charged to commercial insurers vary considerably by type of service, by hospital, and even by insurer within the same hospital, this ratio will also vary. Generally this ratio is higher for outpatient services than inpatient services.

4. The fact that MA payments are considerably less than commercial insurance payments means that hospitals receive less revenue per inpatient stay or outpatient service when the patient has MA coverage than if the coverage is provided through a commercial insurance policy. This may have implications for hospital revenues and the services that a hospital can offer to all patients. The higher the share of MA patients are of a hospital's total patient population, the greater that these impacts will be.

5. In addition to being below commercial insurance payment rates, the total of all MA payments to hospitals, including base rate reimbursement and supplements, is less than the hospitals' aggregate cost of care attributable to MA patients. On a statewide basis, MA hospital payments cover approximately 65% of hospital costs attributable to MA patients. This calculation can vary depending on methodological choices as to which costs and which revenues to consider. Nevertheless, just as there is no dispute that MA pays below commercial insurance rates, there is wide agreement that total MA payments are below average MA costs.

6. One publicly-reported measure of MA underpayment for hospitals can be found in hospitals' reports of community benefits spending. Under federal law, hospitals that operate on a nonprofit basis (which is the case for all but three general medical/surgical hospitals in Wisconsin) are required, as a condition of maintaining their tax exempt status, to devote resources to community benefits, with the goal of improving the health of their communities. Among other specific requirements, these hospitals must report their annual total spending for community benefits. In addition to any unreimbursed costs for charitable care and spending on community health initiatives, hospitals are allowed to count the shortfall between Medicaid patient costs and Medicaid payments. The Medicaid shortfall is the largest component of hospitals' community benefits spending, both nationwide and in Wisconsin. In 2017, Wisconsin hospitals reported a total of $1.056 billion in Medicaid shortfalls, which was out of a total of $1.797 billion in total community benefits.

7. Although increases to hospital supplements could reduce the MA shortfall (although this would also depend upon trends in hospitals' costs), hospitals would not necessarily increase other types of community benefit spending, since the federal law does not have minimum standards for this spending.

8. The total MA reimbursement as a percentage of total costs attributable to MA patients can vary widely by hospital, due to differences in how hospitals fare under the totality of the reimbursement policies, but also differences in underlying costs. In addition to differing with respect to various decisions on staffing, and investments in equipment and building capital, differences in hospital utilization can affect the percentage of costs that MA covers. For example, a hospital that has a low number of vacant inpatient beds may have lower costs per inpatient discharge than a hospital that has a higher number, all else being equal, making it more "efficient" by comparison. In this case, MA reimbursement may fully cover the MA costs or cover a higher percentage of costs attributable to MA patients, whereas the same reimbursement will cover a lower percentage of costs for the less

"efficient" hospital. For these reasons, the percentage of costs measure will vary based on factors that are unrelated to the actual amount of MA reimbursement.

9. The MA reimbursement as percent of hospital cost is a measure of the relationship between aggregate costs and aggregate payments, which should not be mistaken for the relationship between the costs and reimbursement associated with any individual MA patient. The hospital industry is characterized by having high fixed costs (costs that do not change based on the volume of services) as a percentage of total costs. For this reason, it may often be the case that it is to a hospital's advantage to serve additional patients, regardless of payer, since doing so generates revenue to offset its fixed cost investment. Hospitals are, of course, better off if the additional patients are commercially insured rather than covered under Medicaid since this would produce greater marginal revenue. Likewise, they benefit if Medicaid increases its reimbursement rates, since this increases their total revenue if the additional patients are MA enrollees. But as long as the MA reimbursement is higher than the marginal cost of serving a MA patient (the additional costs incurred due only to the patient's presence in the hospital), the hospital will benefit financially. MA takes advantage of this dynamic because it allows the program to pay lower reimbursement rates, thus minimizing costs to the program while also retaining access to hospital services for enrollees.

10. A potential disadvantage of maintaining lower reimbursement rates for MA is that hospitals may try to recover the revenue underpayment from MA by charging higher prices to commercial insurance plans. If the aggregate losses are recovered in this way, employers or individuals purchasing those plans will pay more for insurance. The extent to which hospitals can pass along MA losses to commercial insurance plans depends on having negotiating leverage over those plans that they have not otherwise exercised.

11. There is considerable debate among health economists and healthcare financial specialists regarding the impact of Medicaid (and Medicare) reimbursement on commercial insurance prices. There is no disagreement that Medicaid pays much less than commercial insurers, and as a consequence, that providers would prefer to have a higher share of the higher-paying commercially-insured patients. Rather, the debate centers around whether or not there is a causal link between the low reimbursement associated with Medicaid reimbursement and higher prices charged to commercial insurers. While some argue that it is inevitable that the relative losses associated with Medicaid reimbursement are shifted to commercial insurers, others propose that a provider's prices are largely determined by market forces independent of Medicaid policies. Individual providers will face different circumstances, and will likely respond differently depending on those circumstances.

12. In addition to, or instead of, passing along Medicaid losses to commercial insurance, hospitals may also respond in other ways. First, they could decline to take Medicaid patients, although this does not appear to be a likely outcome at this time. Second, they could seek to increase the volume of patients served to more efficiently utilize their facility, including by contracting with more commercial insurers. Third, they could constrain or reduce costs, either capital (building or equipment) or operations costs. If a hospital is unable to achieve greater efficiencies, constraining or reducing costs could result in a reduction in the volume or quality of services. Finally, a hospital could not respond with any particular strategy, in effect absorbing the losses, resulting in lower net revenues.

13. On a statewide basis, Wisconsin hospitals had net income (all revenues in excess of

expenses) of $2.2 billion in 2017, which was 10.9% of expenses. Although this is an industrywide figure, individual hospitals' financial status varied, with some showing losses and others larger gains. Many hospitals are part of larger health systems, which means that net income at one hospital may be used to support the operation of other parts of the system, such as non-hospital clinics, nursing homes, or other hospitals.

14. Because hospitals may have several options when addressing MA revenue shortfalls in relation to cost, they may, conversely, respond in different ways to increases in MA supplemental payments. An increase in revenue may relieve pressure to seek to increase prices for commercial insurers, but hospitals may also increase costs or receive higher net earnings.

15. In any case, the proposed increases to hospital payments are small in relation to total hospital revenues, equivalent to less than 1% of total net patient revenues for state hospitals. Consequently, the increases would have relatively small impact on the share of MA costs covered by MA reimbursement.

Discussion of Proposed Supplemental Payment Increases and Alternatives

16. Upon introduction of the bill, the administration indicated that the GPR provided by the bill for the five hospital supplement payments items, as well as funding increases for other MA program and public health initiatives, is an allocation of state savings resulting from adopting the full Medicaid expansion. Because the Committee has excluded full Medicaid expansion from the bill, the state will not realize the GPR savings. If the primary justification for providing hospital supplement increases is tied to full MA expansion, the Committee could now determine that hospital supplement increases are no longer warranted.

17. Regardless of whether or not the state adopts full Medicaid expansion, increasing the hospital supplemental payments requires increasing GPR spending for those payments using funds that could otherwise be used for other purposes. As with all legislative budgetary decisions, the Legislature must weigh the benefits of increasing hospital payments against other priorities. The Committee could determine that providing increases for hospital payments is important enough to allocate GPR for that purpose. The following points provide a more detailed discussion the supplement payments proposals, as a whole and individually, along with alternatives for consideration.

18. The following table summarizes the proposed funding increases by year and fund source for the five hospital supplement items under the bill. Over the biennium, total hospital payments would be increased by $367.1 million.

	2019-20			2020-21		
Supplement Item	GPR	FED	Total	GPR	FED	Total
DSH Payments	$29,000,000	$42,428,600	$71,428,600	$29,000,000	$42,428,600	$71,428,600
ACH Access Payments	-7,400,000	107,400,000	100,000,000	-7,400,000	107,400,000	100,000,000
CAH Access Payments	-300,000	1,800,000	1,500,000	-300,000	1,800,000	1,500,000
Pediatric Inpatient	1,407,000	8,593,000	10,000,000	2,557,000	7,443,000	10,000,000
Rural Critical Care	250,000	365,800	615,800	250,000	365,800	615,800
Totals	$22,957,000	$160,587,400	$183,544,400	$24,107,000	$159,437,400	$183,544,400

19. The proposed hospital supplemental payments would increase total hospital reimbursement by approximately 9%, compared to the current hospital payment base that includes base reimbursement and supplemental payments. However, the rate of the increase could vary widely by hospital, since the distribution of supplemental payments is not proportionate to current payments.

Disproportionate Share Hospital Payments

20. Disproportionate share hospital payments are intended to provide supplemental reimbursement for hospitals that serve relatively high numbers of MA recipients and uninsured, low-income patients. The rationale for DSH payments is that because publicly-funded programs, such as Medicaid and Medicare, tend to have lower reimbursement rates than private insurance, a hospital that has a large number of patients with coverage under these public programs is in a weaker financial position than a hospital that has fewer of these patients. The DSH payments are intended to compensate for this imbalance.

21. The current DSH payment program has been in place since 2013-14. The following table shows the GPR allocated each year for payments each year, plus the associated federal DSH matching funds and the total funding. The Governor's proposed funding for the 2019-21 biennium is shown as well for comparison.

Disproportionate Share Hospital Payments
($ in Millions)

Fiscal Year	GPR	FED	Total
2013-14	$15.0	$21.8	$36.8
2014-15	15.0	21.9	36.9
2015-16	15.0	20.9	35.9
2016-17	15.0	21.1	36.1
2017-18	27.5	39.5	67.0
2018-19	27.5	40.2	67.7
2019-20*	56.5	82.6	139.1
2020-21*	56.5	82.6	139.1

*Proposed funding level.

22. Of the $67.5 million of DSH payments distributed in 2018-19, 92% was provided to acute care hospitals, 6% was provided to critical access hospitals, and 2% was provided to the Milwaukee County Behavioral Health Complex.

23. As with other Medicaid spending, states receive federal matching funds for DSH payments, although the total amount of federal DSH funding available to each state is capped. In federal fiscal year FFY 2018-19, the state's total DSH allotment is $108.8 million (a preliminary amount, subject to adjustment). The Governor's proposal would use $82.6 million in each year, and so would not exceed the current federal limit.

24. Although the proposed draw on federal DSH funds would not exceed the state's current allotment, federal DSH limits could be lowered in the future. The federal Department of Health and Human Services is required by current federal law to reduce total DSH allotments by $4 billion in FFY 2019-20 and by $8 billion in FFY 2020-21, reductions of approximately 32% and 63%, respectively. For various reasons, the formula for these reductions generally does not affect Wisconsin's allotment as much as it does other states. Based on reduction simulations of a $2 billion reduction presented by the Federal Funds Information for States, Wisconsin's allotment would decline by $2.8 million. Assuming that the state's share of an $8 billion total reduction would be of the same proportion, the Governor's proposed use of federal DSH funding during the 2019-21 biennium would remain below the state's allotment.

25. Federal DSH reductions were originally scheduled to occur beginning in FFY 2013-14, but have been delayed on several occasions, and so now would first apply in FFY 2019-20. Any additional delay would require enactment of federal legislation.

26. The DSH payment formula computes an add-on multiplier to each hospital's fee-for-service inpatient payments. The multiplier percentage increases as the MA inpatient percentage increases. For the 2018-19 distribution, this multiplier ranges from approximately 12% to 13% for hospitals with MA inpatient percentage of 6.0% to 7.0% up to 20% to 30% for hospitals with an MA inpatient percentage in the 18% to 30% range. The maximum DSH payment is $4,600,000, which effectively caps the multiplier for larger hospitals with high MA utilization. In 2018-19, seven hospitals received the maximum payment.

27. Although the DSH payments are typically viewed as targeting funding to hospitals with high MA utilization, the state's DSH allocation formula spreads the available funding broadly, so that over two-thirds of GMS hospitals receive a payment. In 2018-19, 61 of the state's 71 non-CAH GMS hospitals and 29 of the state's 58 critical access hospitals received a DSH payment. On statewide basis MA patient days account for approximately 21% of all hospital inpatient days. Since a hospital receives a payment if its inpatient percentage is at least 6.0%, many hospitals with below-average MA utilization receive payments. Hospitals that do not qualify for a DSH payment either are below the MA inpatient threshold of 6% or do not meet the other requirements, such as offering emergency department and obstetrical services.

28. The bill would roughly double the total amount available for payments, from $67.5 million to $139.1 million annually. With this increase to total payments, the inpatient payment multipliers would increase to around 35% for hospitals near the minimum threshold to generally between 40% and 55% for hospitals with high MA utilization.

29. The bill would double the maximum payment from $4,600,000 to $9,200,000. For free-standing pediatric hospitals with a MA inpatient utilization above 50% (applicable to Children's Hospital of Wisconsin), the maximum payment would increase to $12,000,000. DHS projects that with the combination of the increase to total payments and increases to the maximum cap, five hospitals would be paid the maximum.

30. Children's Hospital of Wisconsin (CHW) had an MA inpatient utilization percentage of 58% in 2017, the highest rate among state GMS hospitals. Because of its high MA utilization and high volume, CHW is arguably the most adversely affected by the current DSH payment maximum

payment of $4,600,000. Based on its MA inpatient utilization, CHW would have a DSH add-on multiplier of 51% in 2018-19. Due to the payment cap, CHW's effective multiplier was 5.8%. The bill would establish a higher DSH cap for CHW in recognition of its particularly high share of MA patients.

31. The Committee may determine that the proposed funding increase for disproportionate share hospital payments is warranted in order to increase the share of hospital costs allocated to MA patients is reimbursed by the program (Alternative A1). Since the level of funding is not tied to any identified benchmark, the Committee could provide a different amount, after weighing the merits of increasing DSH payments against other potential uses of available GPR funds. The Alternatives section of this paper provides several alternatives in a table format. For each alternative, the maximum cap is adjusted in proportion to the change in funding.

Acute Care Hospital Access Payments

32. Hospital access payments are fixed amounts applied to each inpatient discharge or outpatient service. While access payments have the advantage of simplicity, there are disadvantages relative to disproportionate share hospital payments. DSH payments, within some limits, pay proportionately more for hospitals for that have a higher share of MA patients, and are scaled to the underlying base payment for the service. Thus, compared to access payments, DSH payments are more efficiently targeted to hospitals that experience higher rates of underpayment associated with MA.

33. The principal advantage of access payments, relative to DSH payments, is that the state can take advantage of higher federal medical assistance percentage (FMAP) in some cases, thus reducing state costs. While the state's standard FMAP applies to all DSH payments, the applicable FMAP for access payments depends upon the patient receiving the service. For most hospital services, the standard FMAP applies (59.36 % in 2019-20 and 59.55% in 2020-21), but a higher FMAP applies to hospital services for children covered under the federal Children's Health Insurance Program (CHIP). The CHIP FMAP is projected at 85.93% in 2019-20 and 74.56% in 2020-21. Based on the mix of MA patients currently receiving hospital services, DHS estimates that the blended average FMAP for all hospital access payments would be approximately 63.1% in 2019-20 and 61.5% in 2020-21, in the absence of any other changes. This difference between the standard FMAP and the higher blended FMAP results in state savings of approximately $24 million in 2019-20 and $12 million in 2020-21. [The reduction in the CHIP FMAP reflects the scheduled phase-out of a temporary increase to the CHIP FMAP that applied between FFY 2013-14 and FFY 2020-21. Since this phase-out is complete in FFY 2020-21, the CHIP FMAP in subsequent years should be similar to the 2020-21 rate.]

34. Although the bill would increase annual hospital access payments by $100,000,000, GPR funding for MA benefits would be reduced by $7,400,000 annually due to the interactive effects of other provisions in the bill, most significantly the decision to adopt full Medicaid expansion. The following points provide the background for understanding these effects.

35. Currently, childless adults are covered under the terms of a federal demonstration waiver. DHS does not make hospital access payments for childless adult hospital visits, a policy that effectively reduces the cost of childless adult coverage, in order to comply with federal "budget

neutrality" rules applicable to such waivers. That is, for the purposes of determining the amount of the access payments, DHS currently divides the total access payment pool by the projected number of MA hospital visits, excluding visits by childless adults.

36. Under the bill, childless adults would no longer be covered under the federal waiver, but instead the state would adopt the full Medicaid expansion as a standard (non-waiver) change to income eligibility thresholds. The standard coverage for childless adults would mean that federal budget neutrality rules would no longer apply and the MA program could begin making access payments for childless adults. Furthermore, with the adoption of full Medicaid expansion, the state could claim enhanced FMAP of 90% for these payments. Consequently, although total payments would increase, the use of 90% FMAP for a portion of those payments would reduce the overall state share.

37. The addition of childless adults to the access payment pool would increase the blended FMAP from 63.1% in 2019-20 and 61.5% in 2020-21 to a projected 69.0% in 2019-20 and 67.6% in 2020-21. The following table illustrates these changes.

	2019-20	2020-21
Current Law		
Total Access Payments	$654,028,700	$654,028,700
Blended FMAP	63.1%	61.5%
State Share	36.9%	38.5%
Access Payment FED	412,517,600	402,001,800
Access Payment SEG	241,511,100	252,026,900
Bill Changes		
Access Payment Increase	$100,000,000	$100,000,000
New Access Payment Total	754,028,700	754,028,700
New Blended FMAP	69.0%	67.6%
New State Share	31.0%	32.4%
Access Payment FED	519,917,600	509,401,800
Access Payment SEG	234,111,100	244,626,900
Change to Current Law		
FED Change	$107,400,000	$107,400,000
SEG Change	-7,400,000	-7,400,000

Note: The state share of access payments is paid from the segregated hospital assessment fund, thus the "SEG" designation in the table. A reduction in SEG used for this purpose has the effect of reducing increasing the amount of SEG funds available to offset GPR expenditures for other MA benefits.

38. The GPR savings under the bill is only possible with adoption of full Medicaid expansion and providing coverage for childless adults through a standard state plan amendment rather than through the current waiver. Without the enhanced FMAP for childless adults associated with full Medicaid expansion, a $100,000,000 annual increase to access payments would require GPR increases of $36,926,700 GPR in 2019-20 and $38,534,600 GPR in 2020-21, relative to the base, and $44,326,700 GPR in 2019-20 and $45,934,600 GPR in 2020-21, relative to the bill (Alternative B2).

39. If the Committee decides that an increase to access payments is warranted, but at a lower level, the bill could be amended to reduce the size of the payment. In the absence of adopting full Medicaid expansion, a smaller increase in the total payment would still require an increase in state spending. A $50,000,000 increase to the ACH access payment would require increases of $18,463,300 GPR and $31,536,600 FED in 2019-20 and $19,267,300 GPR and $30,732,700 FED in 2020-21, relative to the base. Relative to the bill, this would be an increase of $25,863,400 GPR and a decrease of $75,863,400 FED in 2019-20 and an increase of $26,667,300 GPR and a decrease of $76,667,300 FED in 2020-21 (Alternative B3).

Critical Access Hospital Access Payments

40. Unlike the acute care hospital access payments, the total amount of the critical access hospital access payments changes each year since the amount collected from the CAH assessment changes. DHS projects that the CAH access payments (SEG and FED total) will be $10,672,200 in 2018-19. Under the current law formula, total CAH access payments are projected to decline (due to a decline of CAH assessment revenues) to $10,075,900 in 2019-20 and $9,513,000 in 2020-21.

41. The bill would increase total access payments by modifying the statutory formula that determines the amount that DHS is required to distribute. As with the increase to ACH access payments, the bill is based on the assumption that the blended FMAP for all CAH payments would increase due to the combined effect of adopting full Medicaid expansion and making payments for childless adults services under the enhanced FMAP that comes with full expansion. Thus, while the bill assumes a total increase in CAH payments of $1,500,000 annually, the state share of payments would decline by $300,000 annually. A decline in the state share of payments, in turn, has the effect of reducing GPR expenditures by that amount.

42. As with the fiscal effect associated with the bill's ACH access payment changes, realizing GPR savings for the CAH access payments is only possible with the implementation of full Medicaid expansion and providing childless adult coverage through standard Medicaid coverage rather than through a waiver. Without full Medicaid expansion, a $1,500,000 annual increase to CAH access payments would require increases of $551,000 GPR and 949,000 FED in 2019-20 and $570,000 GPR and $930,000 FED in 2020-21, relative to the base. Relative to the bill, this alternative would require increases of $851,000 GPR in 2019-20 and $870,000 GPR in 2020-21 and corresponding FED decreases (Alternative C2).

43. As with the ACH access payment, the Committee may wish to provide an increase to the CAH access payment, but at a lower level. A $750,000 increase in the payment would require increases of $275,500 GPR and $474,500 FED in 2019-20 and $285,000 GPR and $465,000 FED in 2020-21, relative to the base. Relative to the bill, this alternative would result in increases of $575,500 GPR in 2019-20 and $585,000 GPR in 2020-21 and decreases of $1,325,500 FED in 2019-20 and $1,335,000 FED in 2020-21 (Alternative C3).

Pediatric Inpatient Supplement

44. Although the bill would increase the total pool of ACH access payments by $100,000,000, the amount of each payment per inpatient discharge or outpatient service would decrease, since the total pool of payments would need to be spread among a larger number of patients

once childless adults are included in the payment. Total access payments to most individual ACH hospitals would increase, since the gains associated with receiving a payment for childless adult services would offset the lower overall average. The notable exception is Children's Hospital of Wisconsin, which, since it does not provide adult services, would experience a reduction in total access payments.

45. DHS estimates that the bill's access payment provisions would reduce Children's Hospital of Wisconsin total access payment by approximately $6.8 million on an annual basis. However, the proposed $10.0 million pediatric inpatient supplement fully offset this reduction to provide a net increase of $3.2 million.

46. Since the Committee has removed the Governor's full MA expansion from the bill (as well as the related provision to cover childless adults through standard Medicaid coverage rather than through federal waiver), the proposal to pay acute care hospital access payments for hospital services provided to childless adults may result in exceeding the federal waiver budget neutrality limits for childless adult coverage. Without the change to access payments, Children's Hospital of Wisconsin would not experience a decrease in access payments and, therefore, the primary rationale of the new proposed pediatric supplement would no longer be applicable.

47. Although the purpose of the new pediatric inpatient supplement would not apply if the MA expansion and access payment changes are not adopted, the Committee could still approve the Governor's recommendation to codify the current $2,000,000 pediatric hospital supplement if it does not approve the new $10,000,000 supplement for Children's Hospital of Wisconsin (Alternative D2).

Rural Critical Care Hospital Supplement

48. The rural critical care supplement was established by the 2017-19 biennial budget to assist hospitals that have an inpatient utilization rate that would qualify for a DSH payment, but do not qualify for a payment due to not offer obstetric services. In 2018-19, DHS distributed a total of $614,900 to seven critical access hospitals under this provision.

49. The bill would double the GPR allotted for these payments from $250,000 to $500,000, which would roughly double the total payments to approximately $1,230,000 annually.

50. In addition to the funding increase, the bill would change the criteria for receiving a rural critical care supplement. Instead of tying the payment to having MA patient inpatient days accounting for at least 6% of total inpatient days, the standard would be at least 6% of total patient gross charges, including both inpatient and outpatient services.

51. Based on current data on MA charges, the number of hospitals who would qualify for the rural critical care supplement would increase from seven to 24. With the addition of more hospitals to this program, all but six of the state's 58 critical access hospitals would receive either a DSH payment of a rural critical care supplement payment.

52. Although funding for the rural critical care supplement would be doubled, the hospitals receiving a grant under the current program criteria would experience a reduction in the amount of the supplement due to the additional hospitals qualifying for a payment. On May 1, 2019, DOA

submitted a letter to the Co-Chairs to request a change to this item. The letter indicates that it was the Governor's intent to provide an additional $125,000 GPR annually so that the existing recipients of rural critical care supplement would not experience a payment reduction (Alternative E2).

ALTERNATIVES

A. Disproportionate Share Hospital Payments

The following table shows various DSH payment alternatives for the Committee's consideration, arranged by level of annual GPR funding commitment. For the purposes of these alternatives, the estimates of the federal matching funds reflects updated FMAP assumptions, which changes slightly the federal match associated with the Governor's proposal, relative to the bill. With each alternative 1b to 1d, the maximum payment applicable to all hospitals and to stand-alone pediatric hospitals is adjusted from the bill in proportion to the GPR funding change (rounded to the nearest $100,000). These amounts are shown at the bottom of each column.

Alternatives for Disproportionate Share Hospital Payments

	(Bill) Alternative A1	Alternative A2	Alternative A3	Alternative A4
Change to Base				
2019-20				
GPR	$29,000,000	$20,000,000	$10,000,000	$5,000,000
FED	42,358,300	29,212,600	14,606,300	7,303,100
Total	$71,358,300	$49,212,600	$24,606,300	$12,303,100
2020-21				
GPR	$29,000,000	$20,000,000	$10,000,000	$5,000,000
FED	42,693,400	29,443,800	14,721,900	7,360,900
Total	$71,693,400	$49,443,800	$24,721,900	$12,360,900
2019-21 Biennium				
GPR	$58,000,000	$40,000,000	$20,000,000	$10,000,000
FED	85,051,700	58,656,400	29,328,200	14,664,000
Total	$143,051,700	$98,656,400	$49,328,200	$24,664,000
Change to Bill				
2019-20				
GPR	$0	-$9,000,000	-$19,000,000	-$24,000,000
FED	-70,300	-13,216,000	-27,822,300	-35,125,500
Total	-$70,300	-$22,216,000	-$46,822,300	-$59,125,500
2020-21				
GPR	$0	-$9,000,000	-$19,000,000	-$24,000,000
FED	264,800	-12,984,800	-27,706,700	-35,067,700
Total	$264,800	-$21,984,800	-$46,706,700	-$59,067,700
2019-21 Biennium				
GPR	$0	-$18,000,000	-$38,000,000	-$48,000,000
FED	194,500	-26,200,800	-55,529,000	-70,193,200
Total	$194,500	-$44,200,800	-$93,529,000	-$118,193,200
Maximum Payment				
General Maximum	$9,200,000	$6,200,000	$3,100,000	$1,600,000
Standalone Pediatric	$12,000,000	$8,300,000	$4,100,000	$2,100,000

B. Acute Care Hospital Access Payments

1. Approve the Governor's recommendation to provide $100,000,000 (-$7,400,000 GPR and $107,400,000 FED) annually to increase the total annual hospital access payments under MA. Require DHS to make total hospital supplement payments equal to the amount collected under the hospital assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%, which has the effect of increasing the annual total from $672,028,700 to $772,028,700. [This fiscal effect of this alternative reflects an assumption that the state adopts full Medicaid expansion and provides childless adult coverage under a standard Medicaid plan amendment rather than through a federal waiver.]

ALT B1	Change to Base	Change to Bill
GPR	- $14,800,000	$0
FED	214,800,000	0
Total	$200,000,000	$0

2. Adopt the Governor's recommendation to provide an additional $100,000,000 annually increase to total hospital access payments, but with funding modifications to reflect that the Governor's full MA expansion proposal has been removed from the bill. Increase funding by $44,326,700 GPR in 2019-20 and $45,934,600 GPR in 2020-21 and provide corresponding FED decreases, relative to the bill, to reflect the effect of providing the access payment increase with the standard federal matching percentage, rather than the enhanced federal match percentage associated with full Medicaid expansion.

ALT B2	Change to Base	Change to Bill
GPR	$75,461,300	$90,261,300
FED	124,538,700	- 90,261,300
Total	$200,000,000	$0

3. Modify the Governor's recommendation to provide an increase to annual ACH access payments of $50,000,000, instead of $100,000,000, under a scenario without full Medicaid expansion. Decrease funding by $50,000,000 annually, relative to the bill, which is the net effect of funding increases of $25,863,400 GPR in 2019-20 and $26,667,300 GPR in 2020-21 and decreases of $75,863,400 FED in 2019-20 and $76,667,300 FED in 2020-21. Require DHS to make total hospital supplement payments equal to the amount collected under the hospital assessment divided by 57.41%, instead of, under current law, the amount of the assessment divided by 61.68%, which has the effect of increasing the annual total from $672,028,700 to $722,028,700.

ALT B3	Change to Base	Change to Bill
GPR	$37,730,700	$52,530,700
FED	62,269,300	-152,530,700
Total	$100,000,000	- $100,000,000

4. Take no action.

ALT B4	Change to Base	Change to Bill
GPR	$0	$14,000,000
FED	0	- 214,800,000
Total	$0	- $200,000,000

C. Critical Access Hospital Access Payments

1. Approve the Governor's recommendation to provide $1,500,000 (-$300,000 GPR and $1,800,000 FED) annually to increase funding for critical access hospital access payments and require DHS to make total supplemental payments to critical access hospitals equal to the amount collected under the CAH assessment divided by 53.69%, instead of, under current law, the amount of the assessment divided by 61.68%.

ALT C1	Change to Base	Change to Bill
GPR	- $600,000	$0
FED	3,600,000	0
Total	$3,000,000	$0

2. Adopt the Governor's recommendation to provide a $1,500,000 annual increase to total critical access hospital access payments, but with funding modifications to reflect that the Governor's full MA expansion has been removed from the bill. Increase funding by $851,000 GPR in 2019-20 and $870,000 GPR in 2020-21 and provide corresponding FED decreases, relative to the bill, to reflect the effect of providing the access payment increase with the standard federal matching percentage rather than the enhanced federal match percentage associated with full Medicaid expansion.

ALT C2	Change to Base	Change to Bill
GPR	$1,121,000	$1,721,000
FED	1,879,000	- 1,721,000
Total	$3,000,000	$0

3. Modify the Governor's recommendation to provide an increase to annual CAH access payments of $750,000, instead of $1,500,000, and under a scenario without full Medicaid expansion. Decrease funding by $750,000 annually, relative to the bill, which is the net effect of funding increases of $575,500 GPR in 2019-20 and $585,000 GPR in 2020-21 and decreases of $1,325,500 FED in 2019-20 and $1,335,000 FED in 2020-21. Require DHS to make total supplemental payments to critical access hospitals equal to the amount collected under the CAH assessment divided by 57.41%, instead of, under current law, the amount of the assessment divided by 61.68%.

ALT C3	Change to Base	Bill
GPR	$1,121,000	$1,160,500
FED	1,879,000	- 2,660,500
Total	$3,000,000	- $1,500,000

4. Take no action.

ALT C4	Change to Base	Bill
GPR	$0	$600,000
FED	0	- 3,600,000
Total	$0	- $3,000,000

D. Pediatric Inpatient Supplement

1. Approve the Governor's recommendation to increase MA benefits funding by $10,000,000 ($1,407,000 GPR and $8,593,000 FED) in 2019-20 and $10,000,000 ($2,557,000 GPR and $7,443,000 FED) in 2020-21 and authorize DHS to distribute $10,000,000 annually to hospitals that are free-standing pediatric teaching hospitals for which 45 percent or more of their total inpatient days are for MA recipients. In addition, approve the Governor's recommendation to codify an existing $2,000,000 pediatric hospital supplement payment.

ALT D1	Change to Base	Bill
GPR	$3,964,000	$0
FED	16,036,000	0
Total	$20,000,000	$0

2. Decrease funding by $10,000,000 annually (-$1,407,000 GPR and -$8,593,000 FED) in 2019-20 and -$2,557,000 GPR and -$7,443,000 FED in 2020-21) to reflect the deletion of the pediatric inpatient supplement, but approve the Governor's recommendation to codify an existing $2,000,000 pediatric hospital supplement payment.

ALT D2	Change to Base	Bill
GPR	$0	- $3,964,000
FED	0	- 16,036,000
Total	$0	- $20,000,000

3. Take no action.

ALT D3	Change to Base	Change to Bill
GPR	$0	- $3,964,000
FED	0	- 16,036,000
Total	$0	- $20,000,000

E. Rural Critical Care Hospital Supplement

1. Approve the Governor's recommendation to provide $615,800 ($250,000 GPR and $365,800 FED) annually to increase funding for supplemental payments made to rural critical care access hospitals under the MA program and modify the formula for making the grants to increase the number of eligible hospitals.

ALT E1	Change to Base	Change to Bill
GPR	$500,000	$0
FED	731,600	0
Total	$1,231,600	$0

2. Modify the Governor's recommendation by providing an additional $307,900 ($125,000 GPR and $182,900 FED) annually to ensure that all hospitals that currently receive a rural crisis care hospital supplement payment do not receive reduced payments due to the modification to the formula.

ALT E2	Change to Base	Change to Bill
GPR	$750,000	$250,000
FED	1,097,400	365,800
Total	$1,847,400	$615,800

3. Take no action.

ALT E3	Change to Base	Change to Bill
GPR	$0	-$500,000
FED	0	-731,600
Total	$0	- $1,231,600

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