



## **Impact of Proposed Washington State Budget Reductions on Hospitals: WSHA Health Information Program Calculations**

### **Purpose of Estimates**

The budgets proposed by the Washington State Legislature make significant cuts to hospitals and health care. The budget documents are complex and sometimes confusing, making it difficult to understand how some of the proposed reductions will be implemented and what the actual dollars cut will be. Our estimates show the cuts to hospitals are about \$310 million for the biennium. In addition, many hospitals will be affected by cuts to nursing home rates, rural health clinic rates, and other provider cuts we are not able to model.

The Washington State Hospital Association (WSHA) and its Health Information Program have generated our best estimates of the impact of the budgets proposed by the Governor, the Senate, and the House, and the final state budget as adopted by the legislature. These estimates are as accurate as we can make them at present – and are made to help hospitals understand the impact of the cuts they will have to face starting in July.

### **Basis for Estimates**

This report describes how WSHA’s Health Information Program calculated each of the numbers included in our estimates. WSHA can develop reasonable estimates for some of the proposed reductions, but for others can only generate a very rough approximation meant to indicate a ballpark range. In many cases, individual hospitals will have more accurate estimates of the impact on their facility.

### **Across-the-Board Reductions in Medicaid Inpatient and Outpatient Payments**

The final state budget, as well as each of the budgets proposed by the Governor, the House, and the Senate, includes an across-the-board reduction in inpatient and outpatient payments. Each exempts certain hospitals.

In our model, we allocated reductions proportionately to the hospitals based on Medicaid payment data from the fiscal year-end data submitted to the Washington State Department of Health. Medicaid inpatient and outpatient payments were calculated by subtracting “Medicaid contractual adjustments” from “total acute care Medicaid revenue” and using that data for the allocations. In most cases, the data used are from 2007, the latest year available. In three cases, 2007 data are not available, and WSHA used 2005 or 2006 data (Garfield County Public Hospital District, Klickitat Valley Health, and Cascade Valley Hospital). In one case (University of Washington Medical Center) we replaced the data in the year end reports, since the year end report data did not match other publicly available data and produced misleading information. We removed payments for the General Assistance Unemployable program from the total Medicaid payments to avoid double counting reductions.

The Governor's budget proposed a four percent reduction in hospital expenditures for Medicaid inpatient and outpatient services, except for payments for inpatient psychiatric care and payments to critical access hospitals. While the Governor's budget showed a \$101 million savings from this reduction we increased it to \$126 million in order to be comparable proportionately to the savings used in the House and Senate budgets. The House and Senate budgets were the same, except the House budget also excluded Harborview from the reductions. The final budget included a savings of about four percent or \$121 million and did not exclude Harborview.

We allocated the savings by hospital to affected hospitals based on the proportion of Medicaid acute care hospital payments to total statewide Medicaid acute care hospital payments. We are not able to identify psychiatric payments separately, except for those to psychiatric hospitals. Public hospitals paid under the Certified Public Expenditure (CPE) program will not see a reduction in inpatient payments unless they receive a state grant. As a result, we did not apply the reductions to inpatient payments at any of the CPE district hospitals. We did include savings from Harborview in all except the House budget and savings from the University of Washington Medical Center in all the budgets.

### **Basic Health Plan Reductions**

All the budgets assume a reduction in the Basic Health Plan through enrollment and benefit changes to achieve an estimated biennial savings from \$236 to \$274.5 million. The lower number reflects an assumption that some of the Basic Health clients will transfer to Medicaid. It is difficult to calculate how the loss in Basic Health will impact hospitals, but we made a rough attempt to calculate a number.

Based on earlier discussions with actuaries, WSHA staff understand that about one-third of health care premium dollars are for hospital care. If this is correct, there would be an estimated loss of \$78.7 to about \$90 million.. We assumed there would be a loss of \$78.7 in the final budget and a loss of \$90 million in the prior proposed budgets.

In order to apportion this loss among hospitals, WSHA staff assumed Basic Health Plan use parallels Medicaid use, except for certain specialty hospitals, such as children's hospitals. We recognize this assumption is not true across-the board, but better data are not available. The biennial loss was allocated to each hospital based on the hospital's percent of total statewide hospital Medicaid payments, as derived from fiscal year end data reported to the Department of Health. We did not allocate any reductions to children's hospitals, since Basic Health enrollees are almost all adults.

Individual hospitals may have more accurate information on data for their hospitals, and can assume there will be about a 40 percent loss in payments.

### **Medicaid Inpatient Transfers**

The final budget, as well as all three budget proposals, assume a reduction in Diagnosis Related Group (DRG) payments for patients with short lengths of stay who are transferred to other care settings. Currently, there are reduced payments for patients transferred to another acute hospital, but full DRG payments when a patient is transferred

to a nursing home or other care setting. All the budgets include a reduction for patients transferred to a skilled nursing facility, rehabilitation facility, or psychiatric facility.

HRSA staff has indicated this proposed change would be implemented consistent with the current policy on transfers to another acute care hospital. For transfer cases, hospitals would be paid twice a per diem payment for the first day of care and then per diem payments for subsequent days, up to the DRG payment as a maximum. Per diem payments are calculated using the DRG rate and the average length of stay for the state. HRSA staff has indicated a wide range of discharge codes would be included in this policy.

To model the impact of this change, WSHA staff used inpatient data from the HIP-enhanced version of the Comprehensive Hospital Abstract Reporting System (CHARS) inpatient discharge file, available from the Department of Health. WSHA staff used discharges where the payer is classified as Medicaid. Calendar year 2005 data were used for all hospitals except Legacy Salmon Creek, where 2006 data were used.

Based on a discussion with HRSA staff, the new codes treated as transfers in the analysis were:

03 = Discharged/transferred to skilled nursing facility

62 = Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct-part units of a hospital

64 = Discharged/transferred to a Medicaid-certified but not Medicare-certified skilled nursing facility

65 = Discharged/transferred to psychiatric hospital

Payments were calculated using the current system with a normal DRG payment and compared to payments under the proposed system, with per diem payments for transfer cases. Losses were doubled to estimate biennial payments.

Our analysis yields a much larger savings number than that given in all the budgets (\$16 million is the assumed savings). Given the budget proviso language which cites that savings estimates need to consider savings achieved across all types of payment programs, we think the state may need to revise its implementation plans and narrow the number of discharge codes where this policy is to be applied. However, to generate a savings by hospital, we used our data on the proportion of total reductions for each hospital under the new proposal and the state's estimate on the total savings to be achieved (\$16 million). We calculated each hospital's reduction based on its proportion of the state total.

### **Medicaid Outpatient Prospective Payments for Children's, Cancer Care, and Other Exempt Hospitals**

The final budget, as well as all three proposed budgets, assumes all non-critical access hospitals would be paid based on the Medicaid outpatient prospective payment system. Currently, children's, cancer care, non-critical access small rural hospitals, and some out-

of-state hospitals are exempt and paid based on a cost-to-charge ratio. The policy in all the budgets is the same. The final budget assumes a savings of \$9 million for the biennium and we used that number in all the budgets.

The hospitals WSHA can identify that will be affected by this proposal are Seattle Children's, Mary Bridge Children's Hospital and Health Center, Seattle Cancer Care Alliance, Samaritan Healthcare, Olympic Medical Center, Providence Centralia, Lourdes Counseling Center, and St. Luke's Rehabilitation. Out-of-state hospitals may also be affected.

In order to roughly estimate the impact of this change, WSHA staff allocated the \$9 million to each affected hospital based on each hospital's percent of the combined outpatient Medicaid payments for all identified hospitals. Outpatient Medicaid payments are estimated by multiplying the "Total Medicaid Payments" (derived as explained above from Department of Health year end reports) by the percent of total Medicaid revenue that is outpatient.

### **Elimination of General Assistance-Unemployable (GA-U)**

The final budget assumes a loss in GAU of \$42.5 million. This is much improved over some of the earlier budgets. The Governor's budget assumed the elimination of medical care for the GA-U program for a total savings of \$291 million for all providers. The Senate budget maintained the program, but cut \$68 million. The House budget maintained the program, but cut \$32 million.

Hospital payments account for about a third of GA-U payments, so in our modeling we used about a third of the total cut.

To model the impact on hospitals, we used information from a HRSA data set on inpatient and outpatient payments made for state fiscal year 2007 on claims for *all* state-only medical assistance programs (including GA-U, Alcoholism and Drug Addiction Treatment and Support Act, Children's Program, and Psychiatric Indigent Inpatient).

While WSHA estimates are based on data for all these programs (some of which will continue), we believe the vast majority of payments were for GA-U. WSHA does not have access to data for every hospital with GA-U claims, since hospitals which do not provide obstetric care are not included in this data set.

For the final budget, we assumed there would be a loss of 18 percent in GAU payments. This compares to a 100 percent loss in the Governor's budget, a 24 percent loss in the Senate budget, and a 12 percent loss in the House budget.

### **Reductions in Disproportionate Share Hospital (DSH) Payments**

The final state budget implements many changes in DSH. It:

- Eliminates rural and non-rural adult indigent assistance DSH for 2010, but restores the payments in 2011
- Eliminates state grants for indigent assistance DSH.
- Eliminates the small rural DSH program.
- Eliminates the IGT DSH, which we assume only affects University and Harborview.
- Increases low income DSH payments in 2010 by \$5 million.

*Governor's Budget.* The Governor's budget assumed no reductions in DSH payments.

*Senate Budget.* The Senate budget assumed the following changes:

- An increase in low income DSH (\$5 million)
- Elimination of small rural DSH (\$6 million)
- Elimination of Inter Governmental Transfer (IGT) DSH for hospitals paid under the certified public expenditure program, and
- Elimination of DSH programs for Certified Public Expenditure hospitals if these programs are no longer in effect for other hospitals.

*House Budget.* In addition to the DSH cuts in the Senate budget, the House budget assumed the elimination of the non-rural and rural indigent assistance DSH program as well as the non-rural state grant DSH program.

To model the impact of these reductions, we used 2009 data on current DSH payments. For low income DSH, we assumed each of the hospitals currently receiving these payments would receive a proportional increase in payments to spread the additional \$5 million. For small rural DSH, we assumed a loss based on current payments. For IGT DSH and other DSH for public hospitals, we assumed a loss in payments only at the certified public expenditure hospitals receiving state grant dollars, Harborview and University of Washington.

### **Graduate Medical Education Payments**

While the Governor's budget assumed no reductions, the final budget as well as the House and Senate all assumed a \$19.6 million reduction in payments made to the University of Washington Medical Center and Harborview. The payments were originally intended to compensate them for graduate medical education costs associated with Healthy Options clients.

### **Cesarean Sections**

All the budgets assume savings from changes in the way Medicaid pays for C-sections. All budgets assume the state will limit payment for uncomplicated C-sections to the rate paid for complicated vaginal deliveries. To model the impact of these changes, we used CHARS data for July 2007 through June 2008, our most recent data available, and reduced payments for uncomplicated C-sections.

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