EYMAN ASSOCIATES
Health Law & Policy

Funding and Financing of Essential Hospitals 101

Sarah Mutinsky
Eyman Associates

March 16, 2015

Overview

- Essential Hospitals and Medicaid
- Medicaid Funding Basics and the Challenge of Adequate Medicaid Payments
- Supplemental Payments to Support Essential Hospitals
  - Medicaid DSH
  - Medicare DSH
  - Non-DSH Supplemental Medicaid Payments
- Financing the Non-Federal Share of Medicaid Payments

Critical Roles of Essential Hospitals

CARING FOR THE MOST VULNERABLE

Members of America's Essential Hospitals serve a disproportionate share of low-income patients. Their patients are generally sicker and have more complex conditions than those served at other hospitals, and roughly half of patients discharged by members are racial or ethnic minorities.

TRAINING FUTURE HEALTH CARE LEADERS

On average, our members train almost four times the number of residents than other acute care hospitals.

PROVIDING COMPREHENSIVE, COORDINATED CARE

Our members average 359,519 outpatient visits per year.

PROVIDING SPECIALIZED, LIFESAVING SERVICES

Two-thirds of our members operate a level I or level II trauma center.

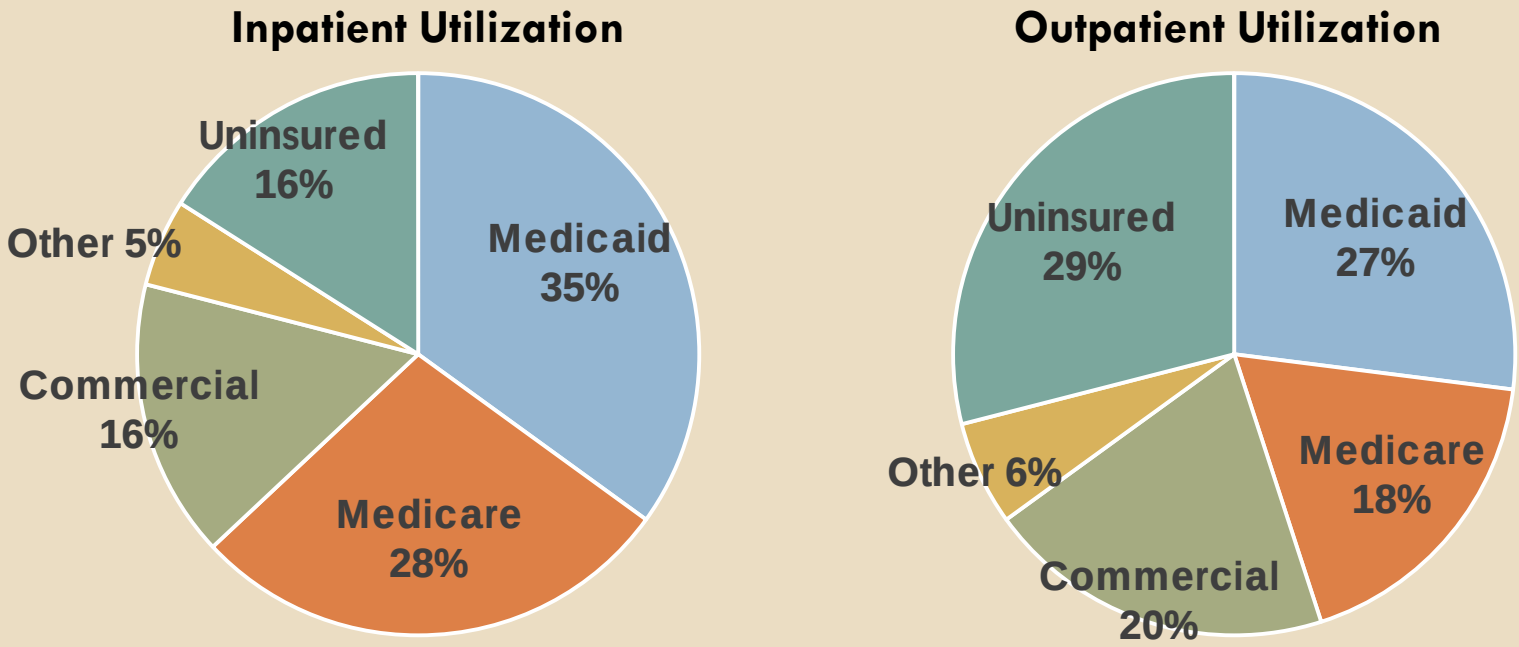
ADVANCING PUBLIC HEALTH

Nearly 70 percent of our members have a relationship with their local health department.

America's Essential Hospitals
Sources: AHA, Annual Survey of Hospitals, FY 2012; Essential HospitalsVital Data: Characteristics Survey, FY 2012

Commitment to Low Income and Uninsured Patients

Members of Essential Hospitals, FY 2012



Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012. America's Essential Hospitals. July 2014.

Rely on Patchwork of Medicaid and Other Federal and State Support

Medicaid

- Disproportionate Share Hospital (DSH) Payments
- Non-DSH Support Payments
  - Hospital, Physician, etc.
- Waiver-based payments

State/ Local Support

340B Drug Discount Program *(savings)*

Federally Qualified Health Centers

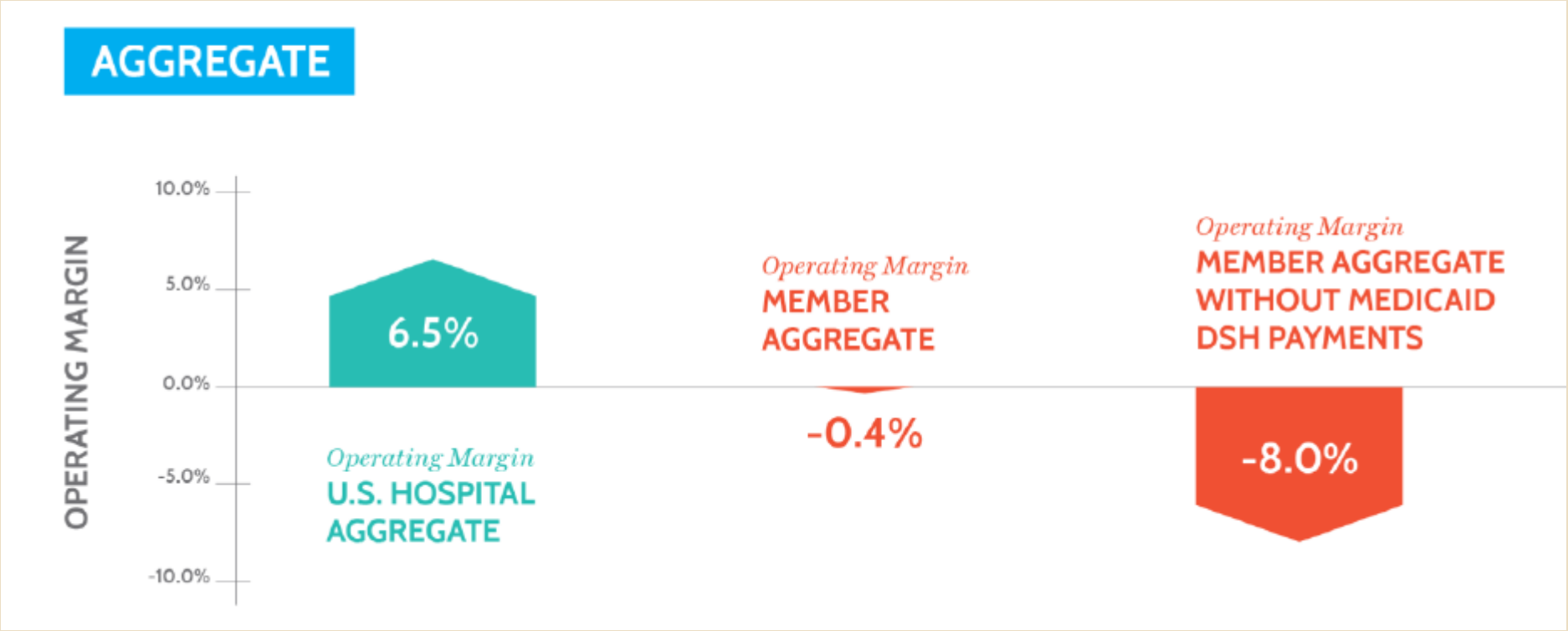
Medicare

- Disproportionate Share Hospital (DSH) Payments
- Direct and Indirect Medical Education

Financial Challenges of Serving These Essential Missions

National Operating Margins

Members of America's Essential Hospitals vs. All Hospitals Nationwide FY2012



Medicaid Funding Basics

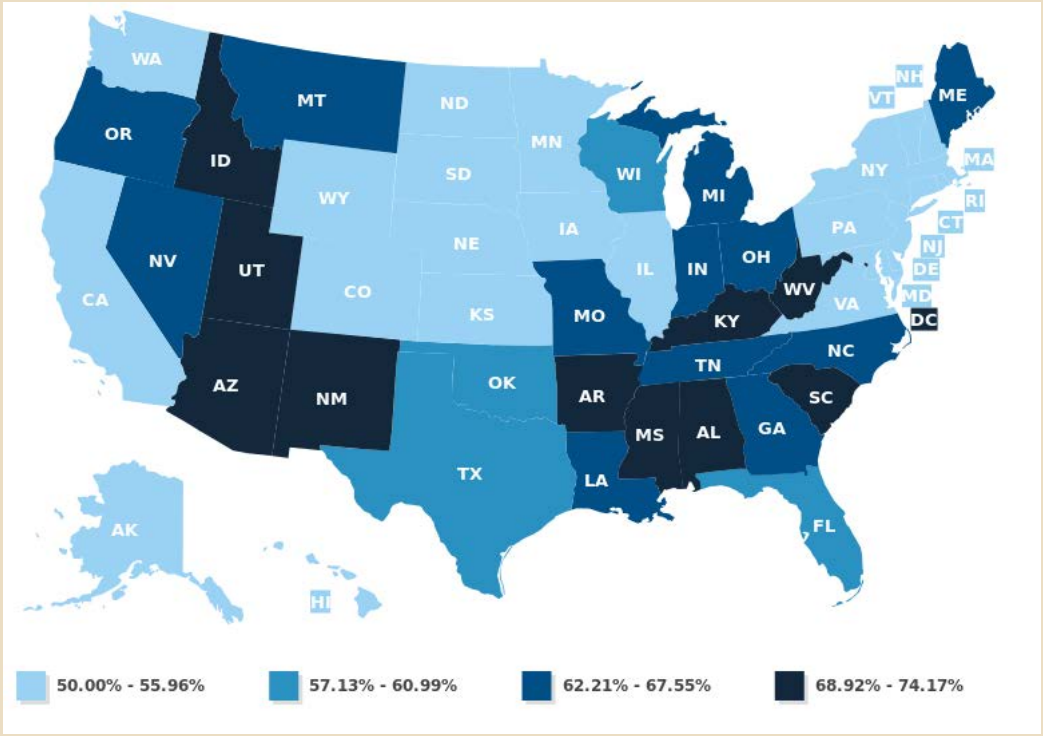
And the Challenge of Adequate Medicaid Payments

Medicaid is a Federal-State Partnership

- State **flexibility** within federal rules
- Shared financing
  - Federal share

generally 50% to 73%

Federal Medical Assistance Percentage



KFF; FY 2016: Federal Register, December 2, 2014 (Vol 79, No. 231).

Implications of Flexibility + Limited Federal Requirements for Rates

- States have **flexibility** in setting payment rates
- Federal requirement: "Equal Access" provision

State Medicaid plans must provide "methods and procedures" for payment to assure that "payments are *consistent with efficiency, economy, and quality of care* and are sufficient to enlist enough providers so that care and services are available under the plan *at least to the extent that such care and services are available to the general population* in the geographic area."

(42 USC § 1396a(**a**)(**30**)(**A**))

What Does it Mean and How to Enforce It?

- ~~Provider lawsuits challenging payment cuts~~
- CMS enforcement through regulations?

2011 Proposed Rule

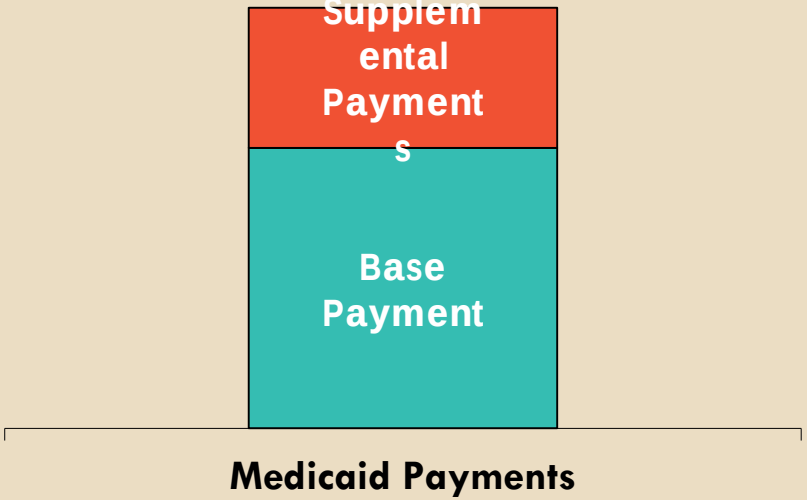
- Access review when states change FFS rates
  - Extent to which enrollee needs are met;
  - Availability of care and providers; and
  - Changes in beneficiary utilization of covered services

+Sufficiency provider payment rates (Medicare, commercial, cost)

- What about managed care? (rule expected 2015)

Reliance on Medicaid Supplemental Payments

- 3 of 4 states reviewed by MACPAC, Medicaid payments to hospitals did not cover cost (Mar. 2014)
- In 2012, 68% of hospitals were underpaid by Medicaid (AHA)
- In 2012, physicians paid average 66% of Medicare, as low as 37%



Medicaid DSH

Overview Medicaid DSH

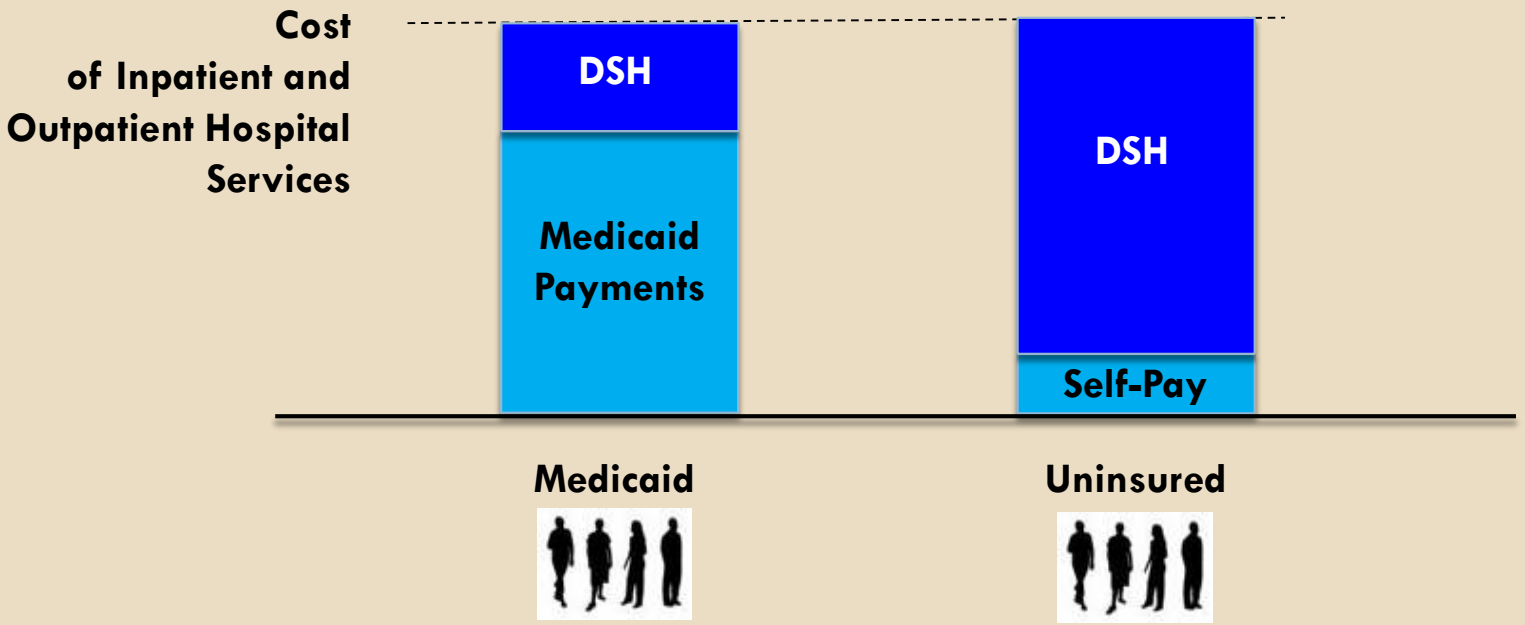
States must "**take into account the situation of hospitals which serve a disproportionate number of low income patients**"

(OBRA) of 1981

- Only Medicaid payment in statute that explicitly pays for uninsured
- Two federal limits on DSH payments to eligible hospitals
  - **Hospital-specific** limit
  - **State allotments** of federal DSH funding
- *State flexibility in how choose to spend DSH funds within limits*

Medicaid DSH Hospital-Specific Limit

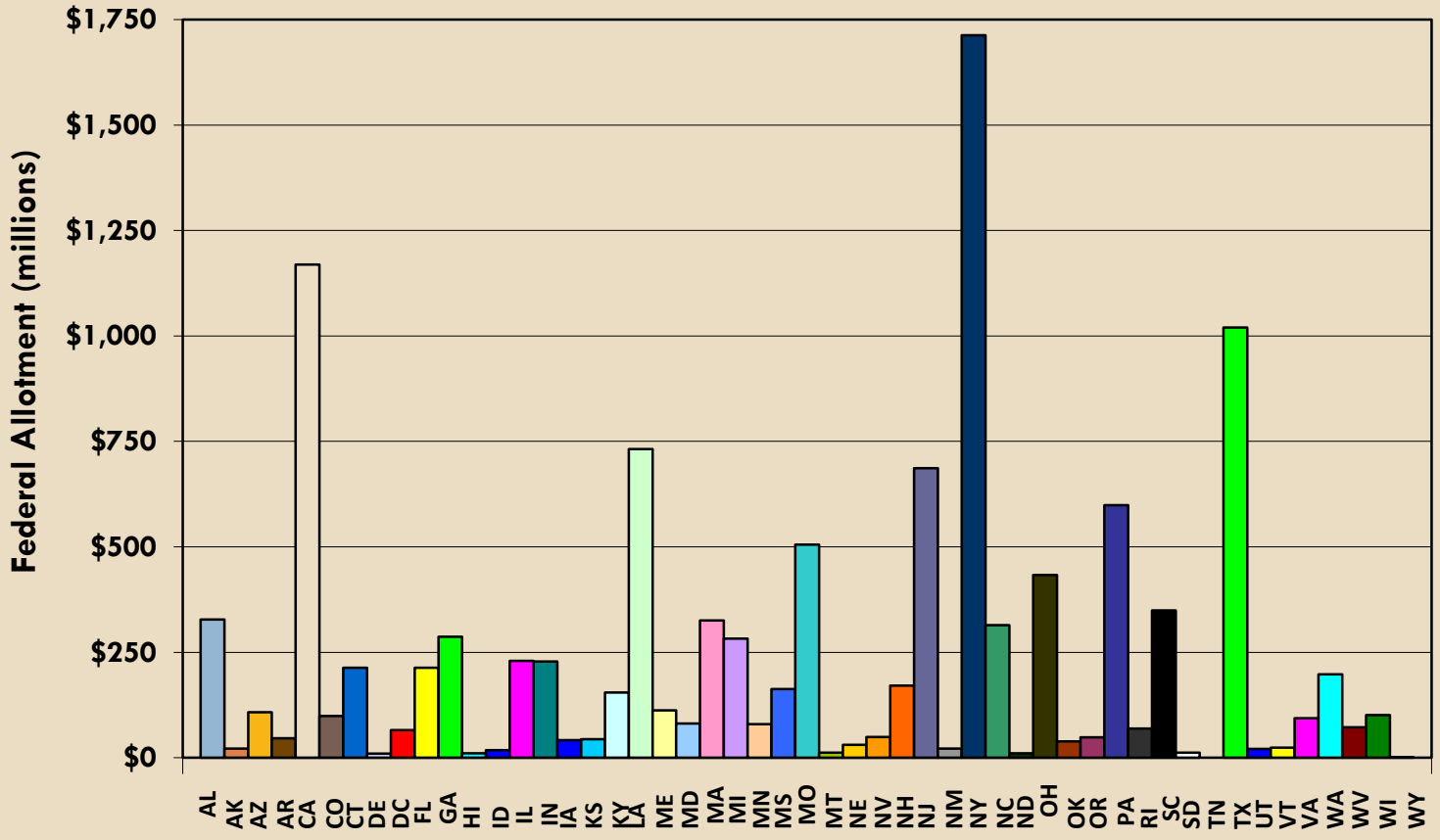
- No more than unreimbursed costs of <u>hospital</u> services to <u>Medicaid</u> and <u>uninsured</u> patients



Audits: Your Hospital Could be Facing Recoupments this Year

- DSH Audit Rule 2009
  - New prescriptive definitions of DSH-eligible costs
  - Not recoup until 2011 payments based on audit report due to CMS Dec. 2014
  - States have 1 year to return federal share of overpayments *unless* got approval to redistribute
- Questions for you:
  - Have you seen independent auditor results?
  - Did your state submit report to CMS?
  - Did your state change state plan so that any "overpayments" redistributed?

State Allotments of Federal DSH Funds



Source: Federal Register , Feb. 28, 2014.

Low DSH States

- Alaska
- Arkansas
- Delaware
- Hawaii
- Idaho
- Iowa
- Minnesota
- Montana
- Nebraska
- New Mexico
- North Dakota
- Oklahoma
- Oregon
- South Dakota
- Utah
- Wisconsin

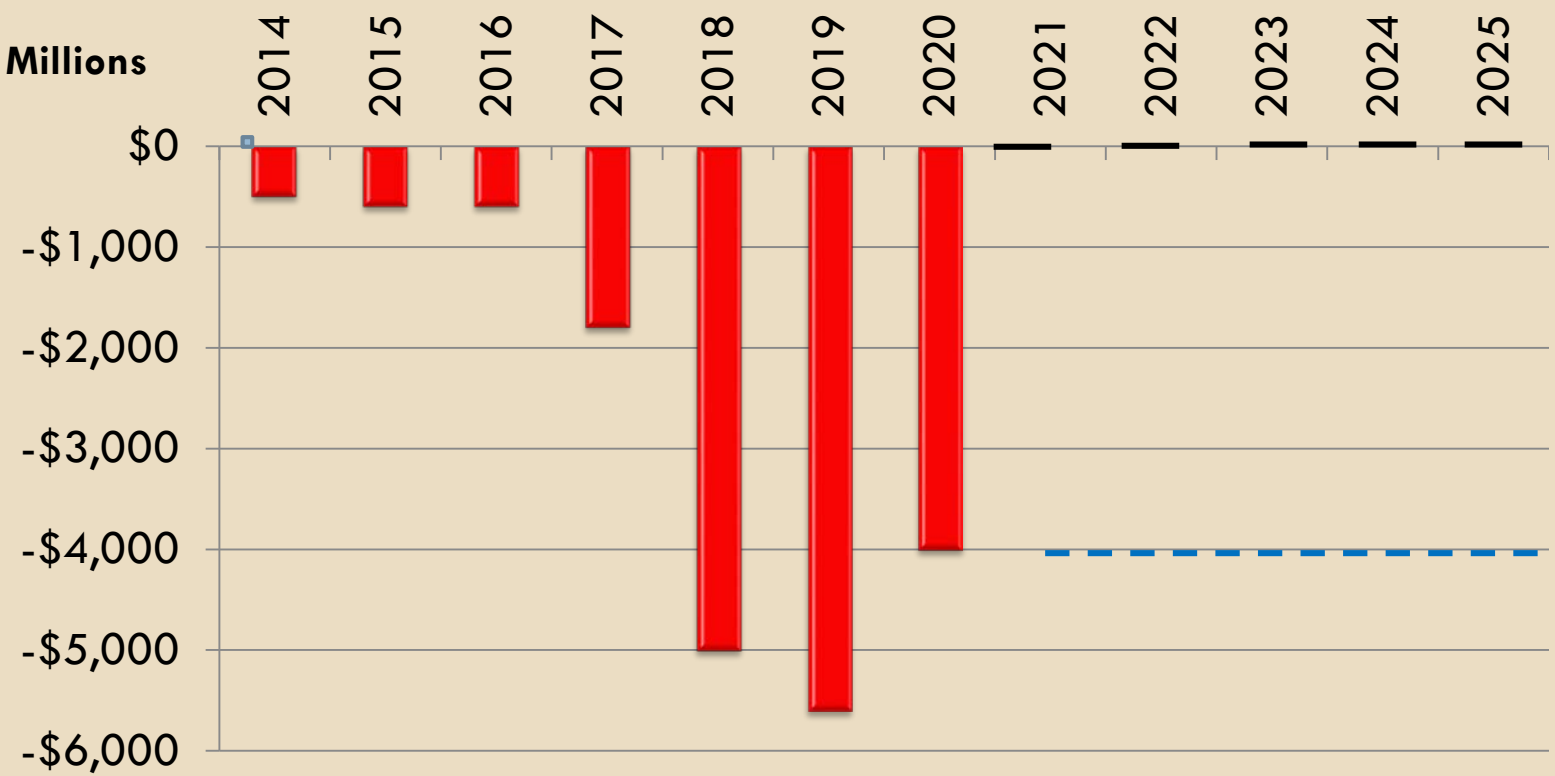
Overview of Successful DSH Delays

ACA DSH Allotment Cuts: $ specified in statute	
Year	Reduction
2014	$500 million
2015	$600 million
2016	$600 million
2017	$1.8 billion
2018	$5 billion
2019	$5.6 billion
2020	$4 billion

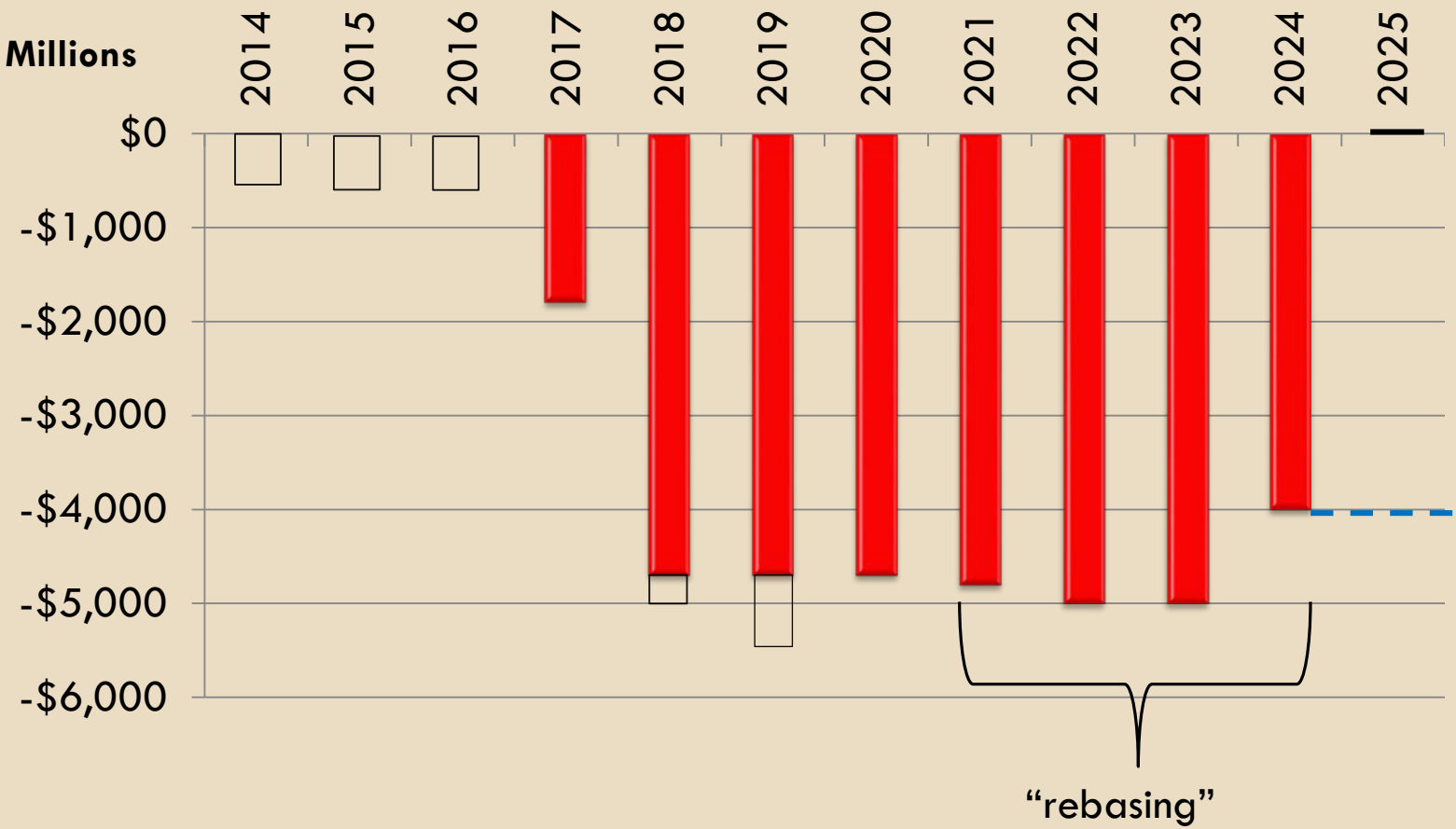
DSH Allotment Cuts After Delays (+rebasing)	
Year	Reduction
2014	**$0**
2015	**$0**
2016	**$0**
2017	$1.8 billion
2018	$4.7 billion
2019	$4.7 billion
2020	$4.7 billion
2021	$4.8 billion
2022	$5 billion
2023	$5 billion
2024	$4.4 billion

"DSH rebasing" Congress use savings from maintained reduced allotments

Medicaid DSH Reductions Under ACA



Successful Delay in Medicaid DSH, But Significant Cuts Still Loom



Implementing the ACA Medicaid DSH Cuts

- ACA cuts are aggregate nationwide
- Statutory methodology for allocating cuts among states
  - how much state's uninsured rate has fallen
  - whether state is targeting DSH payments to high Medicaid volume hospitals, and
  - whether state is targeting DSH payments to high UC hospitals
- CMS must issue new rule for FFY2017 (Oct. 2016)

Successfully Pushed for MACPAC Report on Actual Impact

- First report due 2/1/2016
- Elements of report:
  - Changes in the number of uninsured individuals
  - Amount and sources of UC costs, including costs of unreimbursed or under-reimbursed services, charity care, or bad debt
  - "Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services"
  - State-specific analysis of relationship between most recent allotment, projected allotment for the next year and the data above

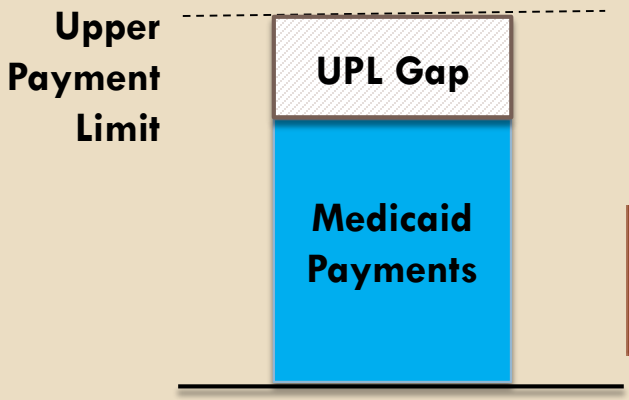
Today's Challenges/Yesterday's Battles

- Defending the ongoing need for DSH as coverage expands
- Embracing accountability
  - State-level work to ensure accurate audits and what happens to DSH "overpayments"
- Avoiding DSH as a tempting "pay-for" target
- Revisiting overzealous DSH reductions
- Humanizing DSH – shining light on the black box
- Focusing on access and quality
- Remaining united/avoiding state vs. state battles

Medicaid Non-DSH Supplemental Payments

FFS "Non-DSH" Medicaid supplemental payments (aka "UPL")

- Statute: Rates paid by state must be consistent with economy, efficiency, quality and access
- Low FFS payment rates often supplemented by additional targeted payments
  - Many forms, defined under state plan (E.g., GME; Trauma support; children's hospital support)
- Federal matching payments if Medicaid payments (except DSH) do not exceed a calculated Upper Payment Limit (UPL)
- States can make supplemental payments up to difference between base rates and upper limit (UPL gap)



"Non-DSH" Medicaid supplemental payments under state plan (aka "UPL")

- Regulations:
  - Hospital/NF/Clinic UPLs: Aggregate rates must be no greater than **Medicare**
    - 1. State-owned and operated providers
    - 2. Non-state government providers
    - 3. Private providers
  - Professional services: No regulatory UPL
    - CMS policy limits payments to **Average Commercial Rate (ACR) or Medicare**
- 2013 CMS accountability guidance
  - States now annual UPL submissions– *CMS scrutiny?*

“Cheat Sheet” DSH vs. UPL

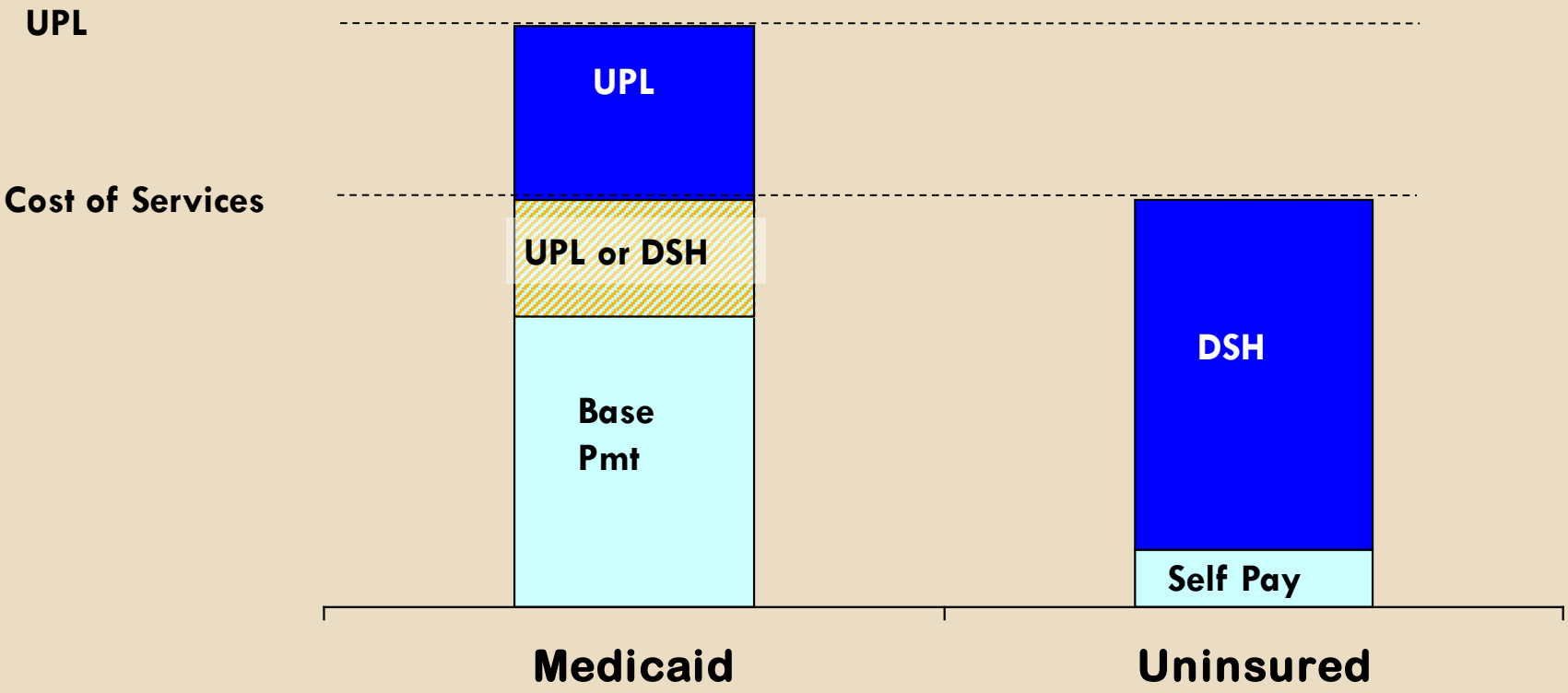
Medicaid DSH

- Includes services to Medicaid and uninsured
- Only for hospital services
- Limit CMS prescriptive definition of costs
- FFS and MC beneficiaries

Non-DSH “UPL” Payments

- For Medicaid services only
- Can create programs for hospital services as well as professionals, etc.
- Limit what Medicare and/or average commercial payer would have paid
- FFS beneficiaries

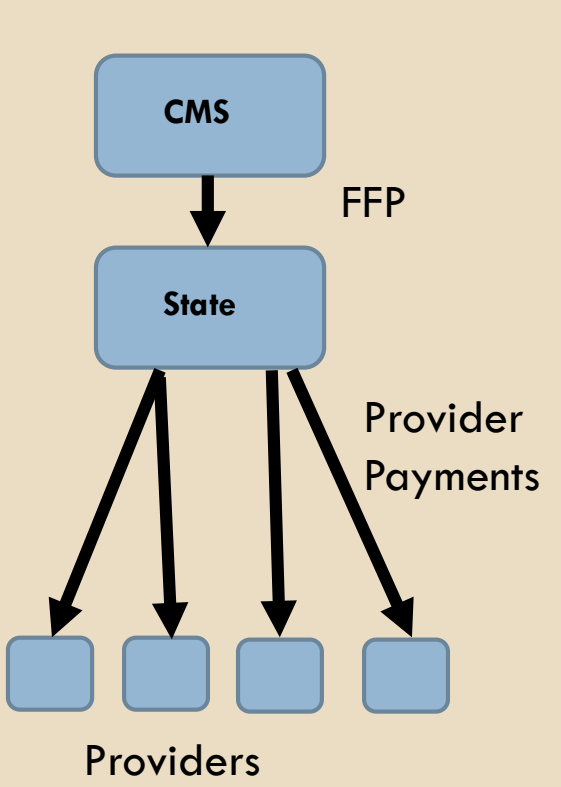
Medicaid Payments for Low Income and Uninsured Patients: UPL & DSH

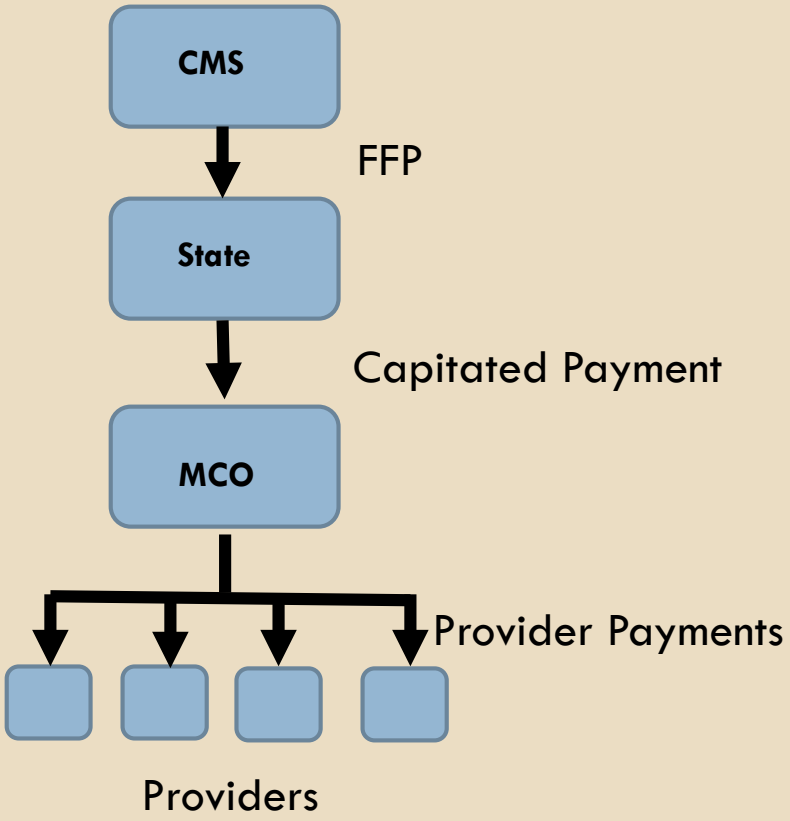


Medicaid Non-DSH Supplemental Payments (continued)

Challenges in Managed Care

Simplified Model FFS vs. Managed Care

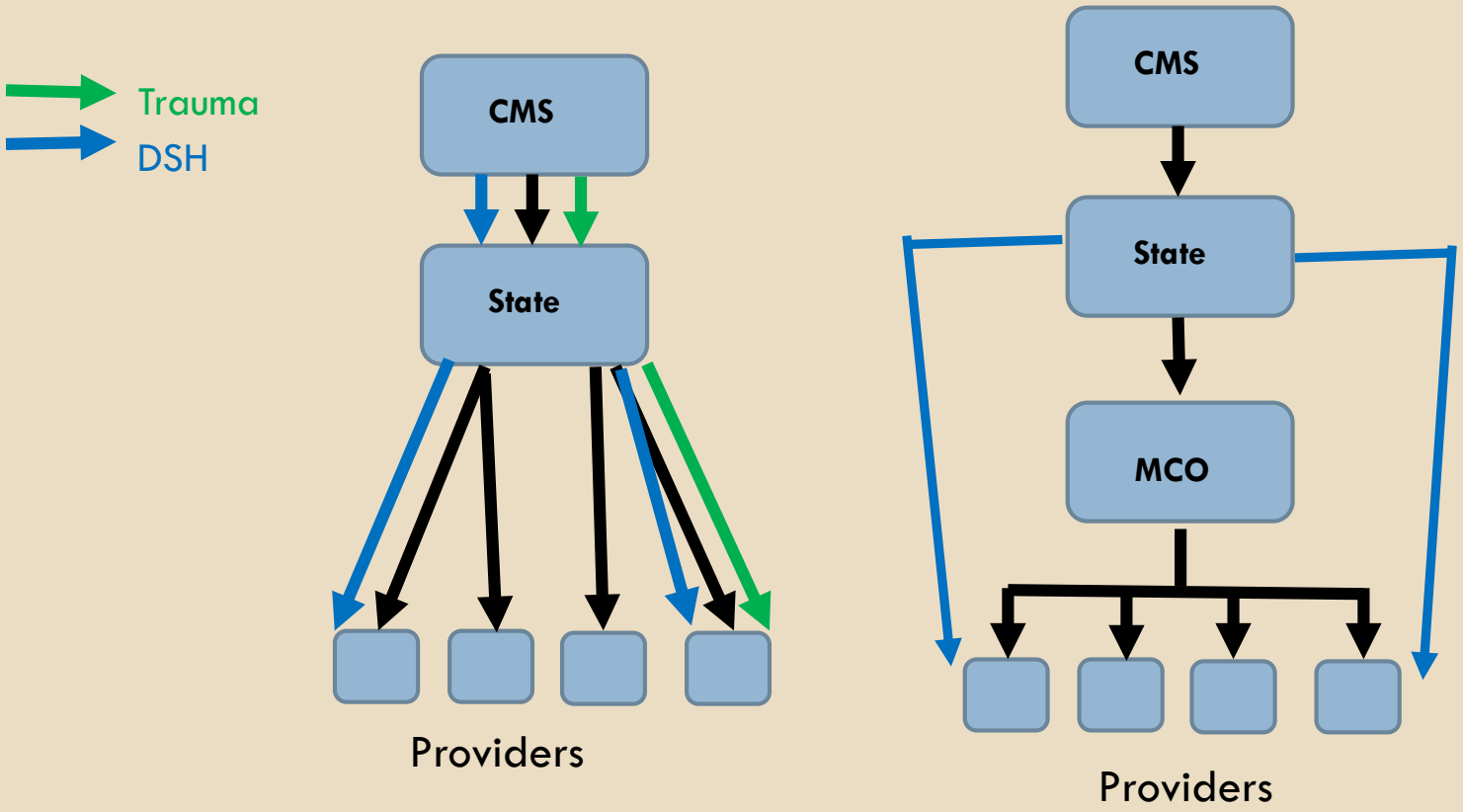




Challenge of Adequate Support Under Managed Care

- CMS regulatory limit on state's payments to plans (actuarial soundness)
  - *But* no limits (or floor) on plan payments to providers
  - Governed by contract
- CMS regulations say states cannot make supplemental payments directly to providers for services under MCO contract
  - Statute requires to pay DSH directly to providers
  - CMS policy allows states to pay graduate medical education directly to providers

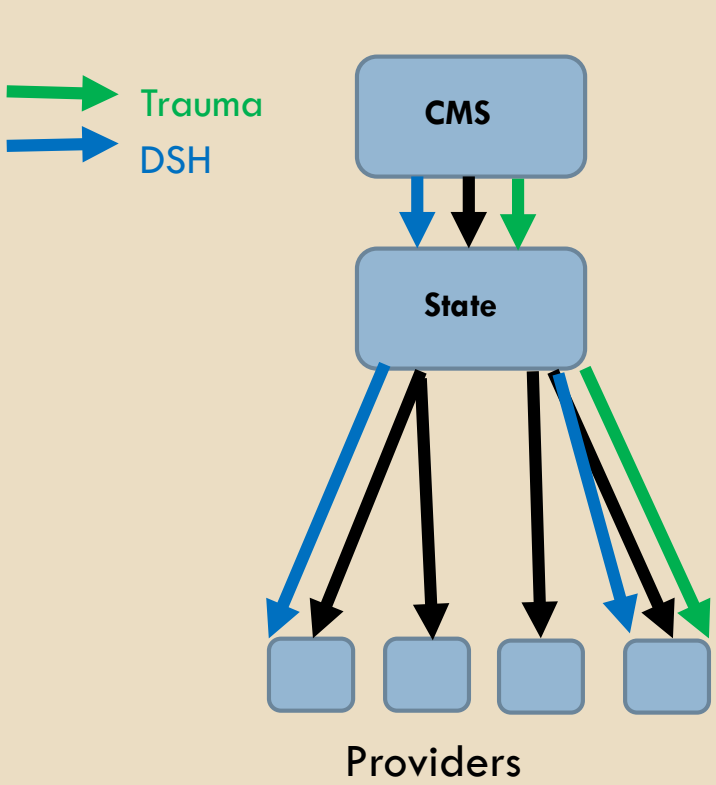
State Generally Cannot Make UPL Payments to Providers for MC Services

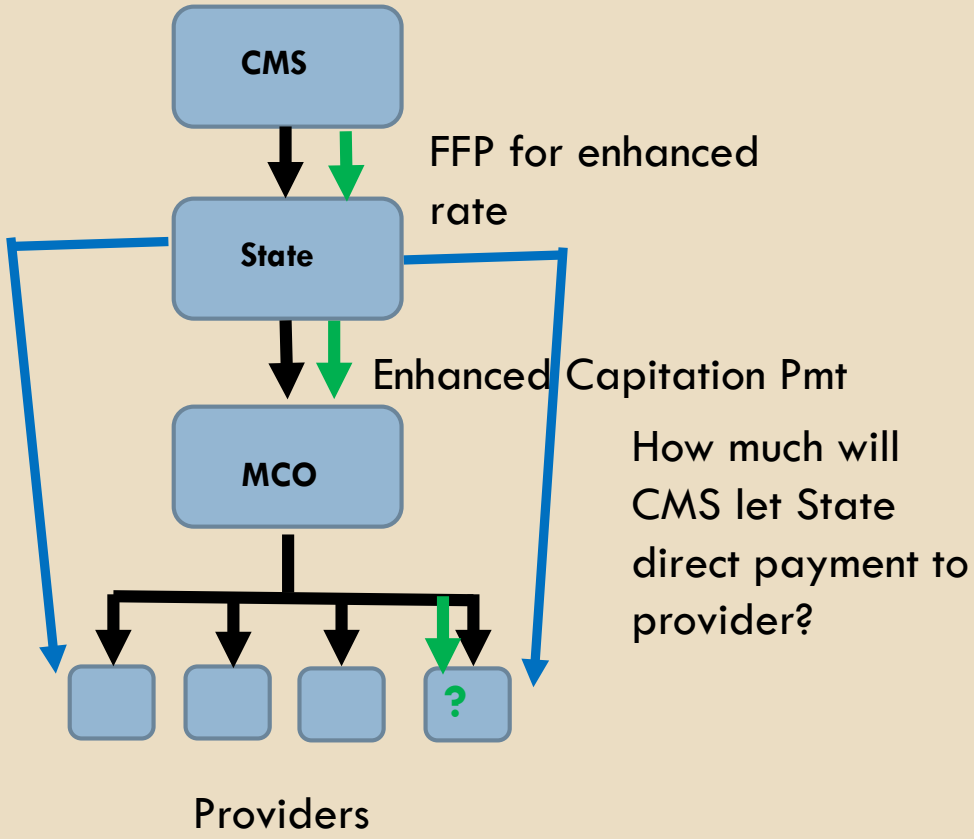


What Can You Do in Managed Care?

- Enhanced payments through the managed care plans
  - Increase capitation payments to plans to enable to fund additional support
  - Limits on ability to direct specific amount of support to specific providers
  - Incentive to steer patients away?

Example of Enhanced Payment Through Plans





What Can You Do in Managed Care?

- Payment pools under a Medicaid waiver demonstration
  - Uncompensated care pool
    - Service-based payments typically limited to cost (defined by CMS and State in Special Terms and Conditions)
    - Can include costs for Medicaid and uninsured
    - Can include costs for range of services, e.g., hospital, physician, FQHC, etc. (depends on state's Special Terms and Conditions)
    - CMS increasingly wants more accountability or transitioning into at-risk payments
  - Delivery System Reform Incentive Pools
    - Different because NOT payment for services
    - Payments for achieving milestones and metrics
    - But can be done in managed care and FFS programs

Medicare DSH

Medicare DSH Pre-ACA

- Medicare add-on payment for hospitals serving a disproportionate share of low-income patients
  - >$12 billion in FY2014
  - Pre-ACA, entire payment adjustment rooted in formula based on hospital's **low income Medicare & Medicaid days**

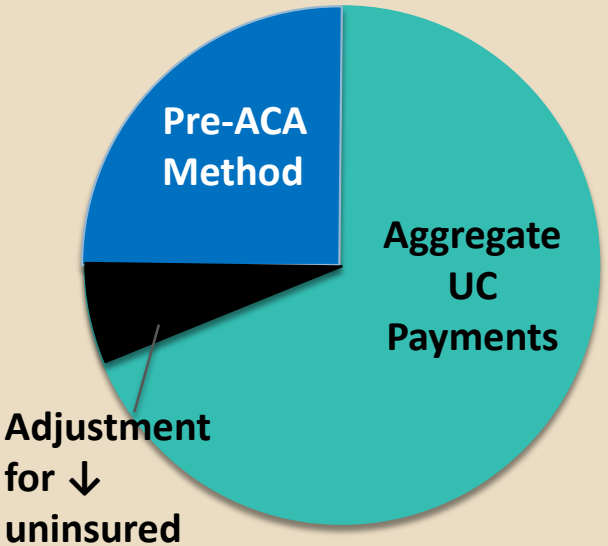
$$\left(\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}}\right) + \left(\frac{\text{Medicaid, non-Medicare Days}}{\text{Total Patient Days}}\right)$$

  - Amount of benefit dependent on Medicare volume b/c adjustment to Medicare claims

Medicare DSH in the ACA

- Reduces Medicare DSH payments by an estimated **$22 billion** over ten years (beginning FY2014)
  - Methodology for implementing reductions:
    - » Current DSH payments reduced to 25%
    - » Reduce total 75% pool by change in uninsurance rate
    - » Portion of 75% cut funds are restored through a new payment
    - » New Payment based on each hospital's uncompensated care costs relative to all DSH hospitals
  - ***Redistribution of DSH funds among hospitals***

Important differences from Medicaid DSH for advocacy

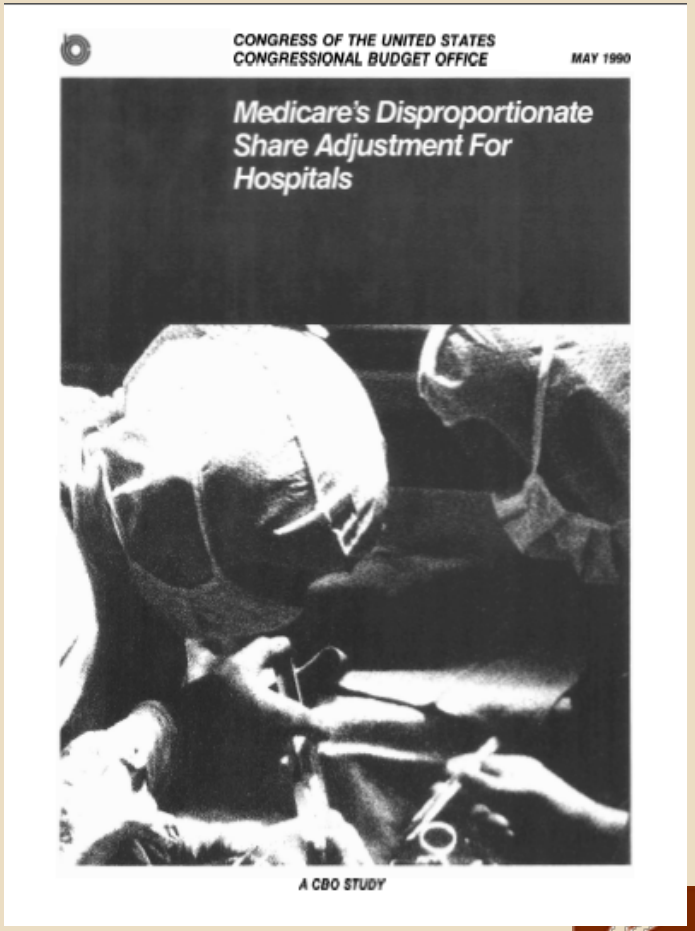


Challenges in Medicare DSH Impact Members

- CMS challenges with determining "uncompensated care"
  - Current proxy (Medicaid and low income Medicare days)vs. S10 data
  - How does your hospital fare under each?
- Expansion vs. non-expansion states
- When is the point that cuts so steep that lose no matter distribution methodology?

Medicare DSH's Evolving Purpose Leads to Challenges

- 1990 CBO report:
  - cost differences had generally "disappeared"
  - second justification for DSH: preserving access to care for low-income patients
- The more expansive mission has gained widespread acceptance over time



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  - As coverage expands
  - As continue support through other payments, e.g., IME
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- Revisiting overzealous DSH reductions
- Humanizing DSH – shining light on the black box
- Remaining united as set "pool" redistributed

Questions?

Sarah Mutinsky
smutinsky@eymanlaw.com
(202) 567-6202

Eyman Associates
810 First Street NE
Suite 201
Washington, DC 20002