



VITAL2015

Connect. Inspire. Lead.

Medicaid and Medicare DSH: Current Rules & Future Challenges

Sarah Mutinsky
Eyman Associates
Washington Counsel, America's Essential Hospitals
June 26, 2015



AMERICA'S
ESSENTIAL
HOSPITALS



YOU'RE ALMOST THERE



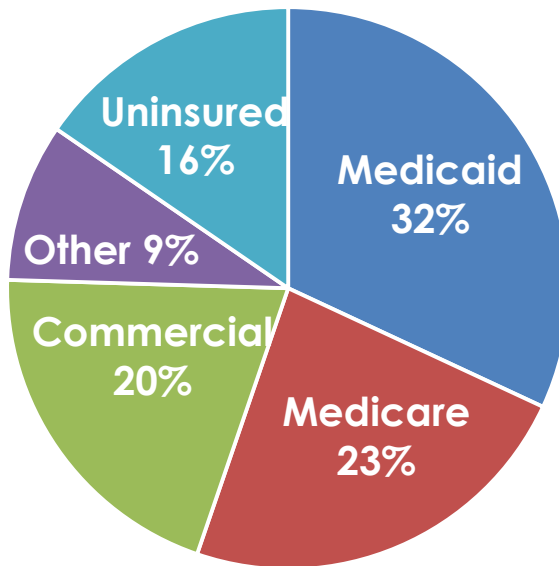
OVERVIEW

- Introduction
- Medicaid DSH
 - » Origins and Overview
 - » Reductions under the ACA
 - » Accountability in Medicaid DSH
 - » Other Issues Affecting Benefit of DSH Payments
- Medicare DSH
 - » Origins and Overview
 - » Evolving Policy Purpose and Impact on Program
 - » ACA Redistribution and Data Issues
 - » Steeply Rising ACA Reductions
- Questions

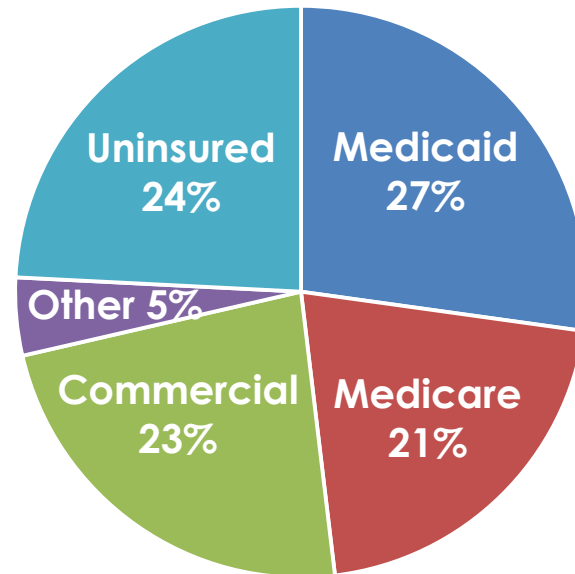
COMMITMENT TO LOW INCOME AND UNINSURED PATIENTS

Members of America's Essential Hospitals, FY 2013

Inpatient Utilization



Outpatient Utilization



Results of America's Essential Hospitals Annual Characteristics Report, FY 2013. America's Essential Hospitals. March 2015

DSH PAYMENTS CRITICAL PART OF THE PATCHWORK OF 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

Medicaid DSH

OVERVIEW MEDICAID DSH

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

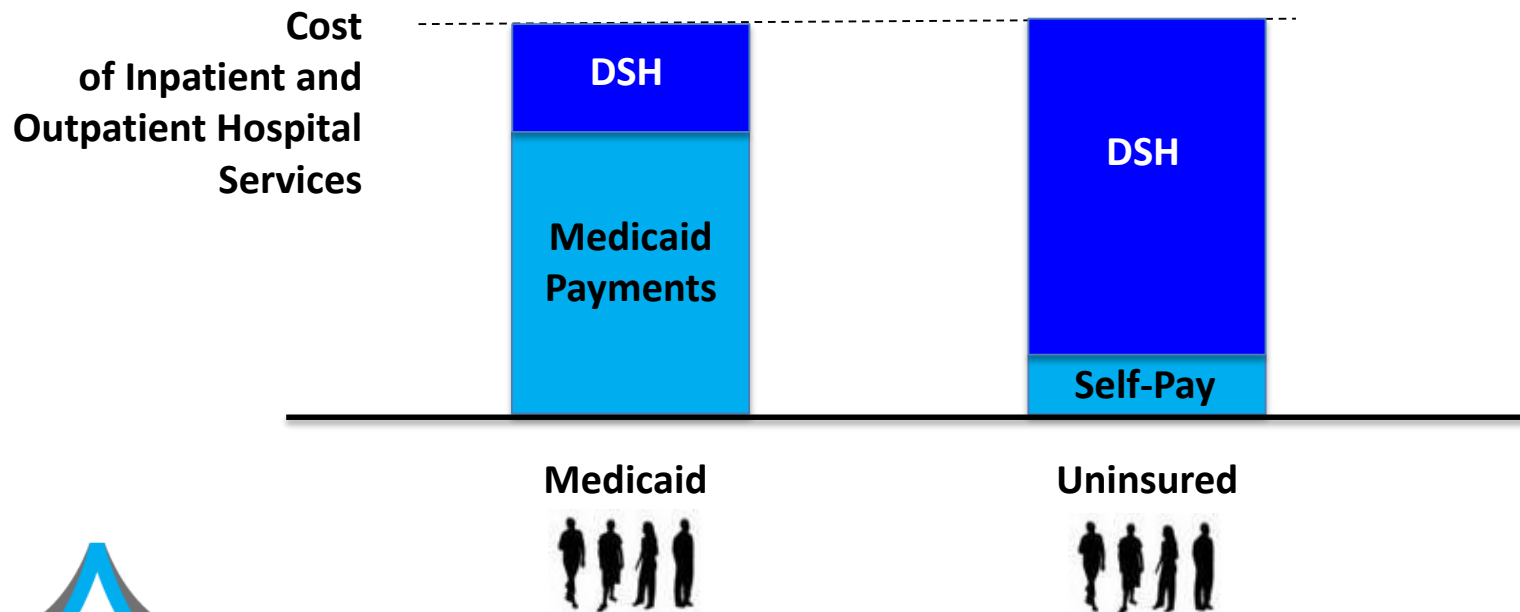
(OBRA) of 1981

- Only explicit Medicaid payment for the uninsured
- **Two federal limits on DSH payments to eligible hospitals**
 - » Hospital-specific limit
 - » State allotments of federal DSH funding

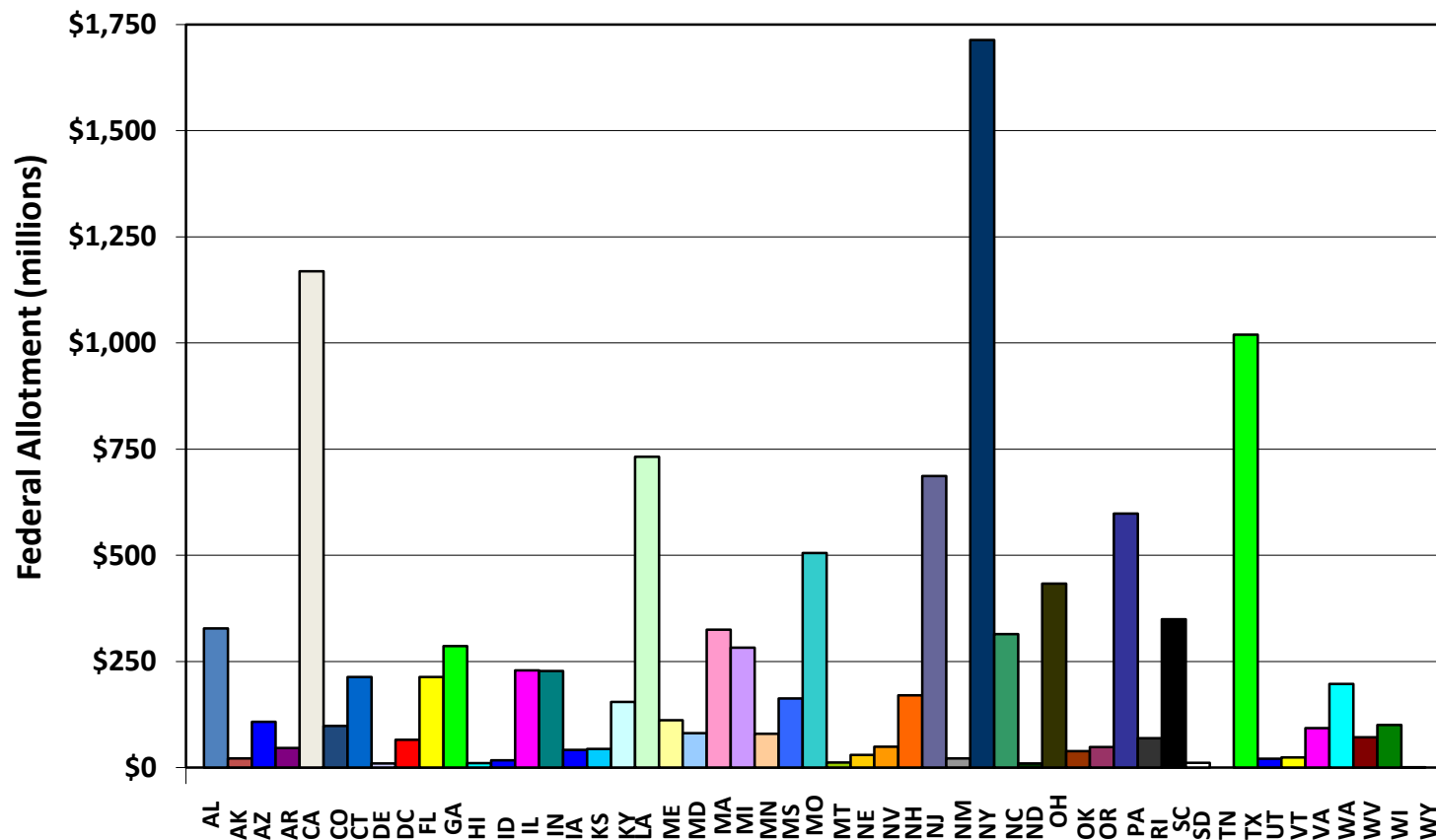


HOSPITAL-SPECIFIC LIMIT

- No more than unreimbursed costs of hospital services to Medicaid and uninsured patients



STATE ALLOTMENTS OF FEDERAL DSH FUNDS



Low DSH States

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

Source: Federal Register , Feb. 28, 2014.

STATE FLEXIBILITY IN STRUCTURING DSH PAYMENTS WITHIN FEDERAL LIMITS

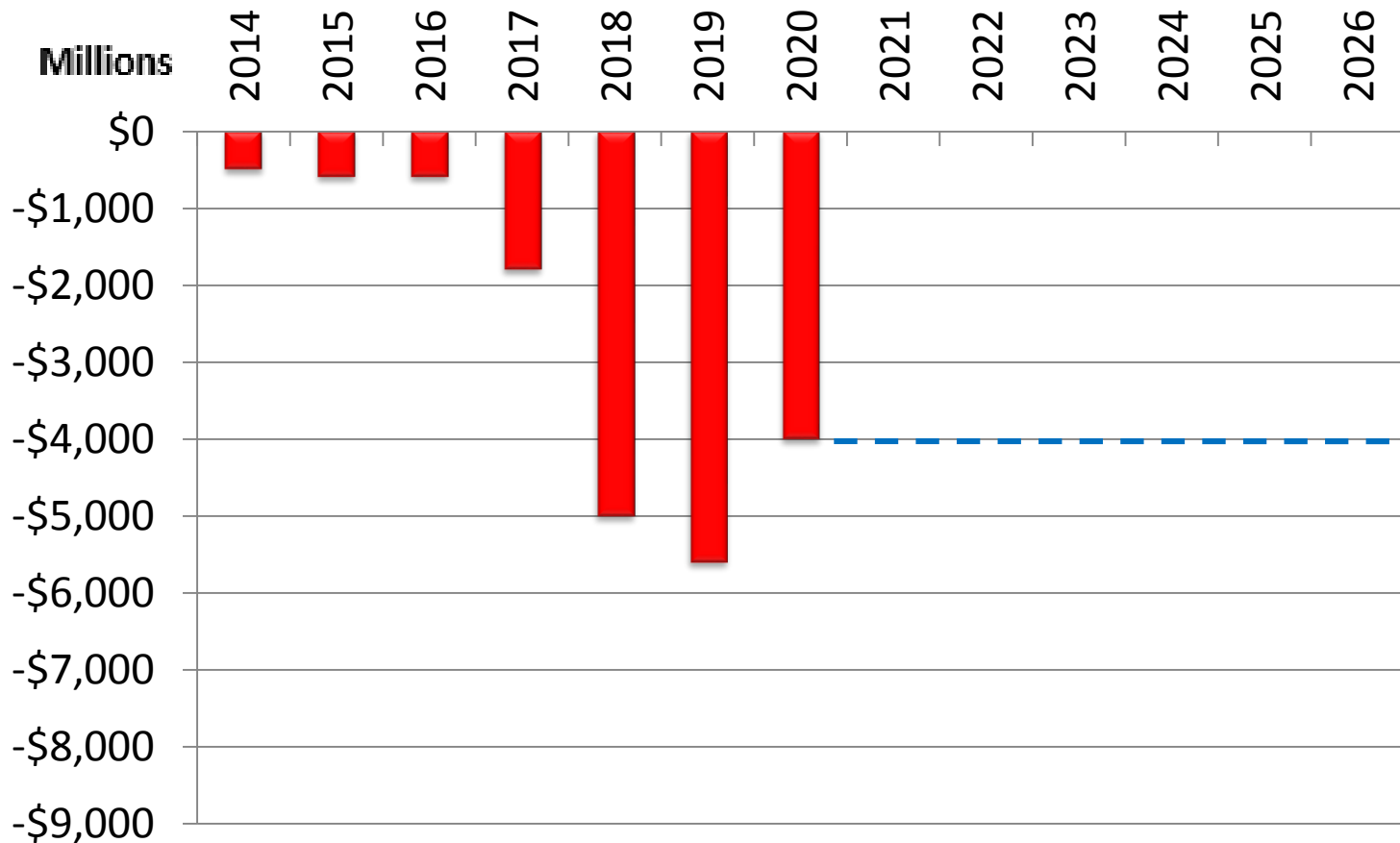


- Targeting **eligibility** for payments
 - » Must include deemed DSH
 - Medicaid inpatient utilization \geq one std deviation above the mean, or
 - Low-income inpatient utilization $> 25\%$
 - » Can designate other hospitals in state plan
 - Low bar—MIUR $\geq 1\%$
- Targeting **distribution** of payments
 - » Can develop state-specific methodology as long as do not pay hospital more than hospital-specific DSH limit
 - » E.g.,
 - Prioritizing DSH funds to certain types of hospitals (teaching, childrens, etc.)
 - Prioritizing funds based on priority metric, e.g., Medicaid utilization or charity care
 - Tiering payments through subpools
- Wide variation among states

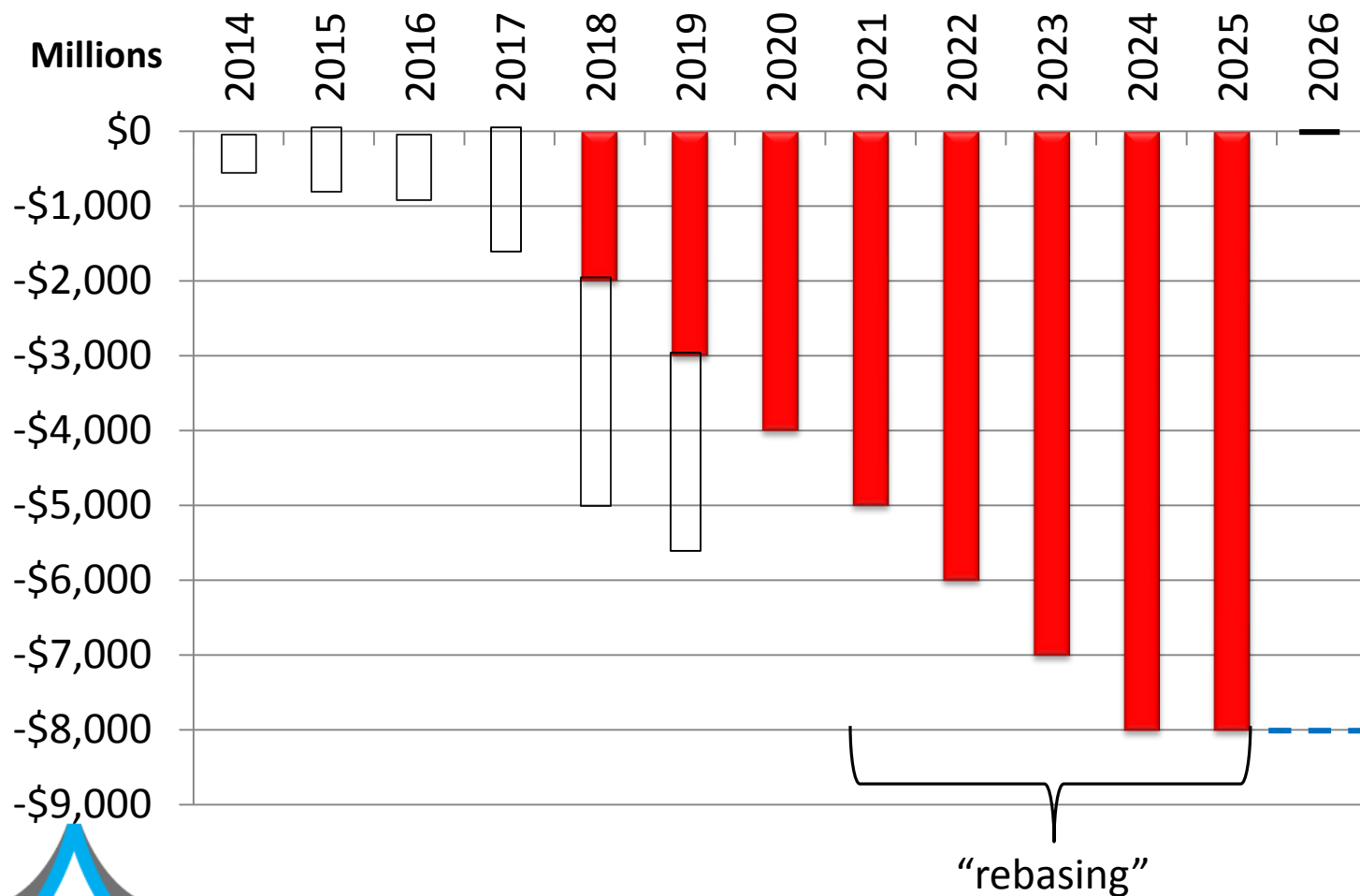
ACA DSH Cuts



ACA MEDICAID DSH REDUCTIONS



ACA MEDICAID DSH REDUCTIONS



IMPLEMENTING THE DSH CUTS

- ACA cuts are aggregate nationwide
- ACA requires HHS to impose the largest reductions on states:
 - » with the lowest percentage of **uninsured individuals**
 - » that do not target their payments on hospitals with
 - **high volumes of Medicaid inpatients** *and*
 - hospitals that have **high levels of uncompensated care** (excluding bad debt)
- Additional factors
 - » Smaller percentage reductions for **low DSH states**
 - » “Take into account” DSH funds folded into **coverage expansion waivers**

REMINDER OF INITIAL CMS METHODOLOGY

- Aggregated annual reduction divided between low and regular DSH states and then into thirds based on factors below
- Each state's share equals the sum of three factor-based amounts

Uninsured Percentage
Factor-Based Reduction
Amount

Relative level of uninsurance in state compared to all states
(ACS census data)

+

High Medicaid Factor-Based
Reduction Amount

Extent to which targets DSH payments to hospitals with relatively high Medicaid utilization within state
(MIUR \geq one std dev above the mean)

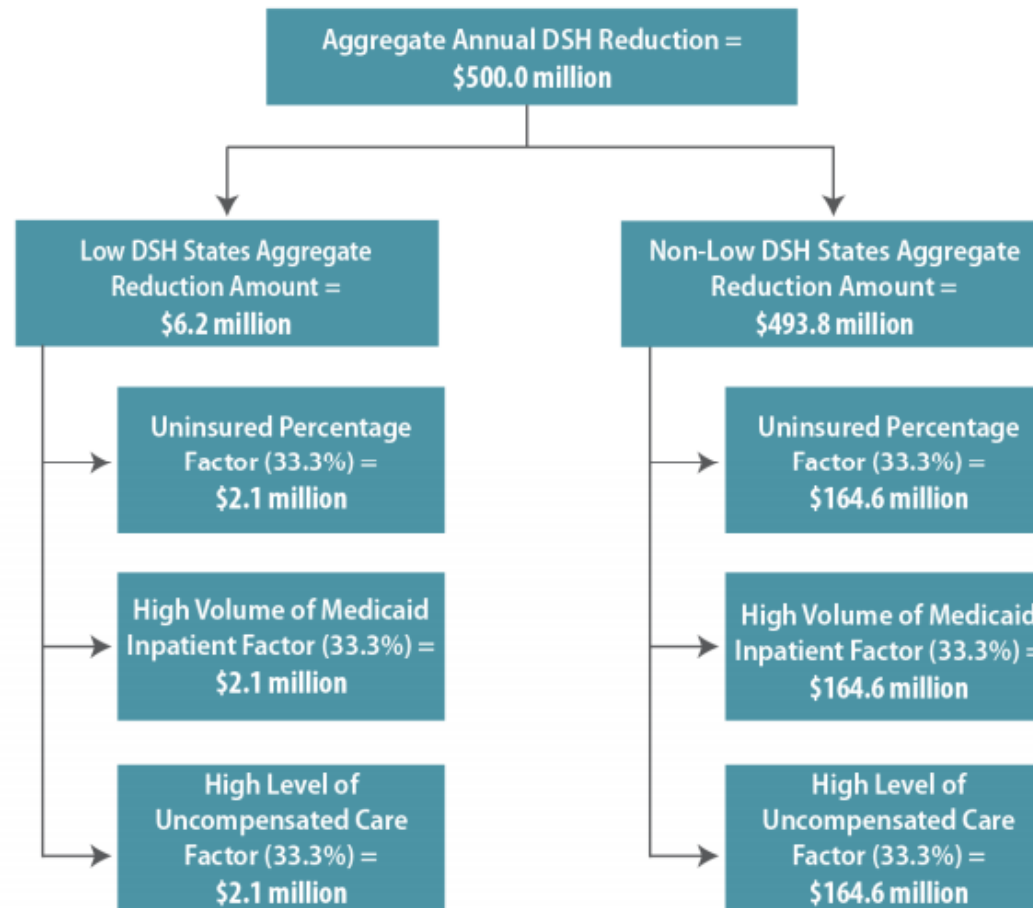
+

High Uninsured Factor-
Based Reduction Amount

Extent to which targets DSH payments to hospitals with relatively high levels of uncompensated care within state
(DSH definition of uncompensated costs uninsured and Medicaid shortfall)

HOW 2014 REDUCTIONS WOULD HAVE BEEN ALLOCATED

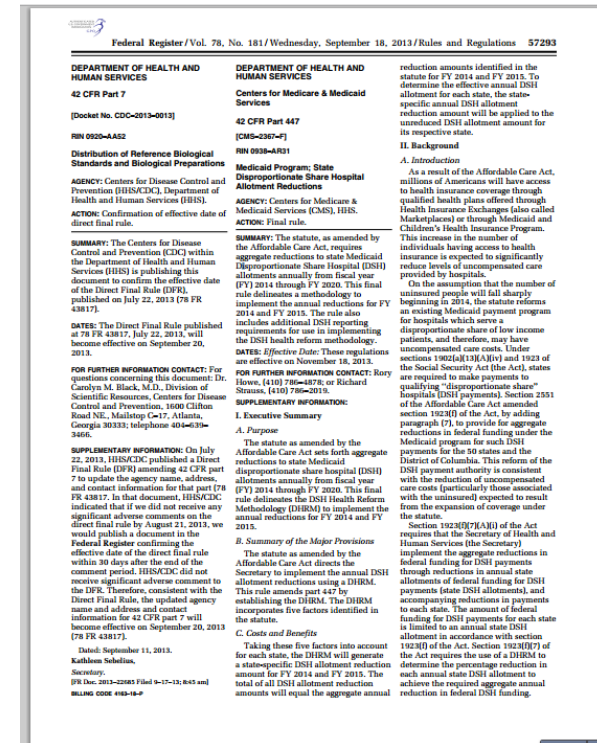
Figure 2. Methodology for Dividing the FY2014 Annual Aggregate DSH Reduction Amount Among the Reduction Factors



Source: CRS using the illustrative DSH reduction factor weighting allocation from the proposed rule, and the changes in the final rule do not impact the distribution of the DSH reduction as shown in this figure. (Centers for Medicare & Medicaid Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions," 78 *Federal Register* 28551, May 15, 2013.)

CMS MUST ISSUE NEW REGULATIONS BEFORE IMPLEMENTING DELAYED DSH CUTS

- Initial rule applied only to 2014 and 2015 cuts—now eliminated
- CMS must issue new rule for FFY2018 (Oct. 2017)
 - » Another notice & comment period
 - » 2013 DSH Audits and reports complete
 - » 2014 DSH Audits due by Dec. 31, 2017



CONGRESSIONALLY MANDATED MACPAC REPORT

By February 1, 2016, MACPAC must report on:

- 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
- **State-specific analysis** of relationship between most recent allotment, projected allotment for the next year and the data above

“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 quaternary care, including the provision of trauma care and public health services”

CRITICAL ROLES OF ESSENTIAL HOSPITALS

1



+

CARING FOR THE MOST VULNERABLE

+4



TRAINING
FUTURE HEALTH
CARE LEADERS

+



PROVIDING
COMPREHENSIVE,
COORDINATED CARE

+



PROVIDING
SPECIALIZED,
LIFESAVING SERVICES

+



ADVANCING
PUBLIC HEALTH

ADDITIONAL CONSIDERATIONS FOR FUTURE DSH REDUCTION IMPLEMENTATION

- Impact of expansion versus non-expansion states
 - » Uninsured percentage factor
- Have states changed targeting to minimize DSH reductions?
- Same targeting metrics and/or percentages of reductions?
 - » MIUR > one std dev for high Medicaid hospitals?
 - » Medicaid weighed twice in targeting– volume and shortfall
 - » % reduction allocation based on targeting factors?
- Delay in DSH reporting data
- Continued legislative delays?

DSH Accountability and Impact on Payments

CMS ACCOUNTABILITY: DSH AUDITS



- As implemented through 2008 CMS rule, DSH payments subject to annual independent audit
- Confirm payments not exceed hospital-specific DSH limit
- State-by-state audit results available on CMS website (2005-2010)

Medicaid FFS payments
Medicaid MCO payments
Medicaid supplemental
payments
Self-pay payments

Medicaid Costs
Medicaid Shortfall
Uninsured Costs
Uncompensated Uninsured
Costs

Hospital-Specific Limit
Total DSH payments

- DSH audit data has become main source for Medicaid payment-related analysis
 - » ***And push for similar accountability in non-DSH payments***

REDUCTION OF HOSPITAL SPECIFIC LIMITS UNDER DSH AUDIT RULE

- **2008 Rule** implementing audits included restrictive new policies for eligible costs of hospital services
- **December 2014 Final Rule** responded to some concerns regarding definition of uninsured
 - » Return to pre-2008 definition of uninsured based on coverage for a particular service
- Effective date Dec. 31, 2014, for 2011 audits and reports

Uninsured costs include costs of:

- services not within benefit package
- services beyond annual and lifetime limits, if exhausted *prior* to provision of service
- inappropriate level of care days or administratively necessary care

Does not include:

- Costs of services if benefits exhausted during course of hospitalization
- Costs of services for patient with high deductible plan prior to meeting deductible
- Physician service costs for uninsured

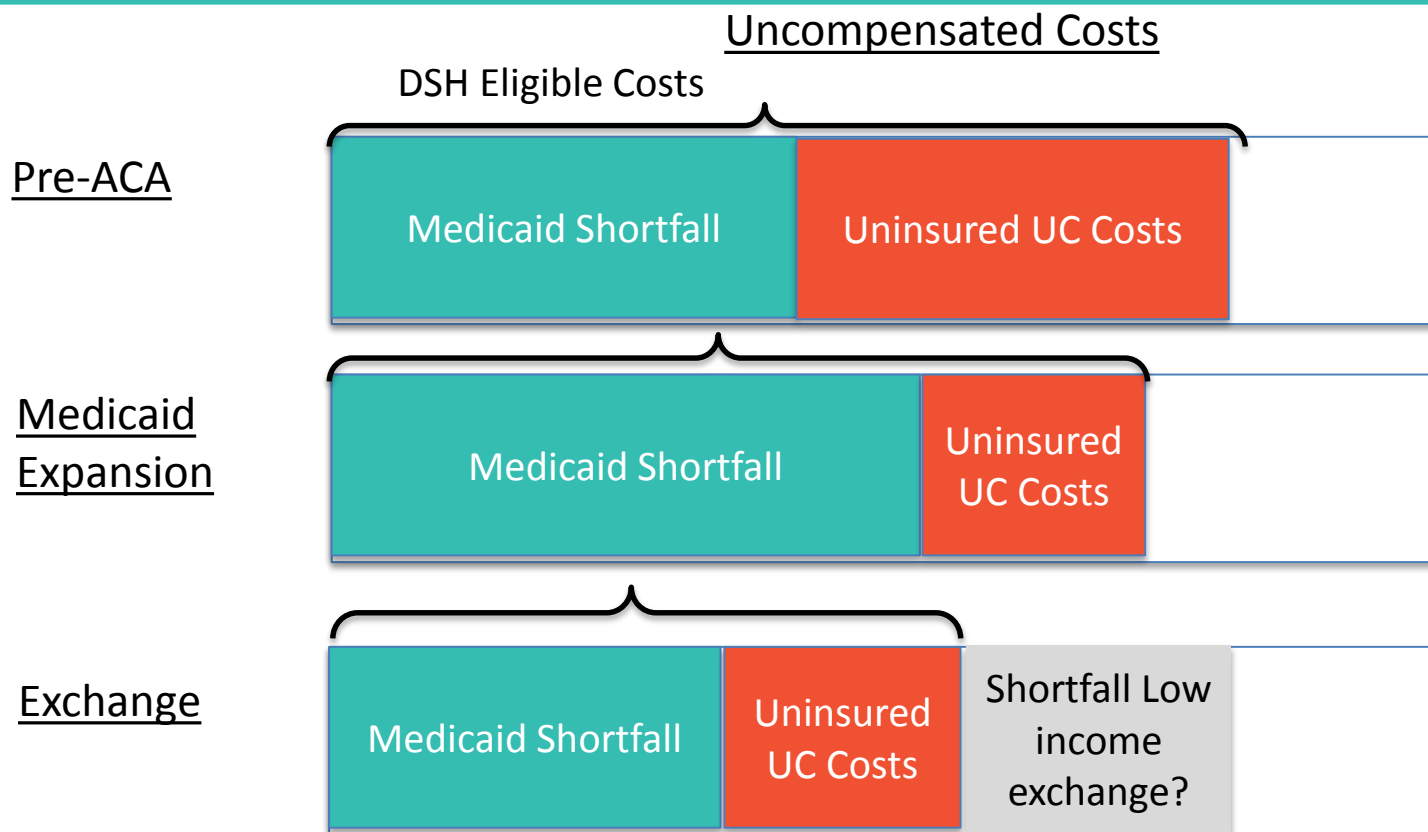
RECOUPMENTS RESULTING FROM AUDITS



- First year of potential DSH recoupments triggered by audit reports
 - » 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 overpayments to other hospitals through state plan amendment
 - » Could be redistributions to hospitals with DSH cap room, but relatively less uncompensated care
- Some states behind in submitting reports

Other Issues Affecting Value of DSH

UNREIMBURSED COSTS AND MEDICAID EXPANSION

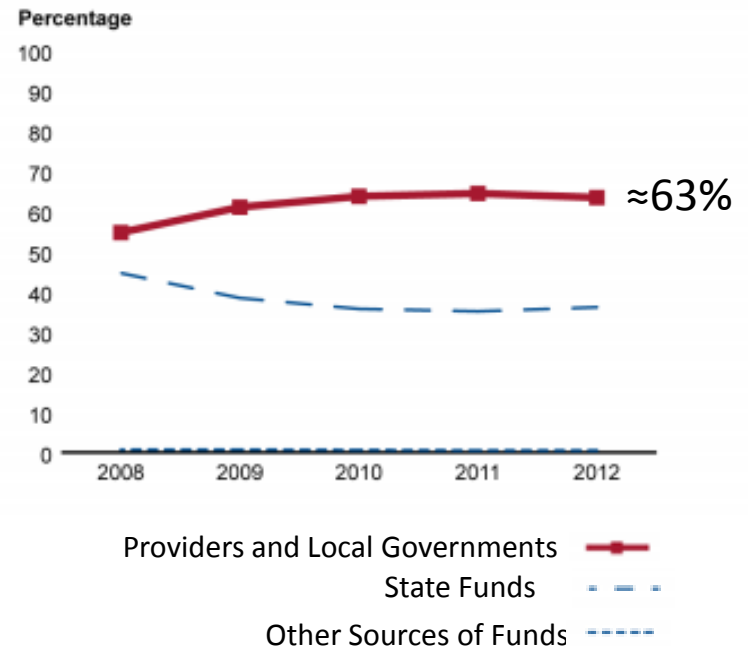


And implications if financing non-federal share of DSH

NET BENEFIT DECREASED WHERE HOSPITAL FINANCING NON-FEDERAL SHARE

- Local financing of DSH increasing
- MACPAC appears to be considering in preparation of its DSH report

Financing of Non-federal Share of DSH Payments



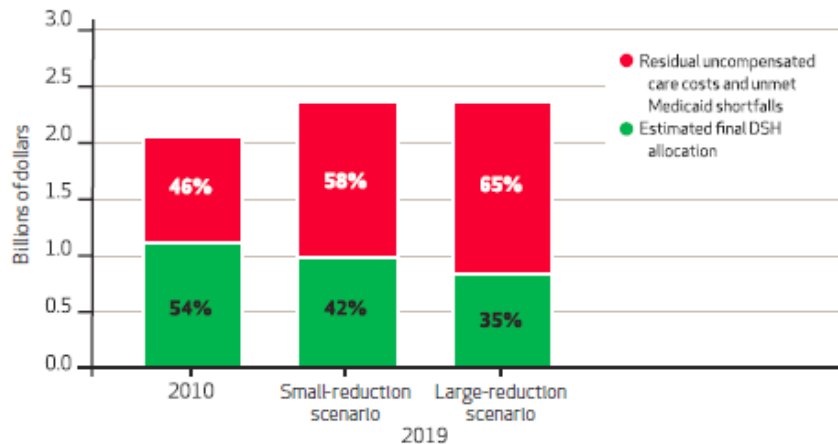
GAO 14-627, 2014

Figure 5: Percentage of Nonfederal Share of Medicaid Payments from Health Care Providers and Local Governments, State Funds, and Other Sources of Funds, State Fiscal Years 2008 through 2012, by Medicaid Payment Type

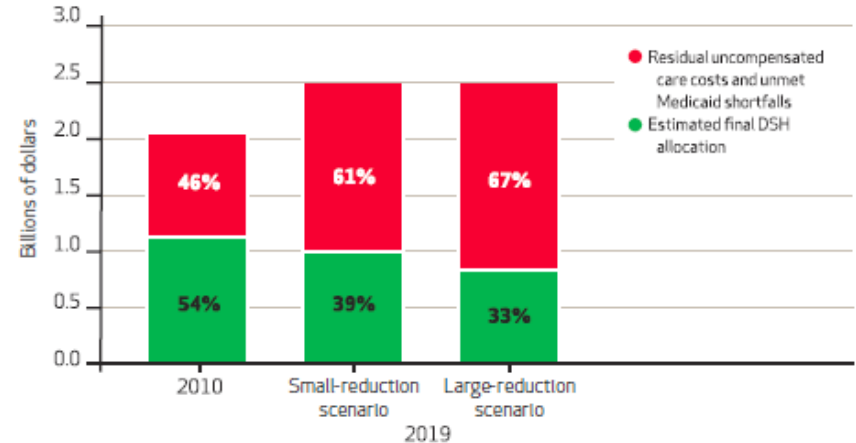
HEALTH AFFAIRS: SIGNIFICANT UNCOMPENSATED CARE COULD REMAIN EVEN IN EXPANSION STATES

Disproportionate-Share Hospital Payment Reductions May Threaten The Financial Stability of Safety-Net Hospitals

California's Estimated Final Disproportionate-Share Hospital (DSH) Allocation As A Proportion Of Total DSH Costs, Assuming Cost-Based Reimbursement For Those Newly Eligible For Medicaid, 2010 And 2019



California's Estimated Final Disproportionate-Share Hospital (DSH) Allocation As A Proportion Of Total DSH Costs, Assuming Lower Reimbursement Rates For Those Newly Eligible For Medicaid, 2010 And 2019



Katherine Neuhausen, et.al., Health Affairs, 33, no.6 (2014):988-996

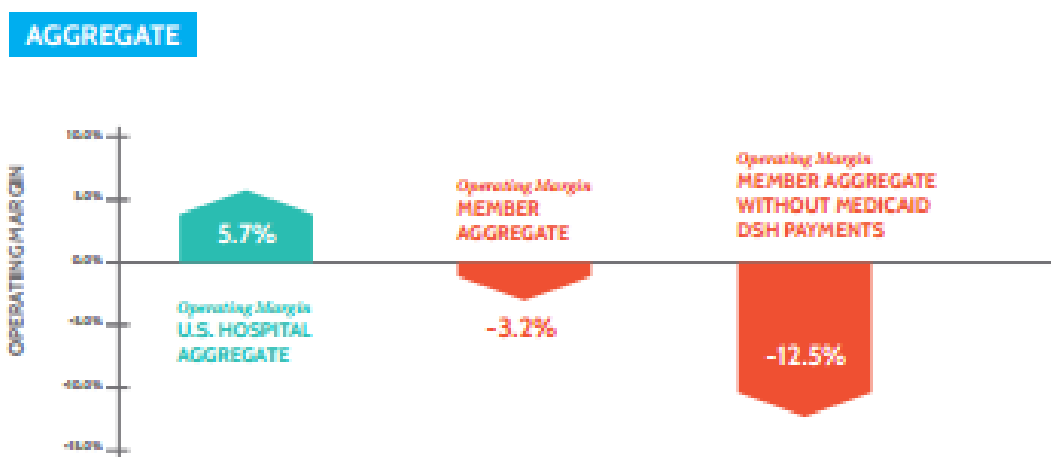
DSH PAYMENTS INCLUDE MEDICAID MANAGED CARE SHORTFALLS

- Increasing move to managed care not same impact on DSH as non-DSH supplemental payments
- States must make direct supplemental DSH payments to eligible hospitals for uncompensated costs of services to managed care patients
 - » Statutory exception to direct pay prohibition
- (*But...*)
 - » Only applies to DSH-eligible services (i.e., inpatient and outpatient hospital services)
 - » Limit is uncompensated costs, which might be lower than limit on non-DSH supplemental payments)

CRITICAL IMPORTANCE OF MEDICAID DSH

National Operating Margins

Members of America's Essential Hospitals vs. All Hospitals Nationwide FY2013



Results of America's Essential Hospitals Annual Characteristics Report, FY 2013. America's Essential Hospitals. March 2015

Medicare DSH

OVERVIEW



- Evolving Purpose
 - » Links to Reductions, Targeting, and Overlap with Other Medicare Support
- Changes in ACA
 - » Disparate impact of change in distribution
 - » Use of Proxy
 - » Ongoing data challenges
 - » Significant and Increasing Reductions Already Implemented

ORIGINAL PURPOSE OF MEDICARE DSH

- » In connection with changing from cost-based to prospective payment for inpatient hospital services, permitted Secretary to provide:
"such exceptions and adjustments to the payment amounts...as the Secretary (of Health and Human Services) deems appropriate to take into account the special needs of public or other hospitals that serve a significantly disproportionate number of patients who have low income."
"(c) concern has been expressed that public hospitals and other hospitals that serve such patients may...[treat patients that are] more severely ill than average and that the DRG payment system may not adequately take into account such factors"

Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

- » Note: no new money for implementation
 - Lowered base DRG rate to all hospitals and *decreased IME* adjustment

MEDICARE DSH PRE-ACA

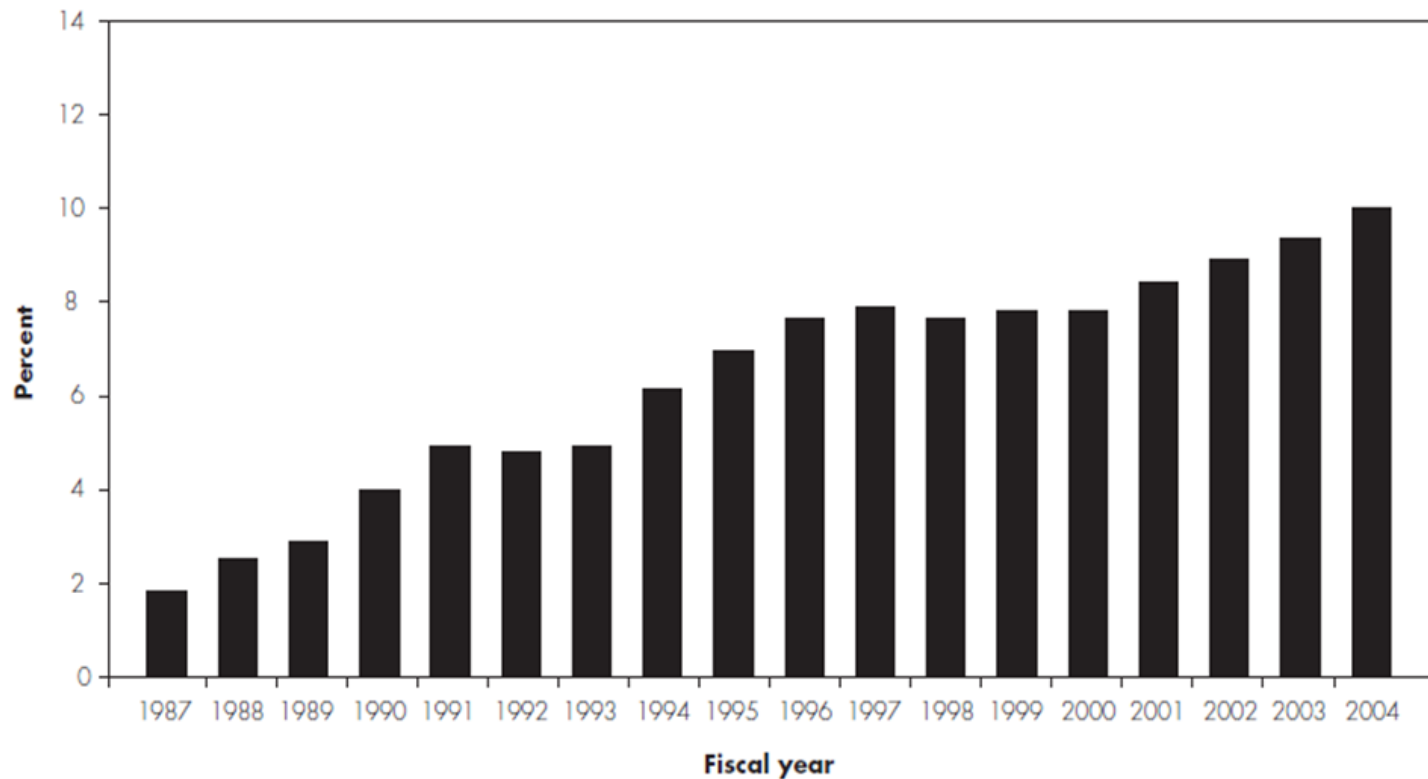
- Medicare add-on payment (per discharge) for hospitals serving a disproportionate share of low-income patients
 - » >\$12 billion in FY2014
 - » Pre-ACA, entire payment adjustment rooted in formula based on hospital's **low income Medicare & Medicaid days**

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

More SSI, relative to Medicare inpatients, and more Medicaid inpatients, relative to all inpatients = higher adjustment percentage

More Medicare discharges = more claims to which DSH adjustment will apply

INCREASE IN DSH PAYMENTS AS % OF BASE PAYMENTS

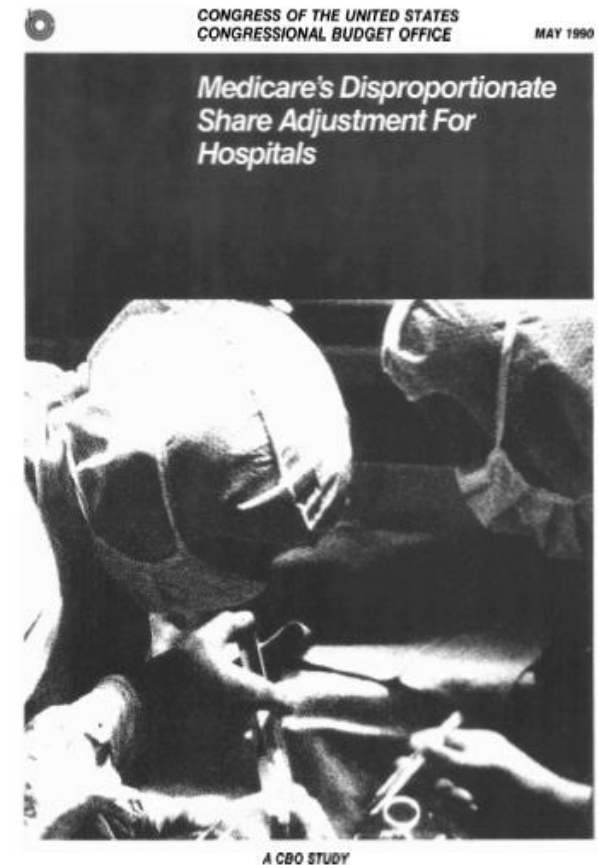


Note: DSH (disproportionate share). Data through 1996 measure operating DSH payments as a percent of operating base payments. Data from 1997 through 2004 measure operating and capital DSH payments as a percent of operating and capital base payments.

Source: ProPAC June Reports to the Congress through 1996 and MedPAC analysis of Medicare cost report data from CMS from 1997 through 2004.

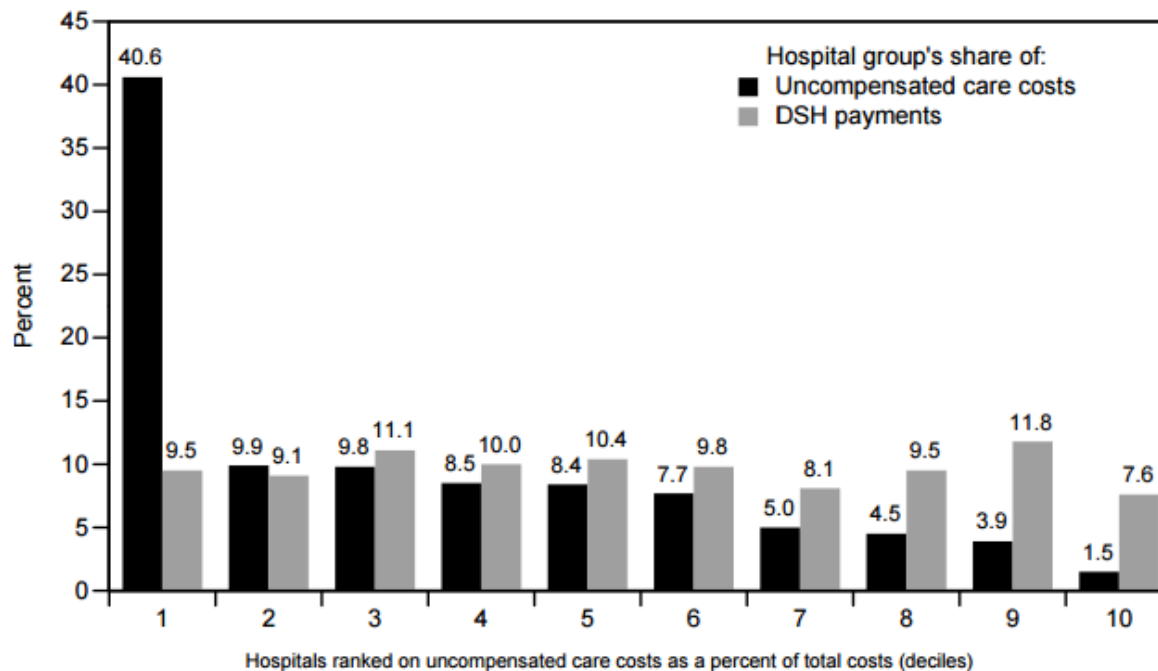
MEDICARE DSH'S EVOLVING PURPOSE

- 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



BUT DSH WAS NOT TARGETED TO HOSPITALS WITH HIGHEST UNCOMPENSATED CARE

Chart 7-21. Relationship between hospitals' uncompensated care costs and disproportionate share payments, 2003

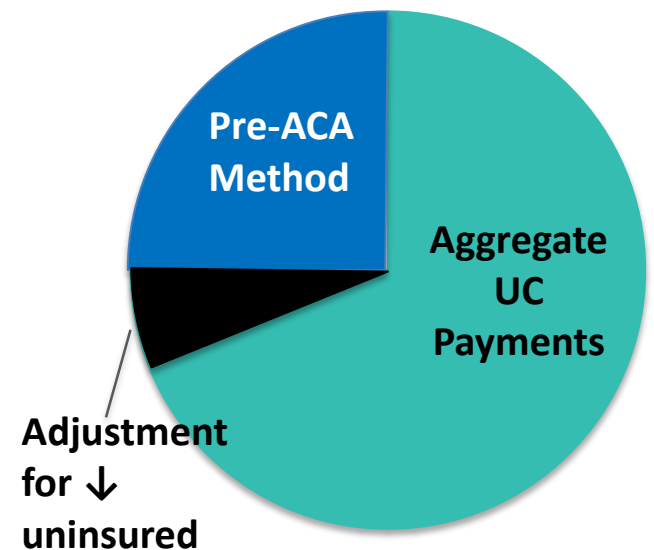


“[A]t most 25 percent of DSH payments were empirically justified as covering higher Medicare costs and DSH payments were poorly targeted at hospitals with high uncompensated care costs...”

MedPAC March 2013
Report to Congress

MEDICARE DSH IN THE ACA

- Reduces Medicare DSH payments by an estimated **\$22 billion** FY2014-FY2019
- Methodology for implementing reductions:
 - » DSH adjustment under prior methodology reduced to 25%
 - » Portion of 75% cut funds are restored through a new payment
 - Reduce total 75% pool by change in uninsurance rate
 - » New payment based on each hospital's uncompensated care costs relative to all DSH hospitals



- *Redistribution of DSH funds among hospitals*

CHALLENGE OF DEFINING UNCOMPENSATED CARE

- ACA definition for allocation of pool:
 - »“the amount of **uncompensated care** for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data *(including, in the case where the Secretary determines that alternative data is available which is a better proxy for the **costs** of subsection (d) hospitals **for treating the uninsured**, the use of such alternative data.)*)”
- CMS implemented in regulations using proxy:

(Hospital's Medicare SSI Days + Medicaid Days)

(Medicare SSI Days + Medicaid Days
for All DSH Hospitals)

CMS SAME CONCERNS REGARDING S-10 DATA IN MEDICARE DSH PROPOSED RULE (FY2016 IPPS)

“For FY 2016, we believe it remains premature to propose the use of Worksheet S–10 for purposes of determining Factor 3...”

“We believe this methodology would give hospitals more time to learn how to submit accurate and consistent data through Worksheet S–10, as well as give CMS more time to continue to work with the hospital community and others to develop the appropriate clarifications and revisions to Worksheet S–10 to ensure standardized and consistent reporting of all data elements.”

“We still intend to propose through future rulemaking the use of the Worksheet S– 10 data for purposes of determining Factor 3.”

“LACK OF DATA” RECURRING THEME IN MEDICARE DSH POLICY

- BBA 1997- Secretary authorized to collect any data needed to implement a new formula
- BBRA of 1999: HHS required to collect data on hospital uncompensated care
 - » Intent that such data could be factored into the Medicare DSH formula
- 2003: CMS added Worksheet S-10 to Medicare Cost Report
- FY2010: “New” Worksheet S-10



“I want to emphasize NAPH's support for ProPAC's suggested reform of the Medicare DSH formula to account for uncompensated care...Nevertheless, in order to implement this kind of a measure of low income care, additional data collection will be necessary, ... [D]ata necessary to develop a reasonably accurate estimate of these costs could be collected with relatively little additional burden on hospitals.”

Larry Gage
Testimony before House Ways & Means
Health Subcommittee, 1997

SUPPORT TARGETING, BUT CHALLENGES IN IMPLEMENTATION

Members Differentially Affected by Use of Proxy...

- Medicaid and low income Medicare days vs. charity care/shortfall/bad debt
- Inpatient data might not reflect:
 - » Complete low-income patient population
 - » Volume of outpatient care provided
 - » Relative resource intensity

And Also Challenges When CMS Moves to S-10

- Need adjustments to capture all patient care costs, such as GME, not currently captured
 - » Include subsidies for physician and other professional services
 - » Inconsistency in reporting charity care versus bad debt
 - » Offsets Medicaid shortfall for provider taxes, but not IGTs or CPEs

FACTORS AFFECTING RELATIVE IMPACT ON YOUR HOSPITAL

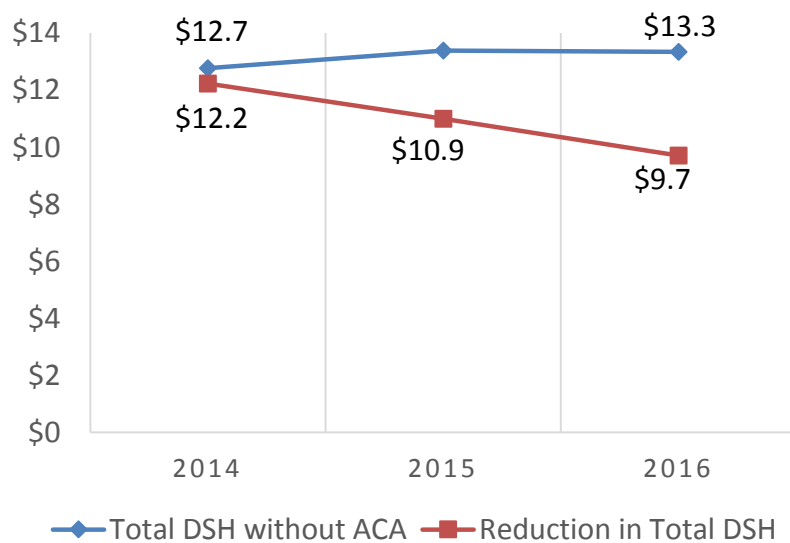
- Hospital patient mix
- Medicaid expansion*
- Inpatient vs. outpatient utilization
- Financing of Medicaid payments
- Hospital case mix

**Lag in data impacts when CMS must account for expansion*

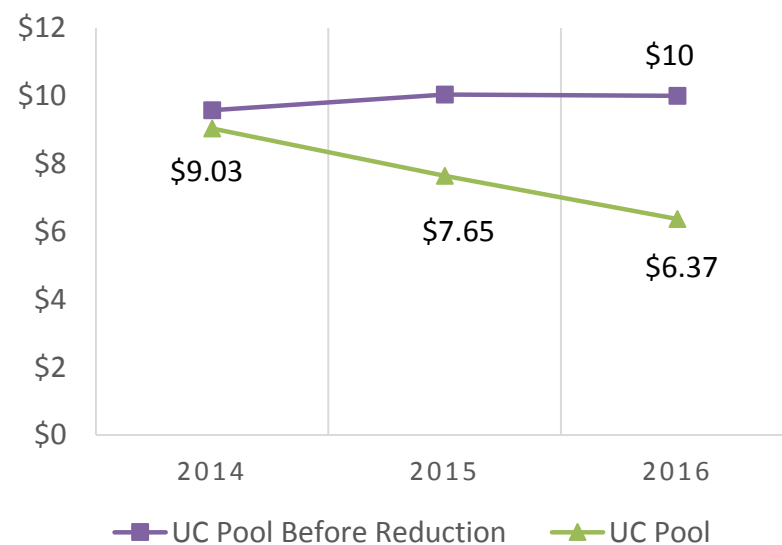
- Medicaid days
 - » CMS says hospitals need more time to report
 - » FY2011 or 2012 data used for both FY2015 and 2016 payment
 - » Expansion not impact until 2018
- Uninsurance rate for reduction of pool

ALL MEMBERS MAY SOON BE AFFECTED BY SIGNIFICANT REDUCTIONS TO DSH UC POOL

**REDUCTIONS IN TOTAL DSH
(IN BILLIONS)**



**REDUCTIONS IN UC POOL
(IN BILLIONS)**



27% reduction between 2014 and 2016

35% reduction between 2014 and 2016

QUESTIONS?

Sarah Mutinsky

(202) 567-6203

smutinsky@eymanlaw.com

