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Foundations of Essential Hospital Financing

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June 25, 2015

AMERICA'S ESSENTIAL HOSPITALS

OVERVIEW

- Introduction
- Medicaid Funding Basics and the Challenge of Payment Adequacy
- Supplemental Payments to Support Essential Hospitals
  - » Medicaid DSH and Medicare DSH
  - » Non-DSH Supplemental Medicaid Payments
  - » Waiver-Based Payments
  - » New (and Renewed) Challenges
- Financing the Non-Federal Share of Medicaid Payments

HOPEFULLY YOU DON'T FEEL LIKE THIS

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

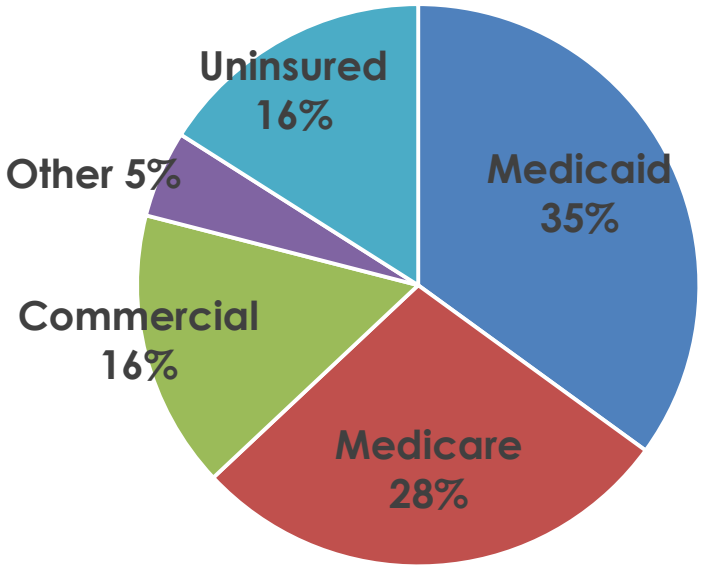
Nearly 70 percent of our members have a relationship with their local health department.

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

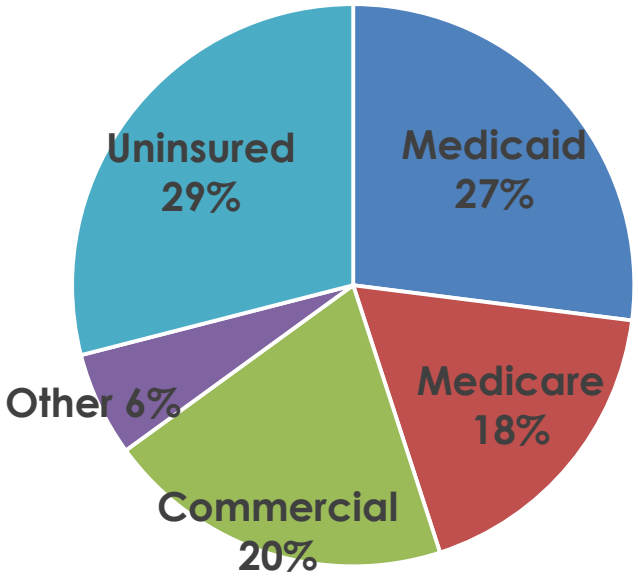
COMMITMENT TO LOW INCOME AND UNINSURED PATIENTS

Members of Essential Hospitals, FY 2012

Inpatient Utilization



Outpatient Utilization



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

PATCHWORK OF SUPPORT FOR MISSION

Medicaid

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

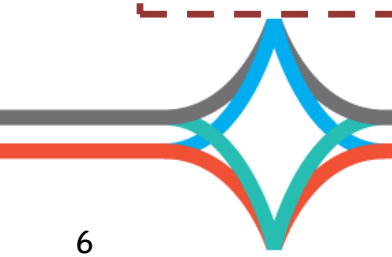
State/ Local Support

Medicare

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

340B Drug Discount Program *(savings)*

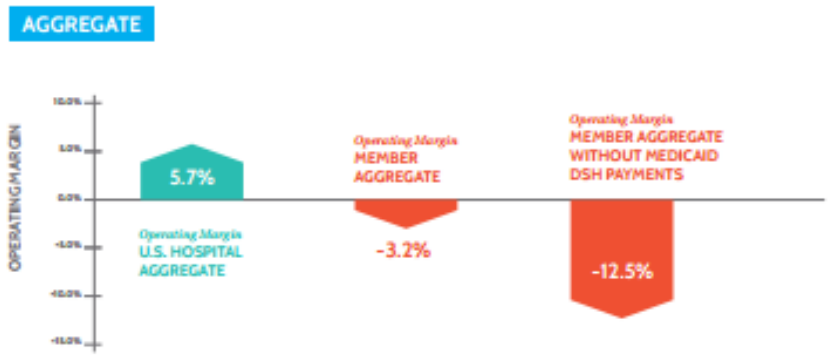
Federally Qualified Health Centers



FINANCIAL CHALLENGES OF SERVING THESE ESSENTIAL MISSIONS

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

ESSENTIAL HOSPITALS FACING CUMULATIVE IMPACT OF CHALLENGES TO TRADITIONAL AVENUES OF SUPPORT

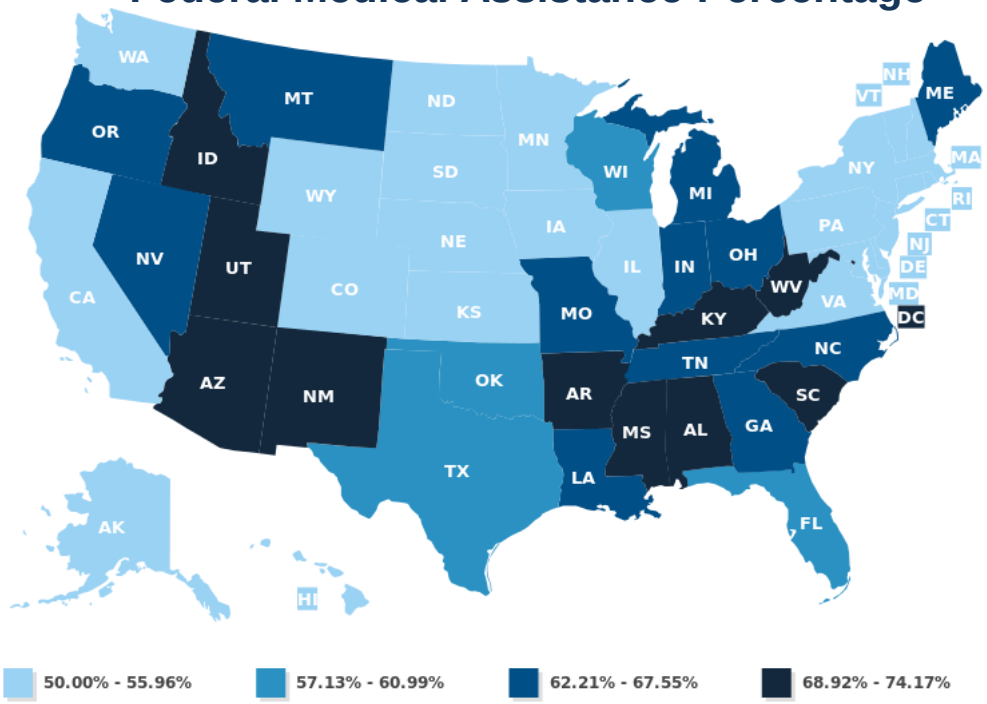
- Renewed scrutiny and potential proposals to limit FFS UPL payments
- No direct supplemental payments for MC services
- No indirect state direction of enhanced payments through MC plans, except limited circumstances
- Transition out uncompensated care pools
- Uncertain future of DSRIPs
- Medicaid and Medicare DSH cuts
- Double-edged sword of local financing
- Scrutiny of public/private Medicaid financing
- 340B-related challenges

Medicaid Funding Basics and Payment Adequacy

MEDICAID IS A FEDERAL-STATE PARTNERSHIP

- State **flexibility** within federal rules
- Shared financing
  - » Federal share generally 50% to 73%
  - » Statute permits use of “local sources” to finance the non-federal share

Federal Medical Assistance Percentage



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

FEDERAL MEDICAID PAYMENT STANDARD

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))

But how to enforce?

- *Armstrong* decision forecloses providers' ability to seek judicial enforcement of adequate rates
- CMS Equal Access Rule pending since 2011
  - » Congressional letter to HHS

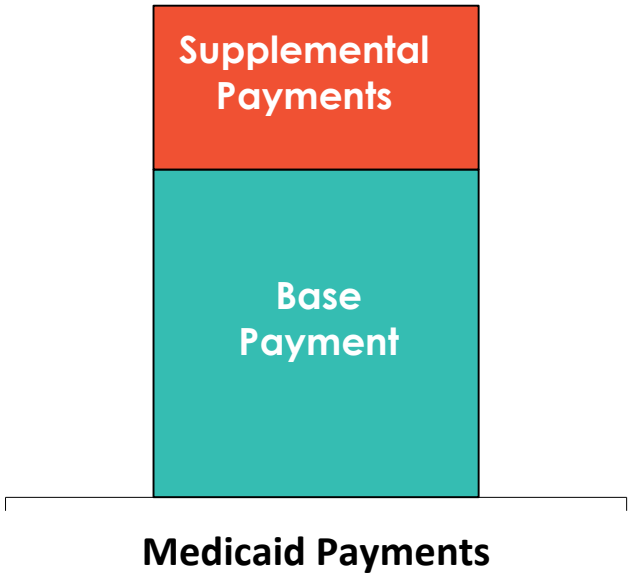
CHALLENGES TO MEDICAID PAYMENT ADEQUACY

- Most Medicaid programs pay hospitals well below cost
- According to AHA data:
  - » Medicaid pays $13.2B below costs
  - » Medicaid pays 90 cents on the dollar (on average)
  - » 62% of hospitals received Medicaid payments below cost

AHA FY2015 Fact Sheet
Medicaid and Medicare Underpayment

HOW DO WE FILL THE GAP?

- Supplemental payments
  - » Disproportionate Share Hospital Payments
  - » Non-DSH Supplemental Payments
  - » Local Funding Sources



Medicaid and Medicare DSH (Detailed session 8am tomorrow)

MEDICAID DSH

- ≈$11.6B federal funds FY14
- Only Medicaid payment in statute that explicitly pays for uninsured

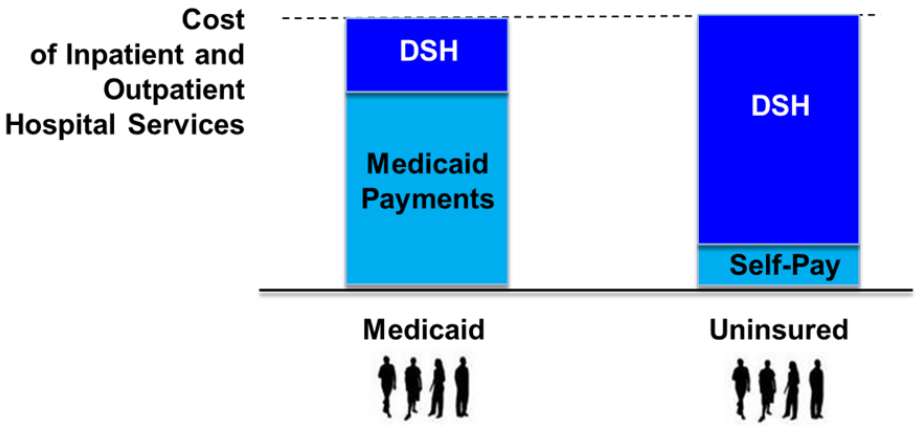
- Two federal limits on DSH payments to eligible hospitals
  - » Hospital-specific limit
    - No more than unreimbursed costs of hospital services to Medicaid and uninsured patients
  - » State allotments of federal DSH funding

- State flexibility in how choose to spend DSH funds within limits

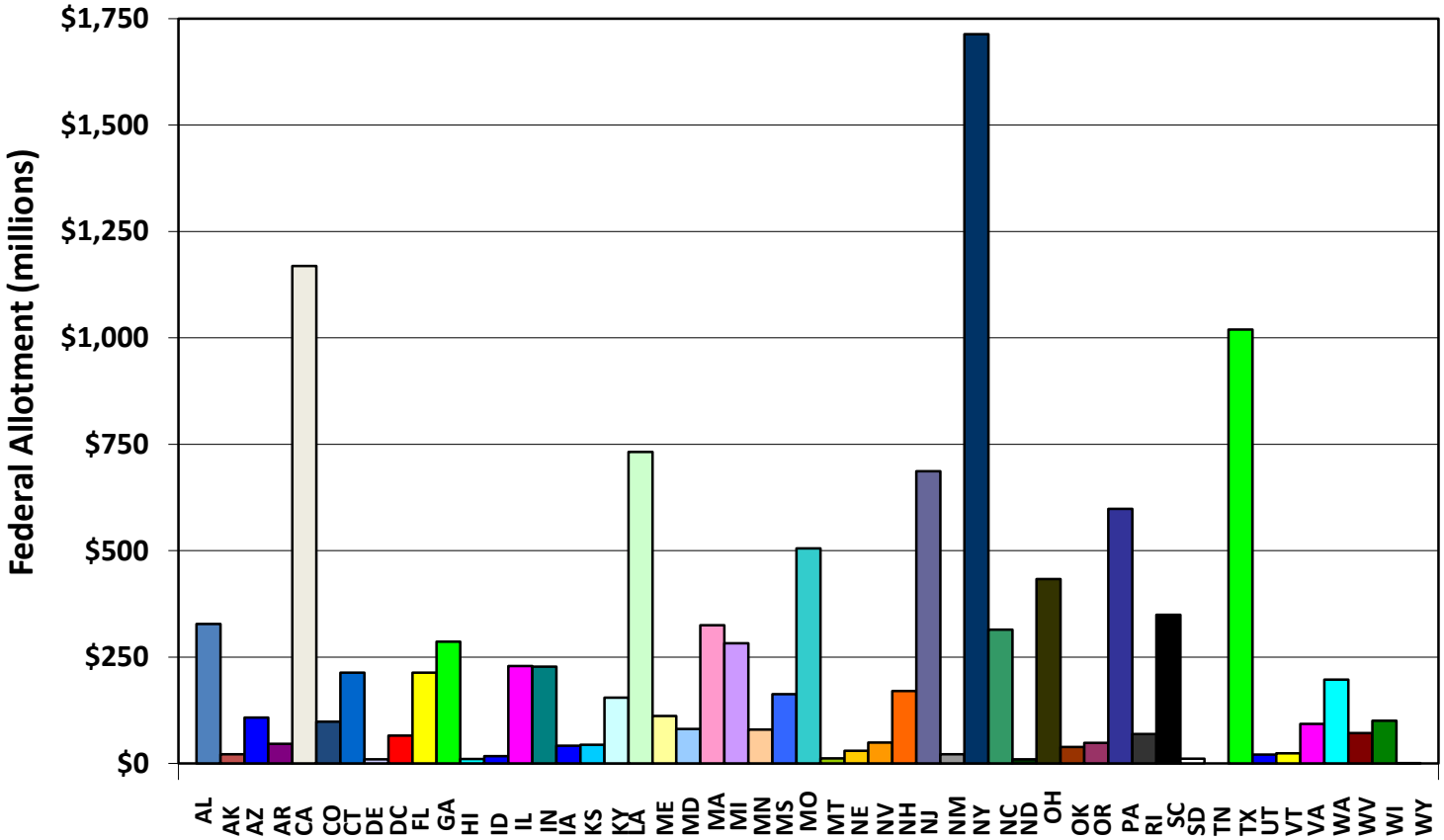
HOSPITAL-SPECIFIC DSH LIMIT

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

- Annual Independent DSH Audits
  - » FY2011 Recoupments
  - » Redistribution of recouped funds?
- Dec. 2014 Uninsured Rule
  - » Return to service-specific definition



STATE ALLOTMENTS OF FEDERAL DSH FUNDS

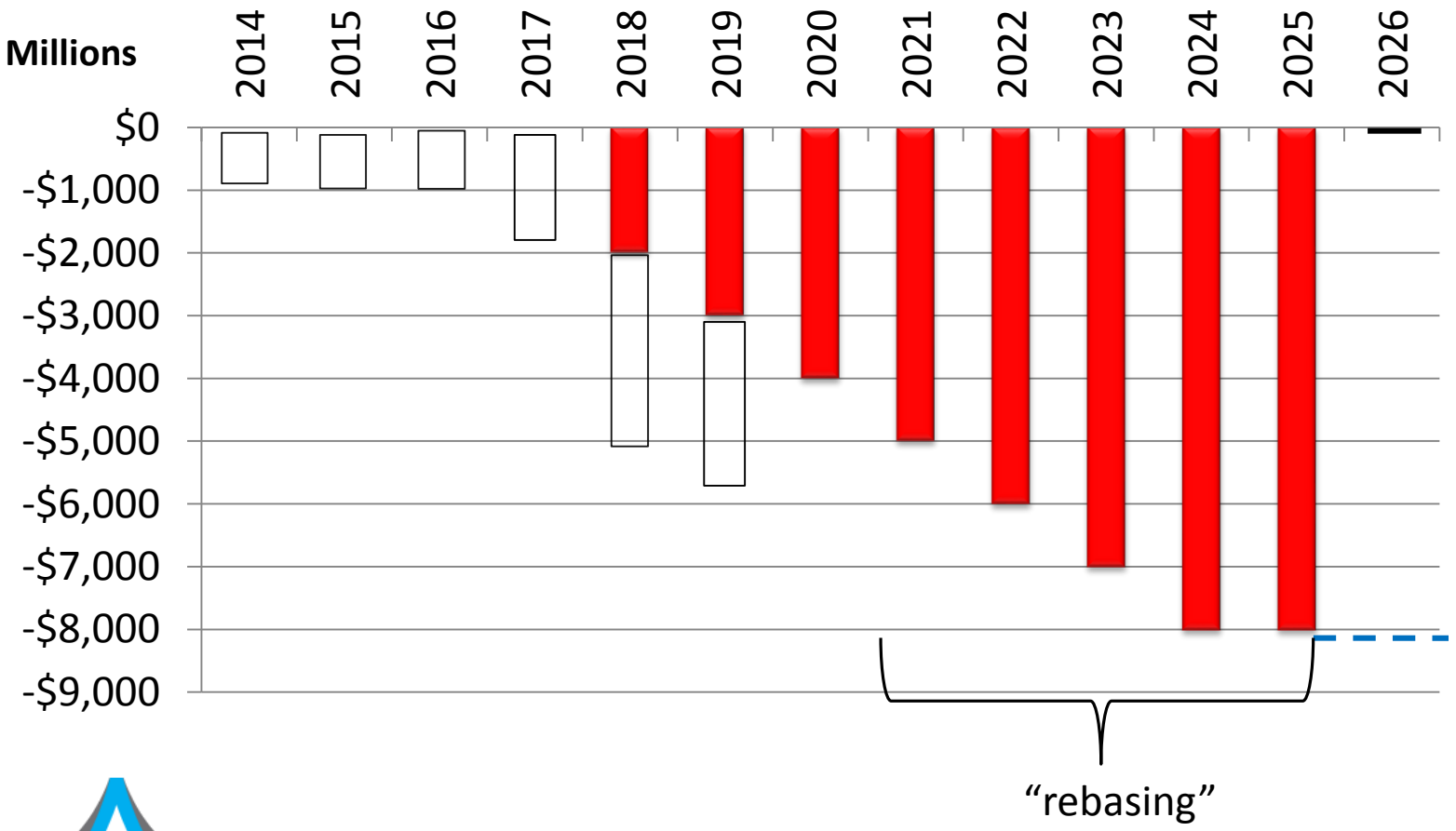


Low DSH States

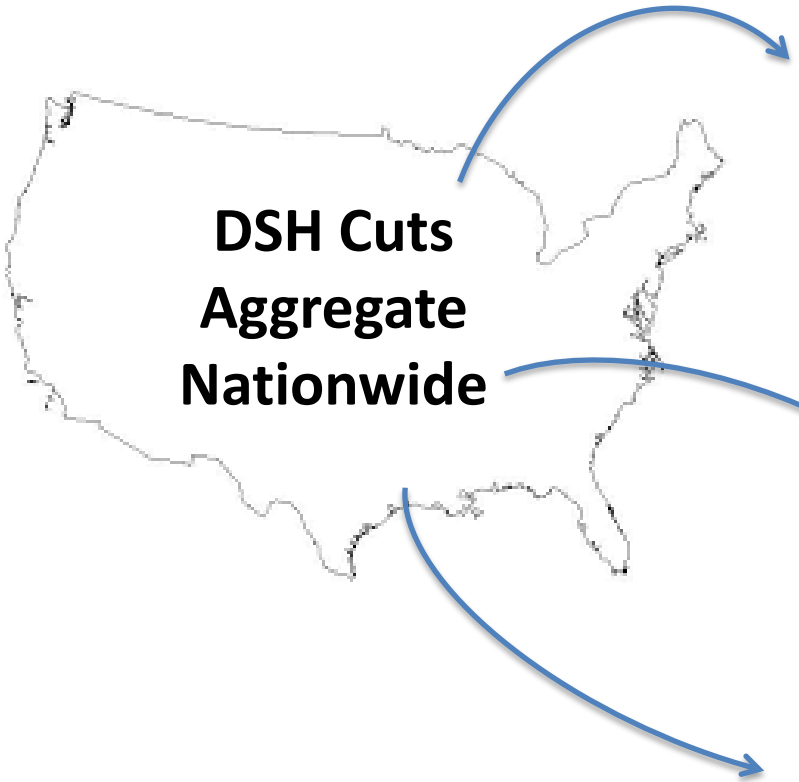
- Alaska
- Arkansas
- Delaware
- Hawaii
- Idaho
- Iowa
- Minnesota
- Montana
- Nebraska
- New Mexico
- North Dakota
- Oklahoma
- Oregon
- South Dakota
- Utah
- Wisconsin

Source: Federal Register , Feb. 28, 2014.

ACA CUTS SUCCESSFULLY DELAYED, BUT SIGNIFICANT CUTS LOOM



IMPLEMENTING THE MEDICAID DSH CUTS



Statutory factors to allocate among states

- Decrease in state's uninsurance rate
- Targeting DSH to high Medicaid volume hospitals, and
- Targeting DSH to high UC hospitals

CMS must issue methodology

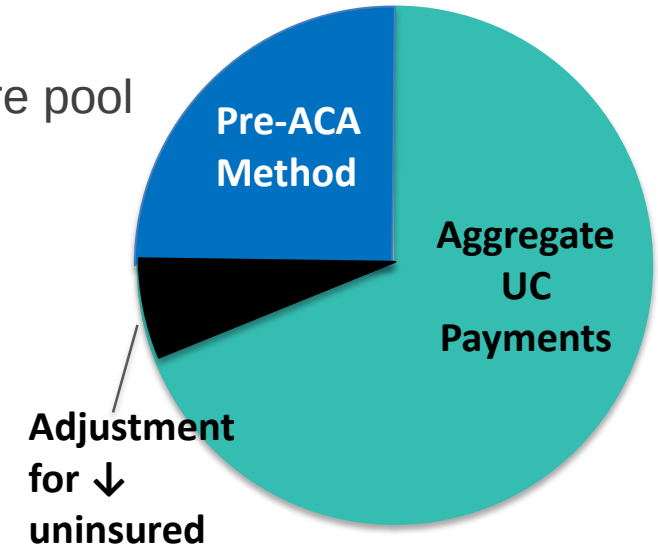
- Initial Rule (FY14 & 15)
- Must issue new rule for FY18 (Oct. 2017)

MACPAC report (first due 2/2016)

- Identify high UC hospitals that provide "essential services"

MEDICARE DSH

- Add-on payment for hospitals serving a disproportionate share of low-income patients
- ACA reductions and change in methodology
  - » 25% pre-ACA adjustment
  - » 75% new methodology: uncompensated care pool
    - Reduce pool for change in uninsured
    - Distribute payments based on UC costs relative to all DSH hospitals nationally



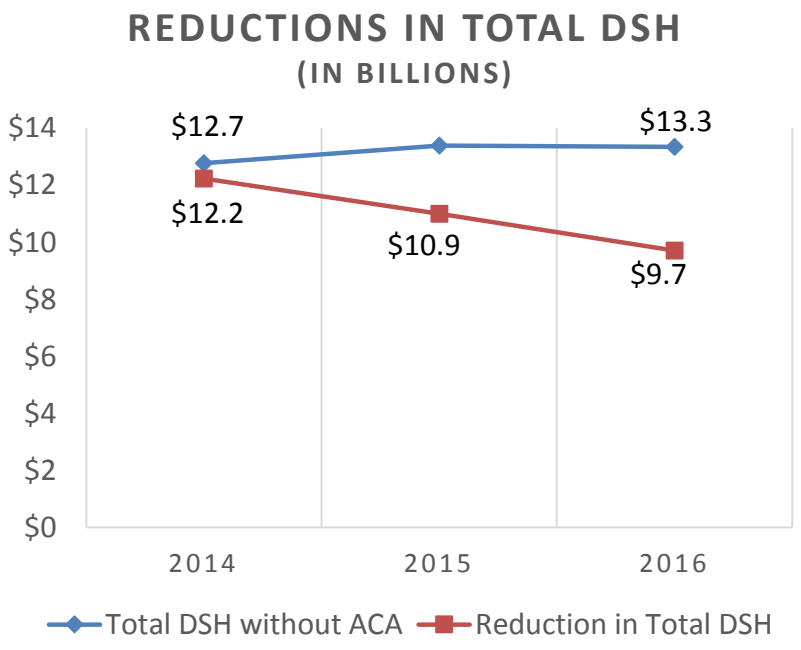
Redistribution of DSH funds among hospitals

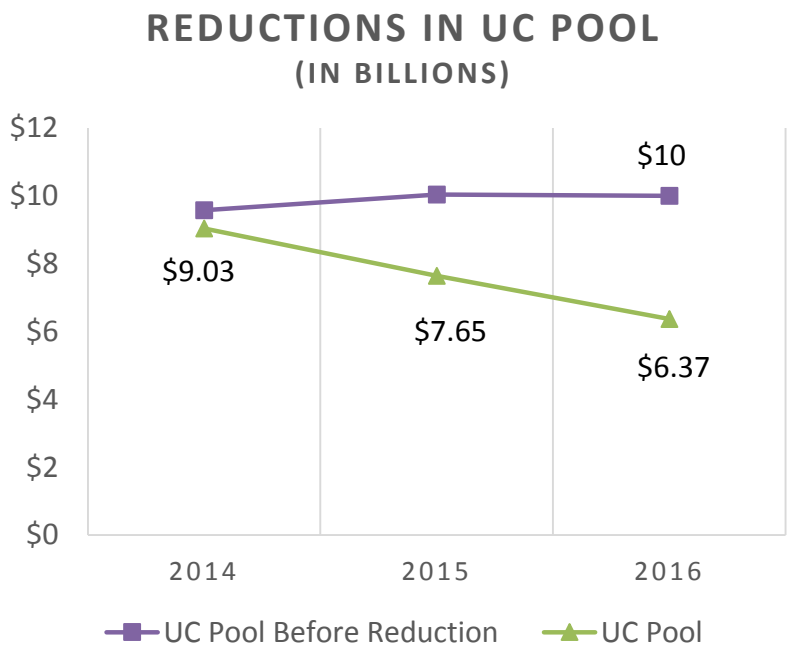
CMS USING PROXY UNTIL S-10 DATA READY

$$\frac{\text{(Hospital's Medicare SSI Days + Medicaid Days)}}{\text{(Medicare SSI Days + Medicaid Days for All DSH Hospitals)}}$$

- Members differentially affected by use of proxy
  - » Versus charity care/shortfall/bad debt
- Data issues
  - » Proxy
  - » Medicare S-10
  - » Impact of Medicaid expansion

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





27% reduction between 2014 and 2016

35% reduction between 2014 and 2016

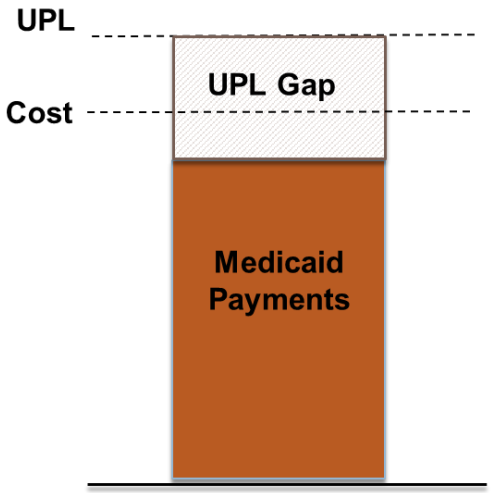
Non-DSH Medicaid Supplemental Payments

OVERVIEW

- Non-DSH Supplemental Payments Under State Plan (“UPL”)
- Waiver-Based Payments
  - » Uncompensated care pools
  - » DSRIP
- Supplemental Payments and Medicaid Managed Care
- Recent Challenges

"NON-DSH" SUPPLEMENTAL PAYMENTS UNDER STATE PLAN

- Federal match only if Medicaid payments (except DSH) do not exceed a calculated Upper Payment Limit (UPL)
- What is the limit?
  - » Consistent with economy, efficiency, quality, access
- States can make supplemental payments up to difference between base rates and upper limit (UPL gap)
- Many forms of UPL payments, defined under state plan
  - » E.g., GME; Trauma support; children's hospital support; safety net hospital payments



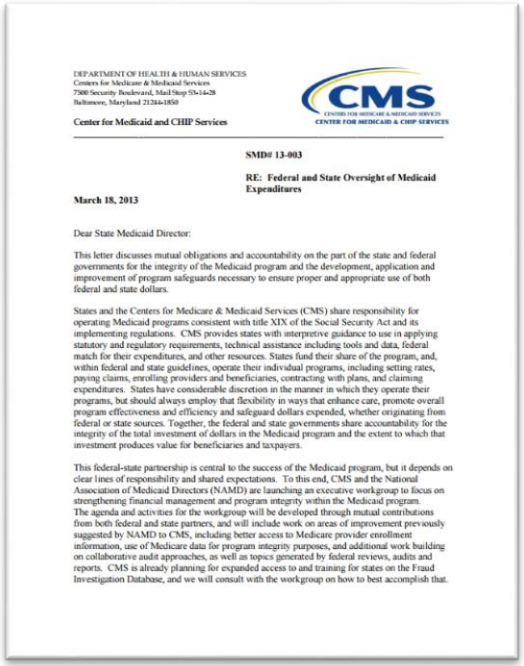
"NON-DSH" SUPPLEMENTAL PAYMENTS UNDER STATE PLAN

- CMS regulations define UPL for institutional services
  - » Limit =Medicare (May be > cost)
  - » Aggregate limit across groups of providers
    - State-owned and operated providers
    - Non-state government providers
    - Private providers
  - » Tied to Medicaid utilization

- CMS policy guidance on limit for professional services
  - » Limit= Medicare or Average Commercial Rate

CMS ACCOUNTABILITY INITIATIVE (2013)

- First time states required to submit annual UPL demonstrations
  - » Inpatient & outpatient hospital, nursing facilities, physician/practitioners, clinics, etc.
  - » Provider-specific reporting
  - » Includes source of non-federal share funding
- First time published CMS guidance on how to calculate the UPLs
- Contractor engaged to organize and analyze the data



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

SMD# 13-003

RE: Federal and State Oversight of Medicaid Expenditures

March 18, 2013

Dear State Medicaid Director:

This letter discusses mutual obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program and the development, application and improvement of program safeguards necessary to ensure proper and appropriate use of both federal and state dollars.

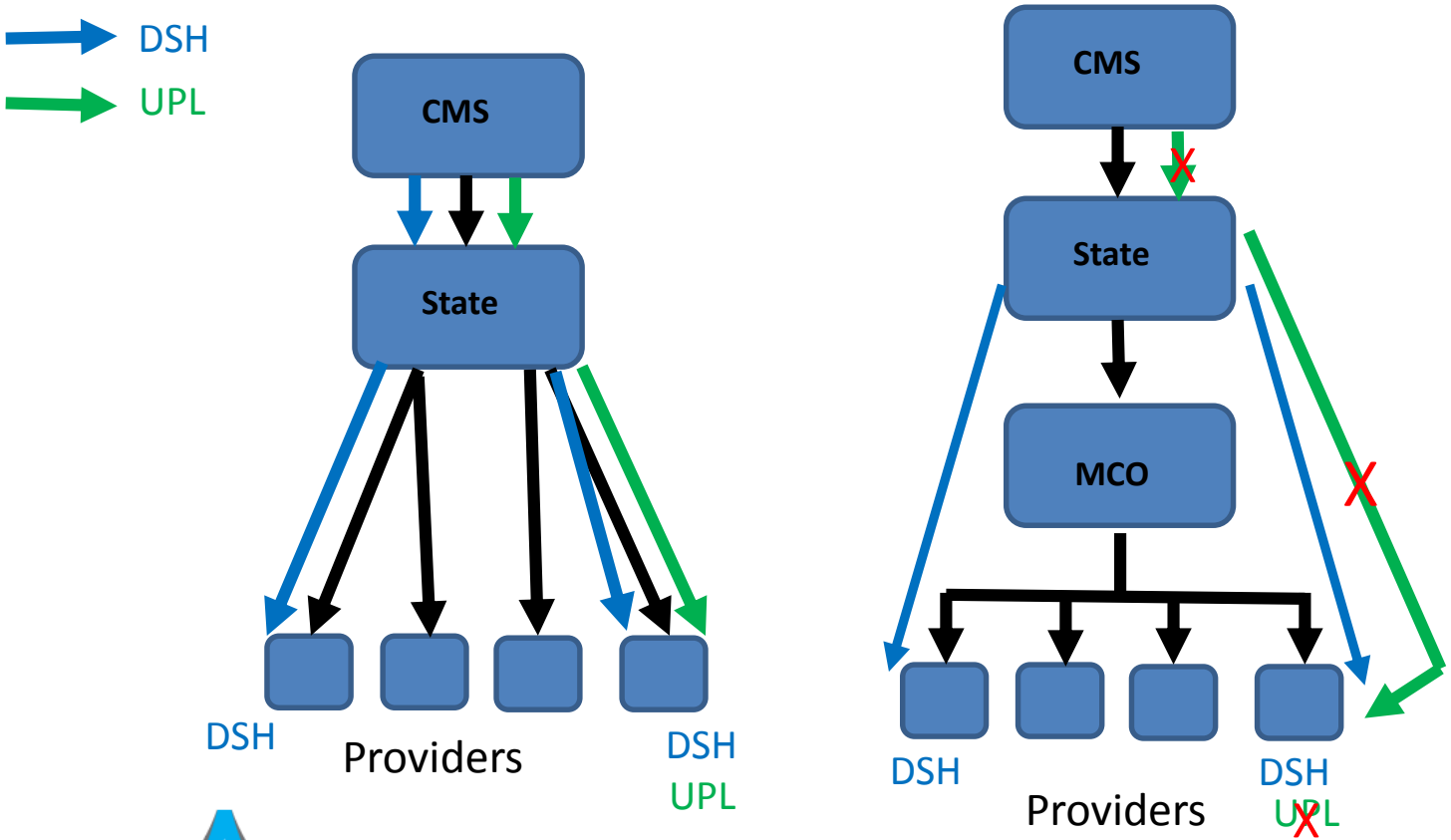
States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act and its implementing regulations. CMS provides states with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, federal match for their expenditures, and other resources. States fund their share of the program, and, within federal and state guidelines, operate their individual programs, including setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures. States have considerable discretion in the manner in which they operate their programs, but should always employ that flexibility in ways that enhance care, promote overall program effectiveness and efficiency and safeguard dollars expended, whether originating from federal or state sources. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers.

This federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. To this end, CMS and the National Association of Medicaid Directors (NAMD) are launching an executive workgroup to focus on strengthening financial management and program integrity within the Medicaid program. The agenda and activities for the workgroup will be developed through mutual contributions from both federal and state partners, and will include work on areas of improvement previously suggested by NAMD to CMS, including better access to Medicare provider enrollment information, use of Medicare data for program integrity purposes, and additional work building on collaborative audit approaches, as well as topics generated by federal reviews, audits and reports. CMS is already planning for expanded access to and training for states on the Fraud Investigation Database, and we will consult with the workgroup on how to best accomplish that.

DIRECT SUPPLEMENTAL PAYMENTS GENERALLY NOT PERMITTED UNDER MEDICAID MANAGED CARE

- CMS regulatory limit on state's payments to plans (actuarial soundness)
  - » *But* no federal requirement for plan payments to providers
  - » Governed by contract
- **"Direct Pay Prohibition"**
  - » **CMS regulations say states cannot make supplemental payments directly to providers for services under MCO contract**
  - » Except
    - Statute requires to pay DSH directly to providers
    - CMS policy allows states to pay GME directly to hospitals
    - FQHC wrap-around payments
- Interpretation limiting state direction of payments through plans

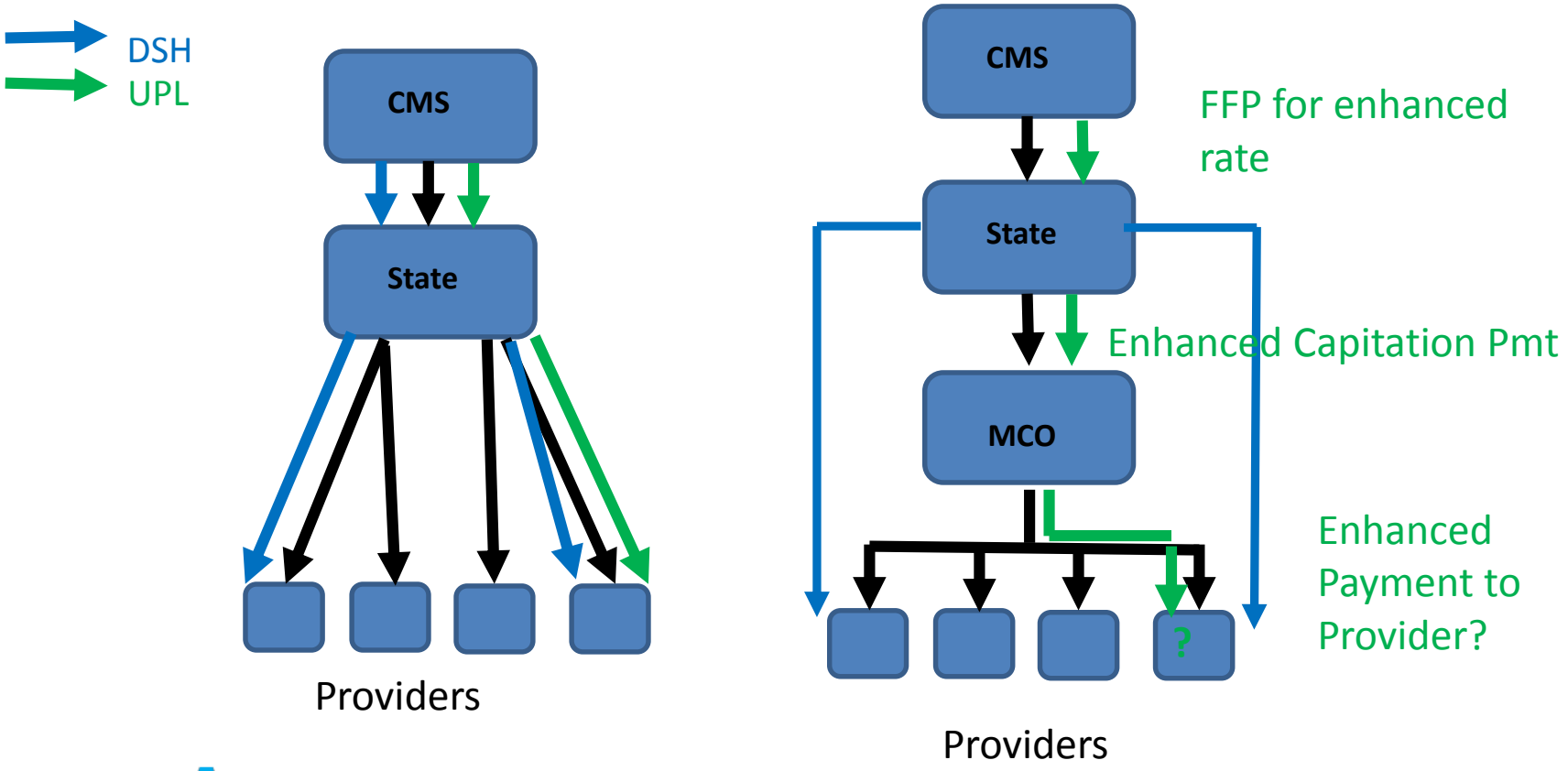
DIRECT PAY PROHIBITION



STATE "WORKAROUNDS"

- Services carve-outs
- Waiver-based UC pools
- DSRIPs (in some cases)
- GME payments (may be paid directly)
- Payments through MCOs

ENHANCED PAYMENTS THROUGH MCOS



How much will CMS let State direct payment to provider?

WAIVER-BASED PAYMENTS

- Uncompensated care pools
  - » Service-based payments typically limited to cost
  - » Can include costs for Medicaid (FFS and MC) and uninsured
  - » Can include costs for range of services,
    - e.g., hospital, physician, FQHC, etc. (depends on state's Special Terms and Conditions)
- Delivery System Reform Incentive Pools
  - » Different because NOT payment for services
  - » Payments for achieving milestones and metrics
  - » Managed care and FFS programs

Challenges to Non-DSH Supplemental Payments

CMS' EVOLVING POSITION ON DSRIPS

- CMS is re-evaluating its DSRIP activity
  - » Return on investment
  - » Administrative burden
  - » New York waiver as preferred approach
  - » DSRIP as a means not an end
  - » Sustainability a concern

CMS' EVOLVING POSITION ON UNCOMPENSATED CARE POOLS

- CMS disfavors **uncompensated care pools**
  - Will review each state's circumstances individually, as pools expire
  - Requiring independent evaluations

- Principles announced in April 14 letter to Florida, later sent to 8 other states with UC pools:
  1) "…uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion."
  2) "Medicaid payment should support services provided to Medicaid beneficiaries and low-income uninsured individuals."
  3) "…**provider payment rates must be sufficient to promote provider participation and access…**"

MANAGED CARE PROPOSED RULE

- Released May 26, 2015
- Comprehensive overhaul of managed care regulations (first since 2002)
- Retains the direct pay prohibition
- Adds explicit prohibition on directing payments through MCOs

CMS PROPOSES TO RESTRICT TARGETED PAYMENTS THROUGH MANAGED CARE PLANS

State cannot direct MCO payments under contract with plans *except under specified circumstances*:
1) requiring implementation of value-based purchasing models,
2) mandating participation in a multi-payer delivery system reform and
3) requiring the plan to adopt
   A minimum fee schedule or
   Uniform rate increase for *all* providers of a particular service.

- Troublesome preamble language characterizes as simply codifying "longstanding CMS policy"
- (Does not impact ability to negotiate higher payment amounts in contract between plan and provider)

RENEWED SCRUTINY REGARDING ROLE OF NON-DSH SUPPLEMENTAL PAYMENTS

- MACPAC
- GAO
- Legislation
- E&C Hearing
- CMS agenda for "Medicaid State Payment Adjustment" rule

- Accountability and reporting at provider-specific level
- DSH-style audits/reporting
- Review economy and efficiency of payments to individual providers
- "proportional to the volume or cost of service delivered or be tied to meeting performance benchmarks"

Mini-Session at 2:15 in Plaza

Non-Federal Share Financing

OPTIONS FOR FINANCING THE NON-FEDERAL SHARE OF MEDICAID PAYMENTS

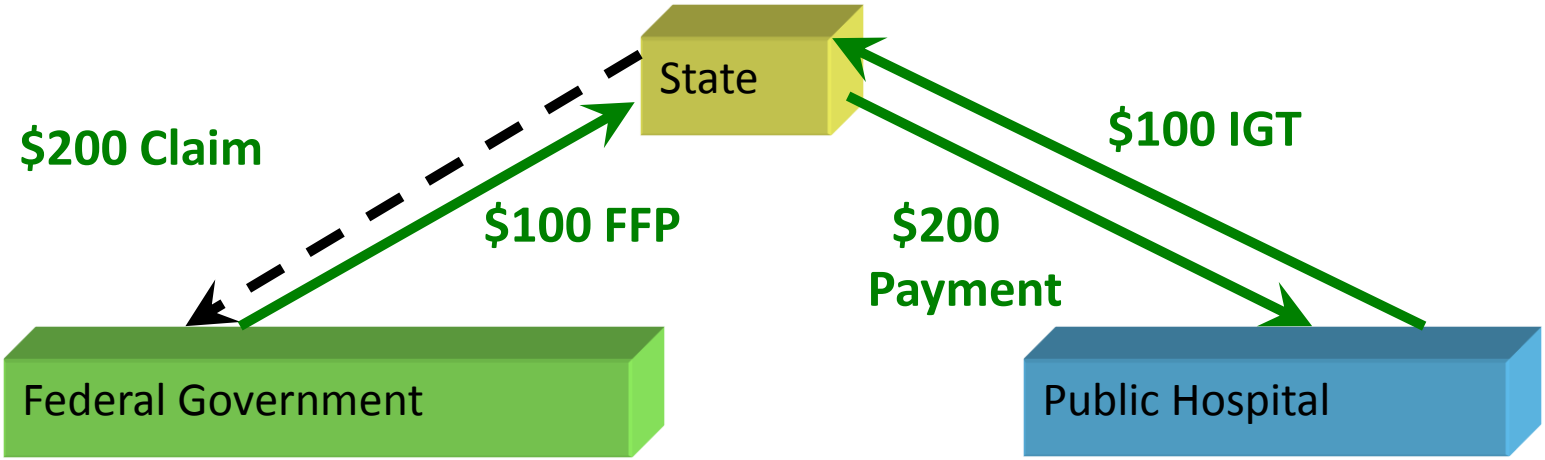
- General Revenues
- Intergovernmental Transfers
- Certified Public Expenditures
- Provider Taxes

INTERGOVERNMENTAL TRANSFERS (IGTS)

- IGTs Are transfers of funds from a governmental entity to the State Medicaid agency
  - » E.g., funds directly from a public hospital; local tax revenues; etc.
- State Medicaid agency uses the funds as the non-federal share of Medicaid expenditures

IGT MECHANICS

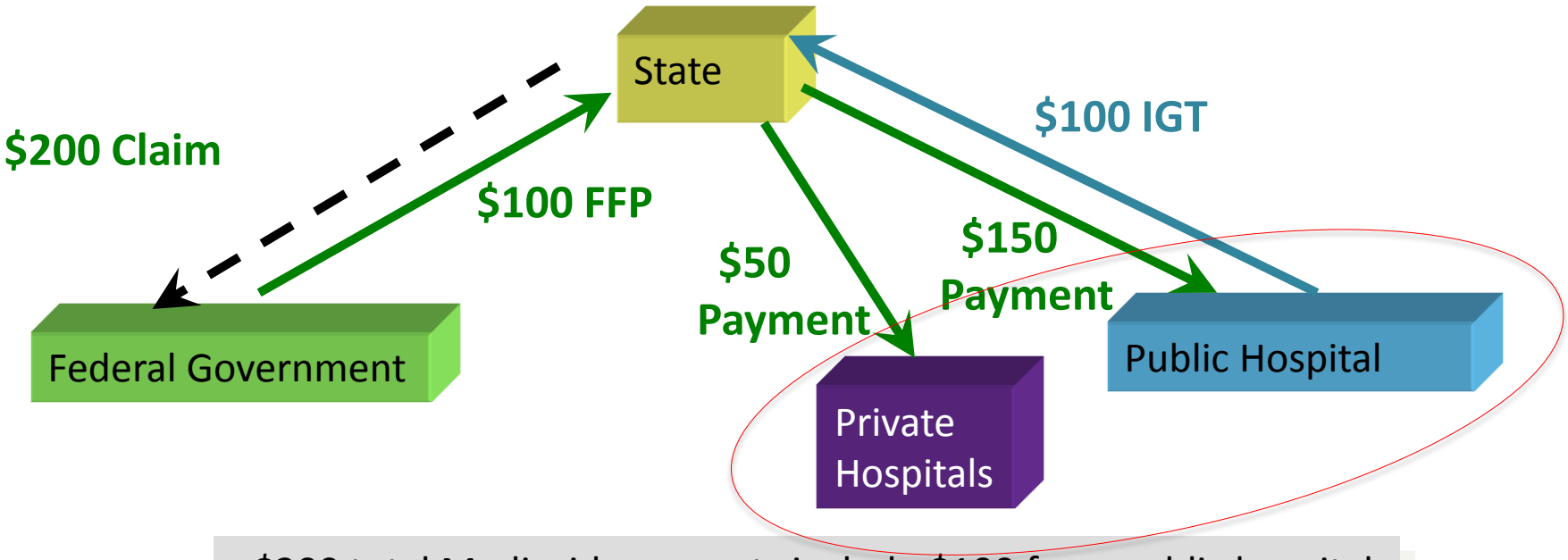
(Assumes 50% FMAP)



- $200 Medicaid payment includes $100 from public hospital and $100 from CMS
- No state general revenues
- **Public provider nets $100 (but is credited with receiving $200)**

PERMISSIBLE TO FUND PAYMENTS TO PRIVATE HOSPITALS

(Assumes 50% FMAP)



- $200 total Medicaid payments include $100 from public hospital and $100 from CMS
- No state general revenues
- Private hospitals receive total of $50
- **Public hospital nets $50 (but is credited with receiving $150)**

RENEWED CMS SCRUTINY OF PROVIDER-RELATED DONATIONS

- CMS will not provide federal match if expenditures funded by donations from private providers or provider-related entities
- Lack of clarity regarding rules
- State/arrangement-specific review and feedback
- CMS accountability guidance in May 2014
  - » Application to public-private partnerships
  - » The provision of a service or in-kind transfer of value by a private provider to “further the purposes of the government entity” may constitute an impermissible provider donation
- CMS using guidance to enforce changes

EXAMPLES OF PARTNERSHIPS INVOLVING POTENTIAL IMPERMISSIBLE DONATIONS FROM MAY 2014 GUIDANCE

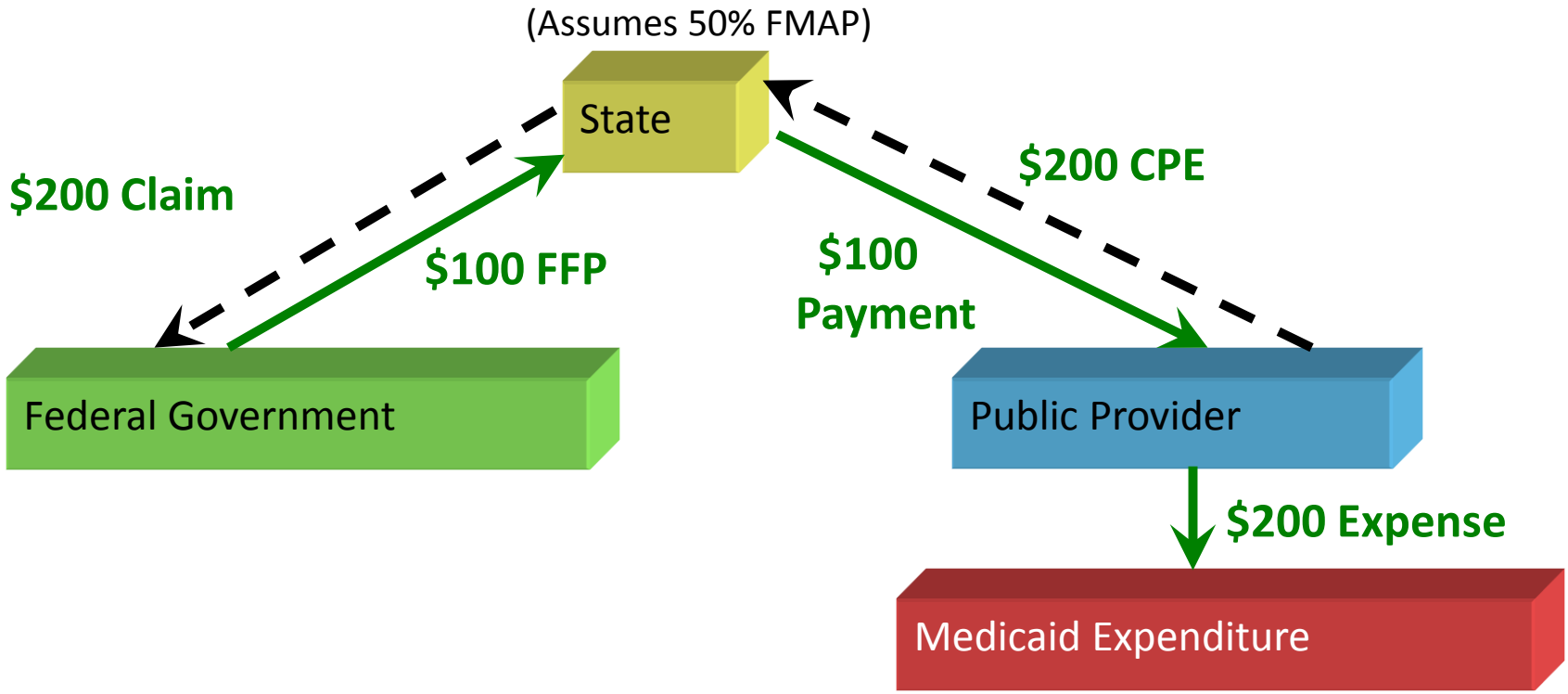
- Example 1
  - » Private hospital lease space from a government entity at an amount above fair market value
  - » Government entity uses lease payments to fund IGTs for the non-Federal share of Medicaid supplemental payments to the private hospital

- Example 2
  - » Government entity and private hospital enter public-private partnership arrangement
  - » Government entity terminates existing contract with a non-profit organization for certain services
  - » Private hospital executes the same contract with the same non-profit organization
  - » Government entity sends an IGT to Medicaid agency to fund Medicaid payments to the private hospital
  - » IGT is in an amount approximately equal to the amount that it would have spent on the now-terminated contract

CERTIFIED PUBLIC EXPENDITURES (CPES)

- Public entities certify that they have made expenditures eligible for federal match under the Medicaid State Plan
- Federal matching funds are provided for the federal share of such certified expenditures
- Difference from IGTs:
  - » Payments funded are based on cost
  - » CMS favors(ed)

CPE MECHANICS



- Public provider incurs $200 Medicaid expense
- Federal Government provides $100 FFP
- State passes $100 FFP to provider
- **Public provider nets $100 (but is credited with receiving $200)**

INCREASING USE OF PROVIDER TAXES

- Medicaid statute permits state or local governments to impose fees on certain categories of health care services/providers of health care services
  - » E.g., hospitals, nursing facilities, health plans

- In 2014, 49 states and DC used some form of tax (NCSL)

PREVALENCE OF HOSPITAL AND OTHER PROVIDER TAXES

Provider Class Taxed	# of states	
Hospital	38	AL, AZ, AR, CA, CO, CT, FL, GA, HI, ID, IL, IN, IA, KS, KY, ME, MD, MA, MI, MN, MS, MO, MT, NH, NJ, NY, NC, OH, OK, PA, RI, SC, TN, UT, VT, WA, WV, WI
ICF	37	AR, CA, CO, CT, DC, FL, GA, ID, IL, IN, IA, KY, LA, ME, MD, MN, MS, MO, MT, NE, NJ, NY, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI
Nursing Facility	44	AL, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IO, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NY, NC, OH, OK, OR, PA, RI, TN, UT, VT, WA, WV, WI, WY
Other	24	AL, AR, CA, DC, IL, KY, ME, MD, MA, MN, MS, MO, NH, NJ, NM, NY, PA, RI, TN, TX, VT, WV, WI (FY2011- MCO, 9 states: AZ, DC, MD, MN, NJ, NM, RI, TN, TX)

Source: KFF, FY2014, 2015
MCO data, Smith et al, 2011

FEDERAL REQUIREMENTS, FLEXIBILITY

- Broad-based
  - » Can exclude publics without a waiver
- Uniformly imposed
  - » But a number of options for tax base (revenues, beds, days, etc.)
- No hold harmless
  - » “Safe harbor” if tax rate 6% or less of net patient revenues received by taxpayer
- CMS can waive if meet tests

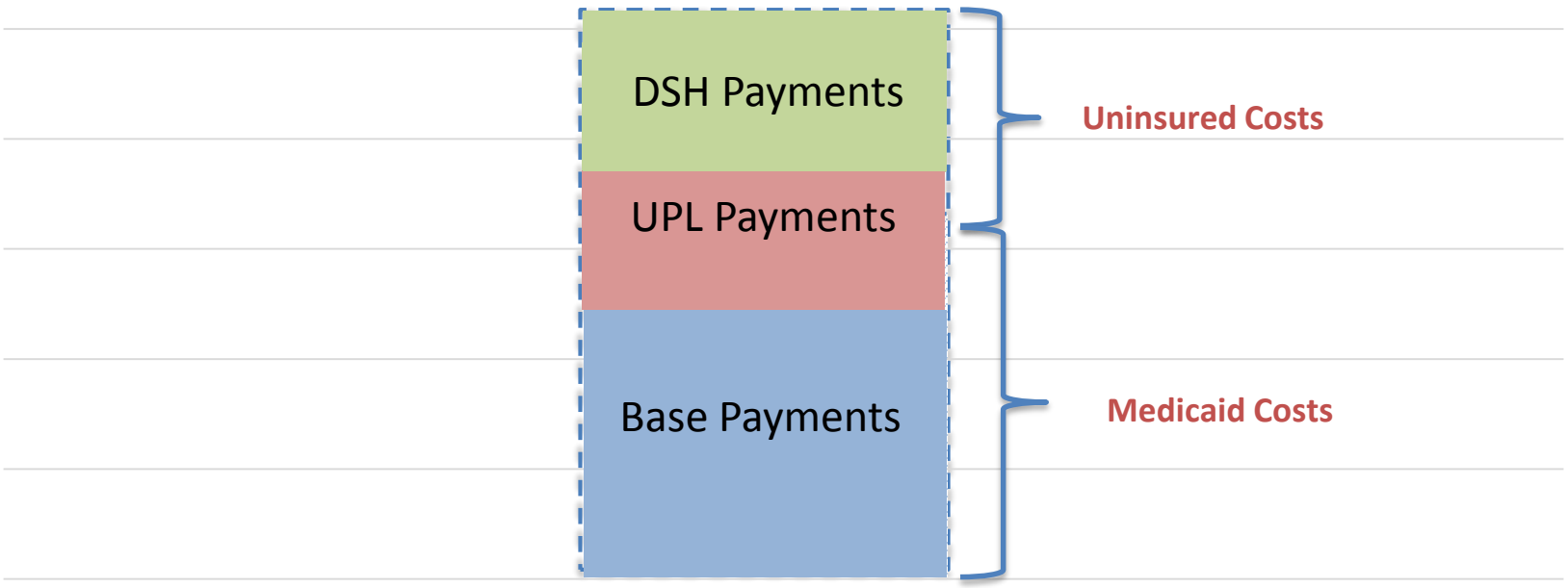
- “Winners” and “Losers”

DOUBLE-EDGED SWORD OF MEDICAID FINANCING

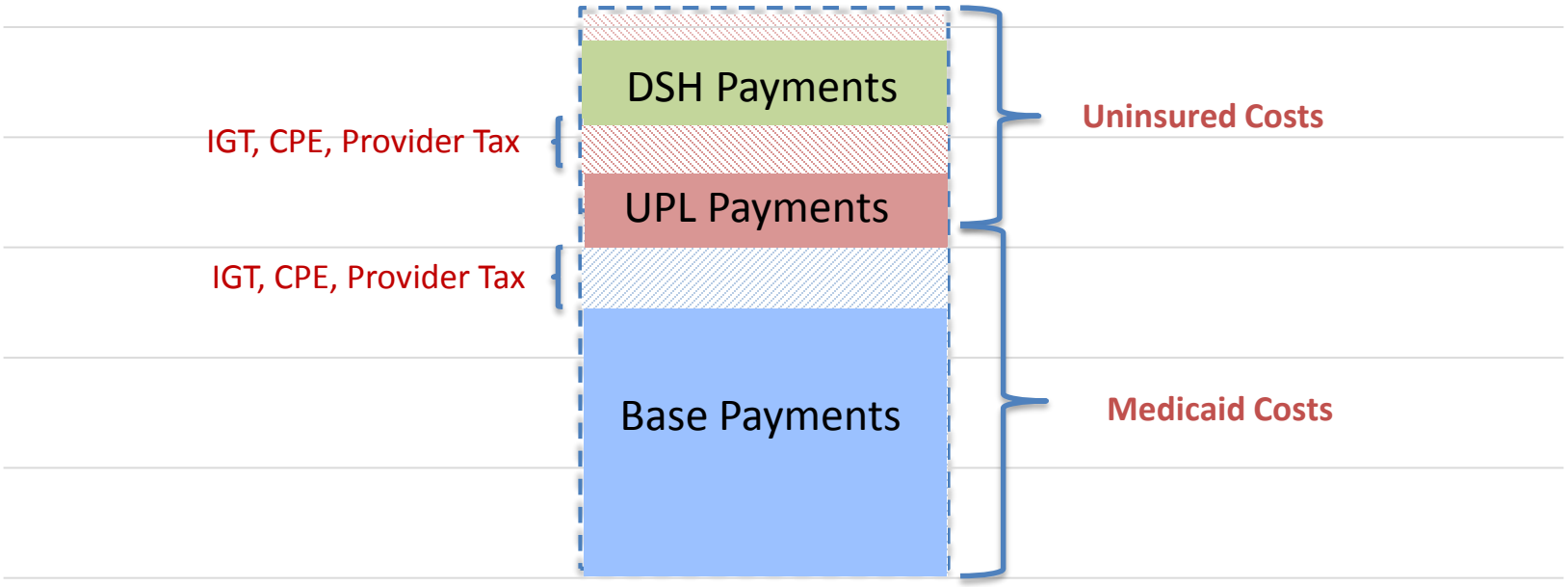
Critical to the receipt supplemental payments

Enables states to continue underfunding the Medicaid program

PUTTING IT ALL TOGETHER: SUPPLEMENTAL PAYMENTS STILL DON'T COVER THE COST OF CARE



PUTTING IT ALL TOGETHER: SUPPLEMENTAL PAYMENTS STILL DON'T COVER THE COST OF CARE



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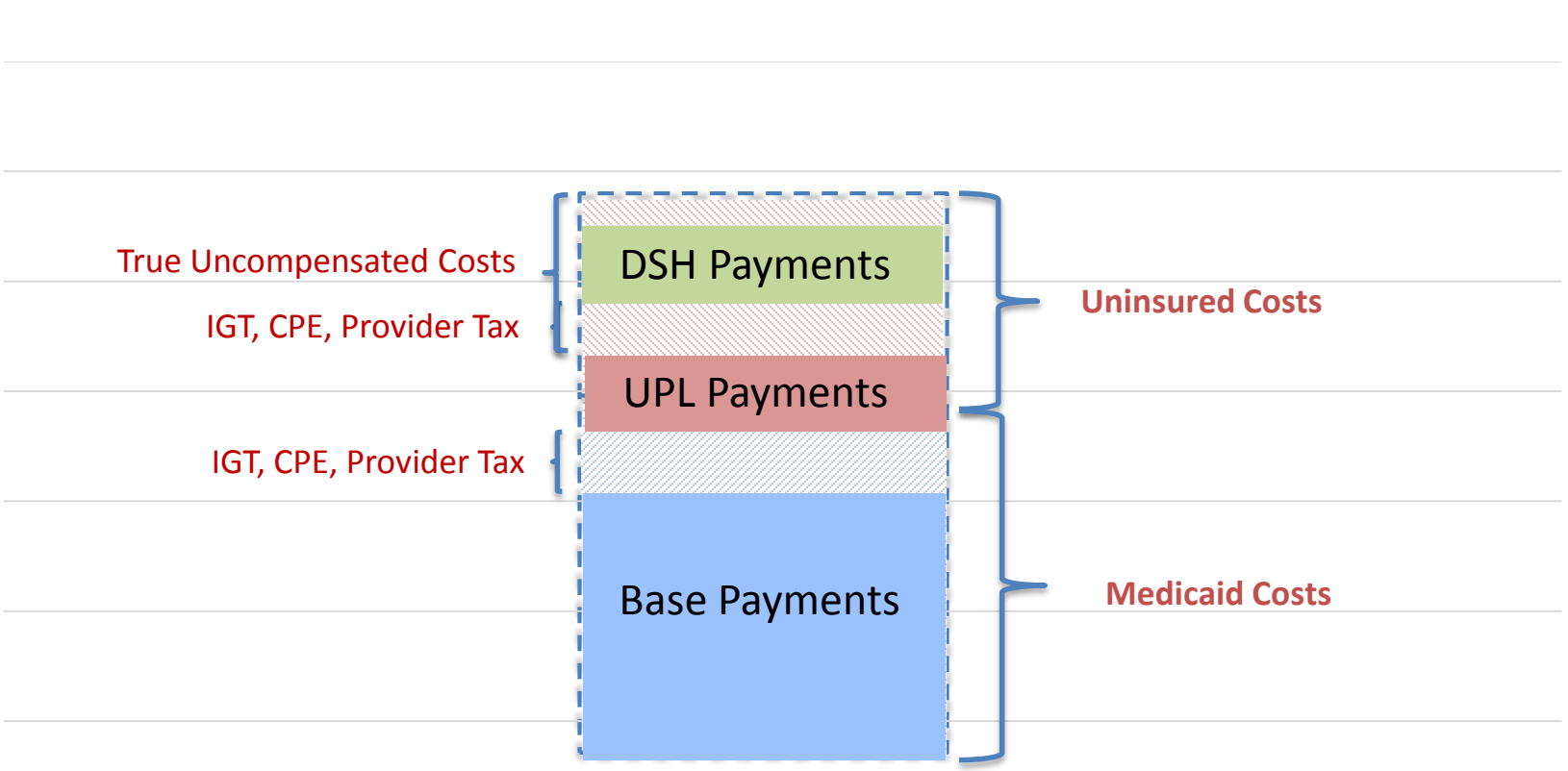
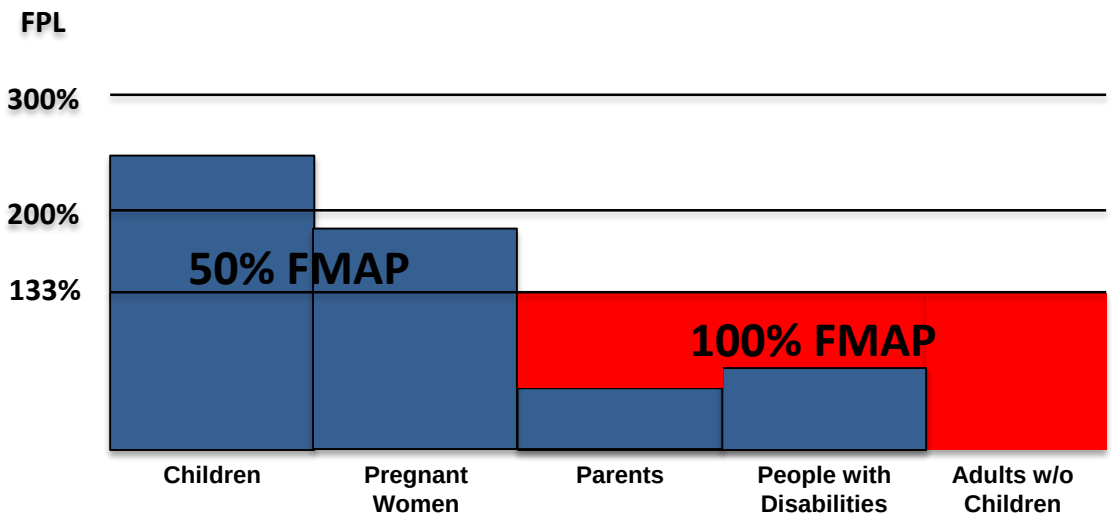


A PIECE OF GOOD NEWS (FOR SOME OF YOU)

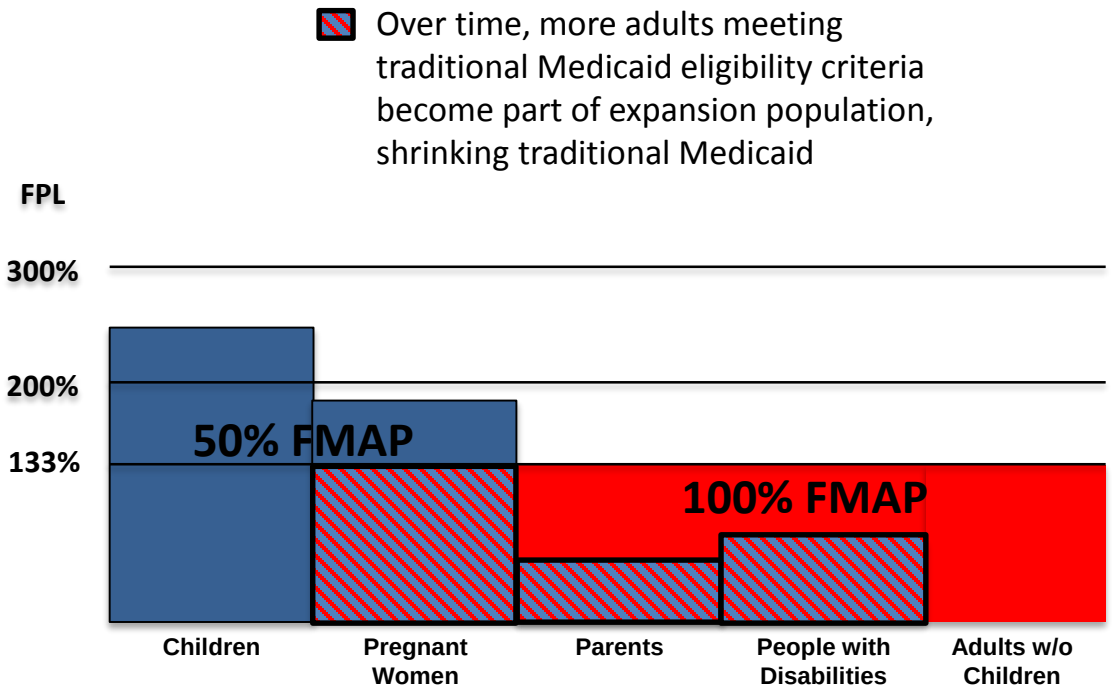
- Higher federal matching rate for expansion population
- Applies to non-DSH supplemental payments for services
  - » (DSH traditional FMAP)
- Reduced non-federal share financing obligation *or* higher payments for same amount

FMAP for Newly Eligible	
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
Thereafter	90%

DIFFERING FMAP RATES BY POPULATION



COVERAGE SHIFTS OVER TIME TO EXPANSION GROUP



Conclusion

SHARED DESIRE TO CHANGE MESSY SYSTEM

- Work to develop sustainable, adequate support for all missions

BUT, IN THE MEANTIME, ESSENTIAL HOSPITALS CANNOT SUSTAIN BARRIERS ACROSS MEANS OF SUPPORT

- Renewed scrutiny and potential proposals to limit FFS UPL payments
- No direct supplemental payments for MC services
- No indirect state direction of enhanced payments through MC plans, except limited circumstances
- Transition out uncompensated care pools
- Uncertain future of DSRIPs
- Medicaid and Medicare DSH cuts
- Double-edged sword of local financing
- Scrutiny of public/private Medicaid financing
- 340B-related challenges

QUESTIONS?

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