

Safety Net Hospital Financing 201

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Safety Net Hospital Financing 201



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Systems



March 19, 2013

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Agenda

- **Sources of Funding for Unreimbursed Care**
 - NAPH Member Financing Sources
 - Medicaid DSH
 - Medicare DSH
 - Other Medicaid Support Payments
- **Financing the Non-Federal Share of Medicaid Payments**
- **Ongoing Challenges to the Safety Net**

Safety Net Held Together by Medicaid and Other Federal Support Systems

■ Medicaid

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

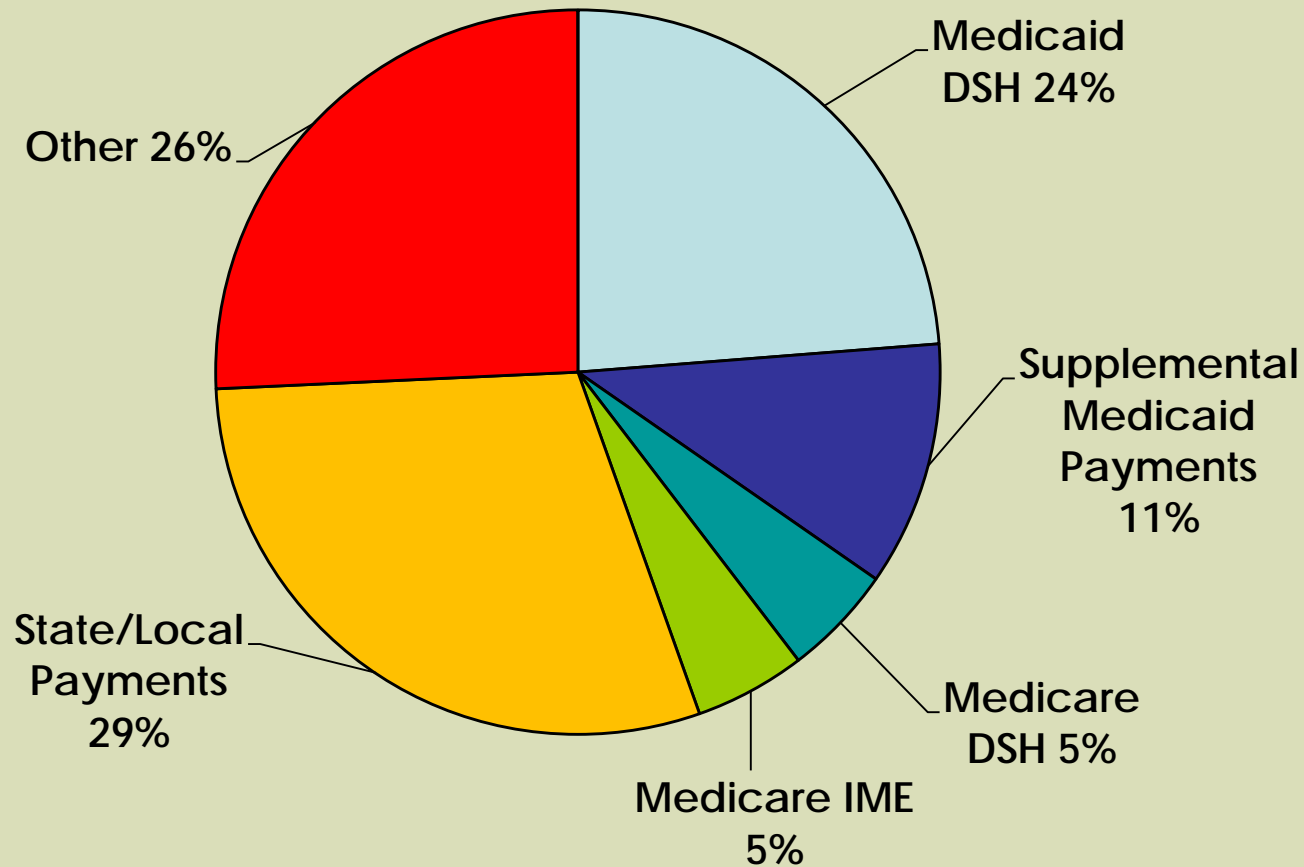
■ Medicare

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

■ Federally Qualified Health Centers

■ State/Local Support

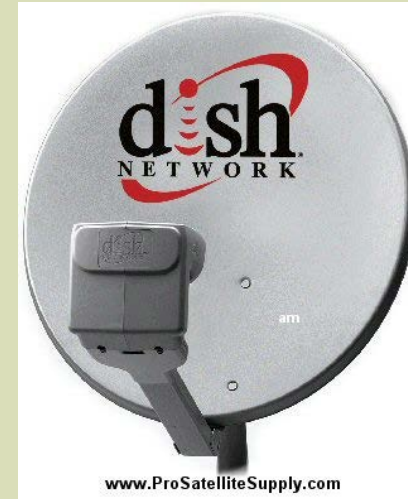
Financing Unreimbursed Care at NAPH Hospitals



Source: NAPH Hospital Characteristics Survey, FY 2010

Medicaid DSH

Medicaid DSH



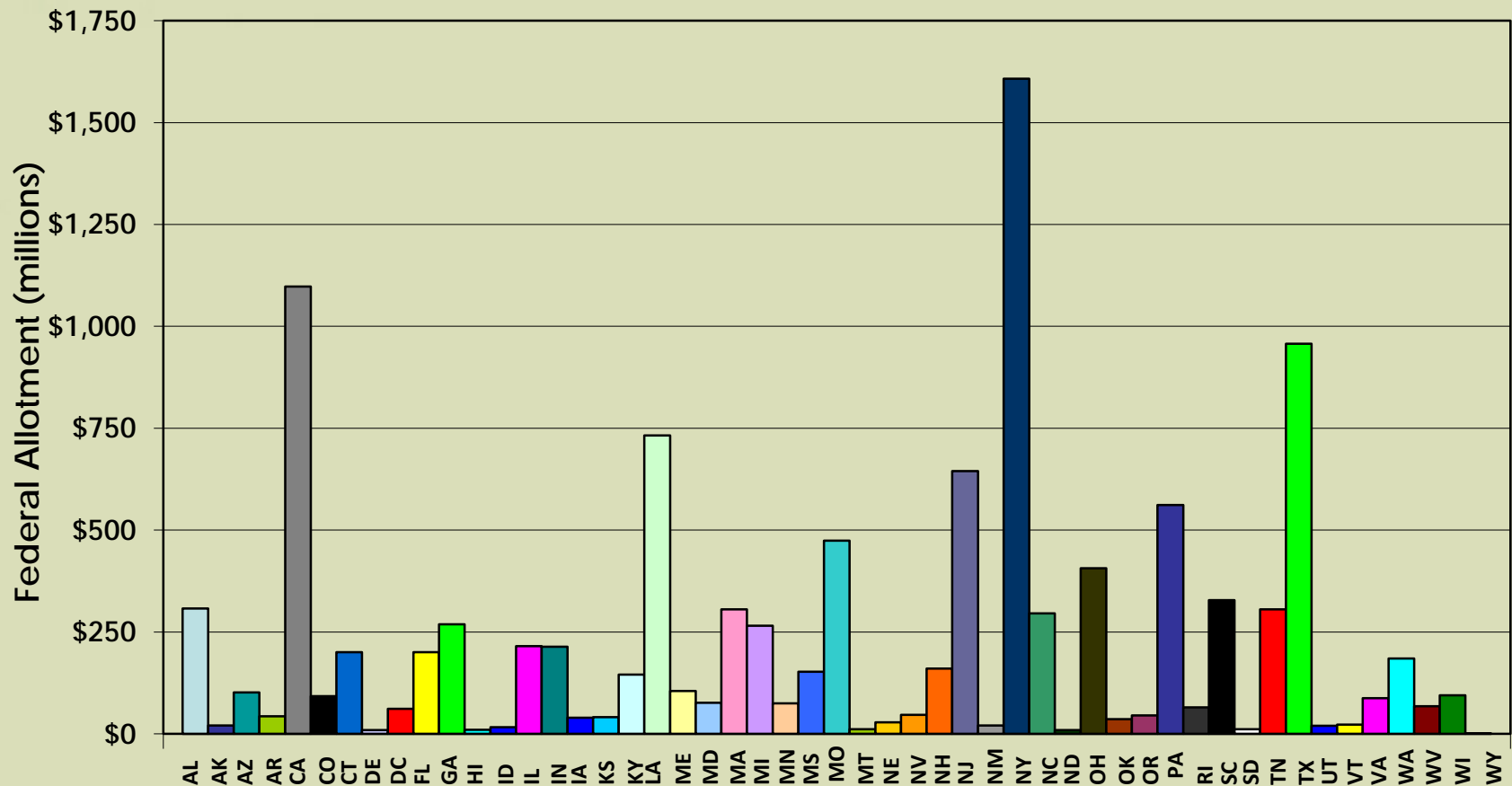
- Only Explicit Medicaid Payment for the Uninsured
- Two Federal Limits:
 1. Hospital-Specific DSH Limits
 2. State Allotments

Hospital-Specific DSH Limits

- Based on unreimbursed costs for Medicaid and uninsured patients
- Now subject to independent audit
 - Restrictive policies on eligible costs
 - May have changed DSH allocations *within* states
 - State-by-state audit results available on CMS website (2005-2008)
- Has enhanced accountability and transparency



Federal DSH Allotments by State (FY 11)



- Picture may change after DSH cuts implemented
 - Depends on CMS methodology expected this spring

State Variation in Use of DSH Funds

- States Have Broad Discretion in Allocating DSH Funds
- DSH Programs Designed to Meet Local Needs, e.g.:
 - Disperse broadly
 - Support specific services (trauma, GME, primary care, etc.)
 - Target on high volume safety net hospitals
 - *Targeting may change based on CMS guidance implementing DSH cuts*
- Through Waivers, DSH Funding Has Been Converted to Coverage
 - Ex. Tennessee, Indiana, Massachusetts

Health Reform and Medicaid DSH

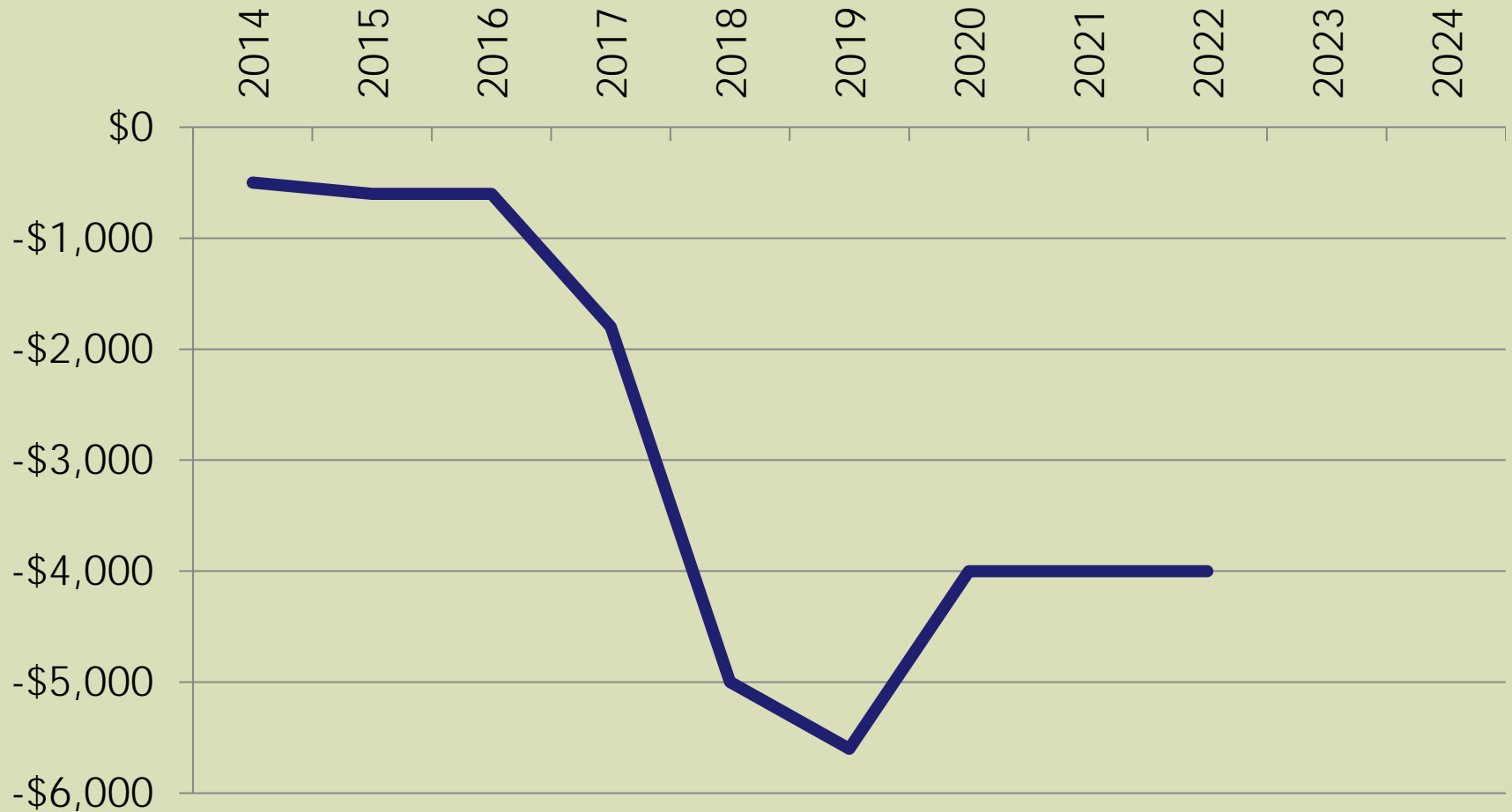
- Payments reduced in ACA to fund expanded coverage
- But 29 million uninsured remain in 2019 (after Supreme Court decision)
- Amount of DSH cuts baked into the law

DSH Allotment Cuts	
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
2021	\$4.1 billion
2022	\$4.2 billion

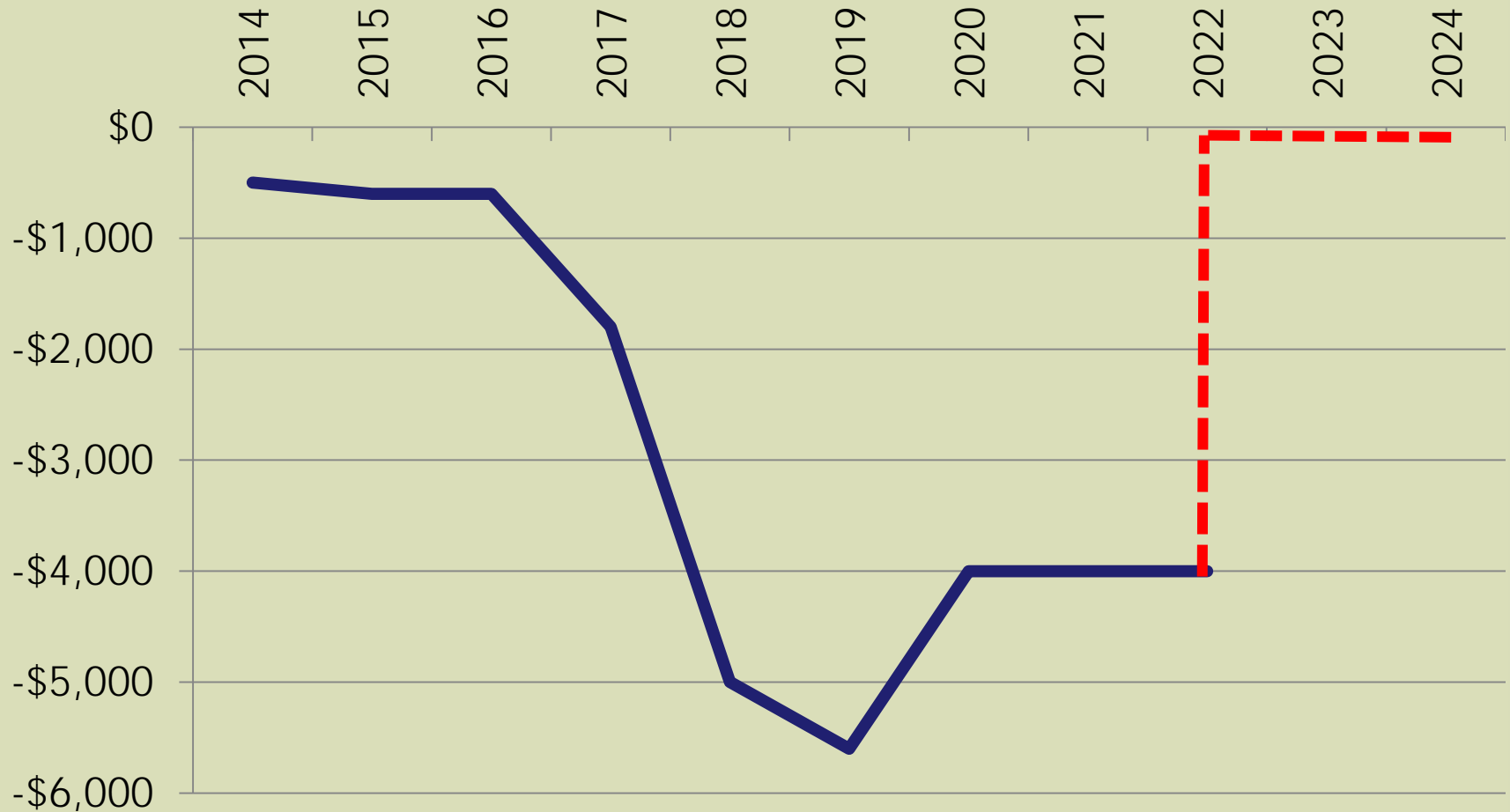
DSH “Rebasing”

- Congress has continued to use savings from maintaining reduced level of DSH allotments– “DSH rebasing”
- \$4 billion/year in rebasing
- Funds become available at the start of each fiscal year
- 2021 and 2022 rebasing funds used for SGR fix

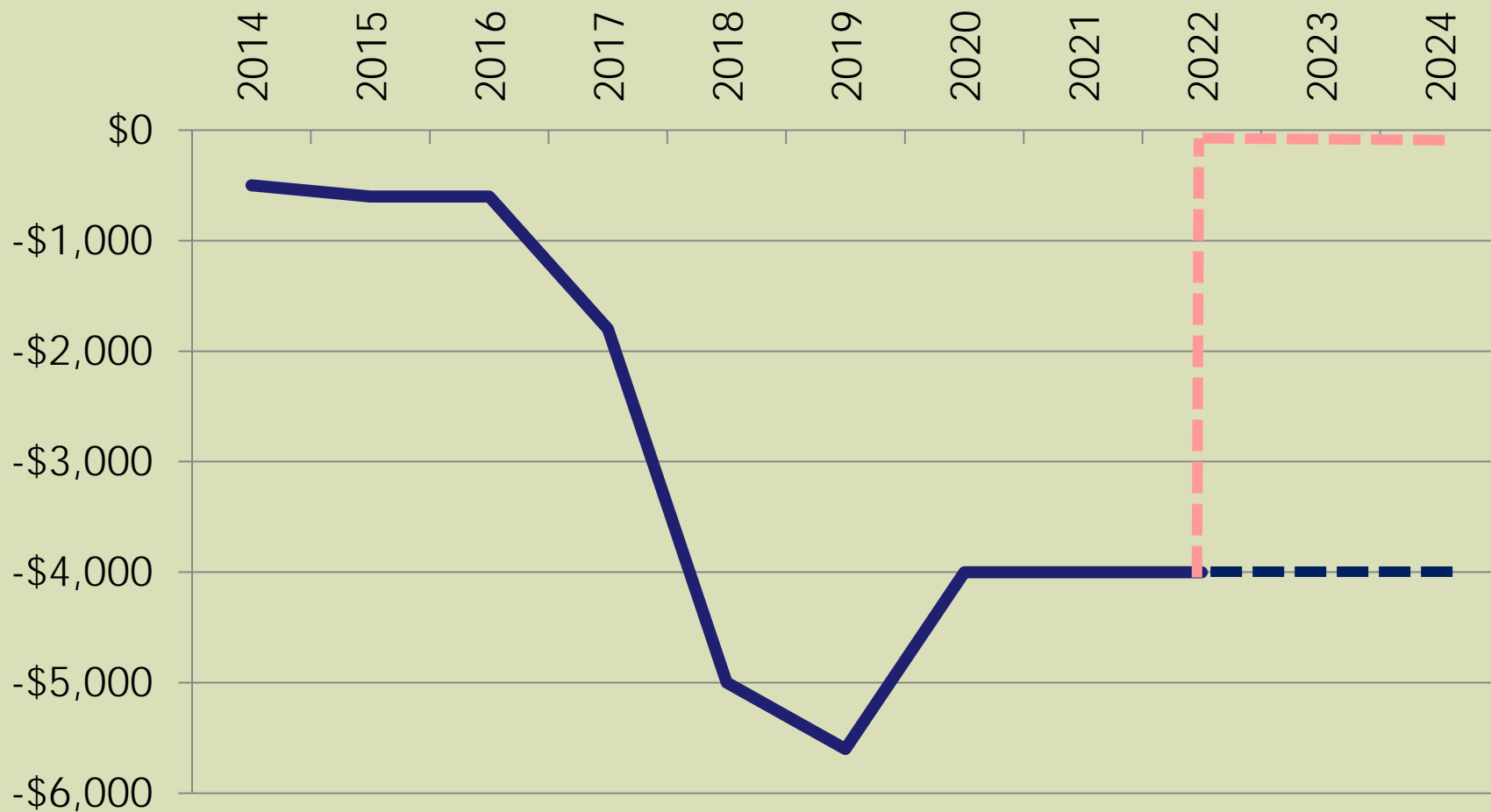
DSH Allotment Cuts



DSH Allotment Cuts (current law)



DSH Allotment Cuts (with rebasing)



Implementing the ACA Medicaid DSH Cuts

- ACA cuts are aggregate nationwide
- CMS to issue a rule this spring to implement methodology allocating cuts among states:
 - Largest reductions to states with low % of uninsured and/or that do not target DSH payments
 - Low DSH states will receive smaller reductions
 - Consider if state allotments used for coverage
- Once rule issued, expect advocacy by states with highest cuts
- Response by state legislatures to avoid future cuts?

Medicaid DSH Advocacy Issues: What You Could Encounter

- **Ongoing need for DSH?**
- **How to handle non-expansion states?**
 - Punish with higher DSH cuts?
 - Minimize cuts due to higher need for DSH?
- **Use of DSH rebasing savings**
 - Reduce DSH cuts?
 - Retain in Medicaid?
 - Preserve for hospitals?
- **DSH Transparency**
 - What is DSH????

Medicare DSH

Medicare DSH

- **Medicare add-on payment for hospitals serving a disproportionate share of low-income patients**
 - \$11 billion nationwide
 - Current formula based on Medicare/SSI & Medicaid days
 - Uninsured/uncompensated care does not count
- **Hospitals with high Medicaid and high Medicare receive greatest DSH funding under current formula**
 - But low Medicare hospitals receive little DSH, even if DSH % is high
 - And high Medicare, low uninsured/Medicaid may still receive significant DSH
- **MedPAC: DSH payments are poorly targeted**

Health Reform and Medicare DSH Payments

- **Reduces Medicare DSH payments by an estimated \$22 billion over ten years beginning 2014**
 - Current DSH payments reduced to 25%
 - Portion of 75% cut funds restored through payment based on uncompensated costs
- **Hospitals with high uncompensated care receive greatest DSH funding under new formula**
 - Optional Medicaid expansion affects distribution of UCC across states
- **Regulation expected April 2013**
 - Medicare IPPS Proposed Rule

Medicare DSH Advocacy Issues: What You Could Encounter

- CMS rule will produce big losers, minimal losers and maybe some winners
- Supreme Court Medicaid decision has significant impact on Medicare DSH
 - Greater portion of Medicare DSH dollars will go to hospitals in non-expanding states
- Expect technical issues to impact amount of cuts for your hospital
 - Does uncompensated care include Medicaid shortfall?
 - Will CMS take into account cost of provider taxes in determining UC? Intergovernmental transfers?

Other Medicaid Support Payment Programs

“Non-DSH” Medicaid Support

(*aka “UPL”*)

- **State flexibility in setting payment rates in Medicaid**
- **Low payment rates are often supplemented by additional targeted payments**
 - Sometimes called UPL payments because they are subject to the “Upper Payment Limit”
 - Financing is typically not State general revenues
- **Support Payments Take Many Forms**
 - GME, IME payments
 - Trauma payments
 - Teaching physicians
 - Primary care payments
 - Safety net payments
 - *Other*

Challenges to Medicaid Support Payments

- **GAO report (Nov. 26, 2012)**
 - Called for additional transparency like Medicaid DSH reporting
 - Concluded better reporting and audits could improve CMS oversight
 - Based on DSH audit data, determined hospitals paid \$2.7 billion above cost
- **Congress is not seeking savings or reforms in Medicaid support payments ... for now**
- **Congress does not understand them**
 - Lack of transparency
 - What are they for? Why are they important?

Challenges to Medicaid Support Payment Under Managed Care

- States are expanding MC for current and expansion populations
- Challenges to maintaining/creating supplemental payment programs
 - State cannot make supplemental payments directly to providers for services under MCO contract
 - Exception for GME and DSH
 - As managed care expands, supplemental payments are threatened

Waiver-Based Payments

■ Uncompensated Care Payment Pools

- Uncompensated costs Medicaid and uninsured
- Costs of services beyond DSH
- CMS willingness to continue past 2014? More accountability?

■ Delivery System Reform Incentive Pools

- Payments for achieving negotiated milestones in delivery system improvement
- Significant investment
- CMS willingness to approve more pools? Changes in structure or expectations?

■ What's next??

Financing the Non-Federal Share of Medicaid Payments

Financing the Non-Federal Share of Medicaid Payments

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

Provider Taxes

- For FY 2013, 49 states and DC have at least one Medicaid provider tax (KFF, Oct. 2012)
 - 39 states have hospital provider taxes
- Often the only option to ensure adequate rates
 - Recession increased reliance on provider taxes
 - But complex federal rules can make it challenging to obtain industry support
- Public hospitals can and often are exempted
 - Separate public hospital deals can make state-level advocacy challenging
- Some state legislatures recoil from the “T” word



Challenges to Provider Taxes

- **Provider Taxes have been on the chopping block for deficit reduction**
 - Less tax revenue to fund Medicaid= lower federal matching costs
 - Lingering concerns about financing “schemes”
- **No Immediate threat in Congress**
 - Admin/Dems don't want to take away financing option for expansion
 - R's seeking more comprehensive entitlement reform (see Ryan budget)
 - But....

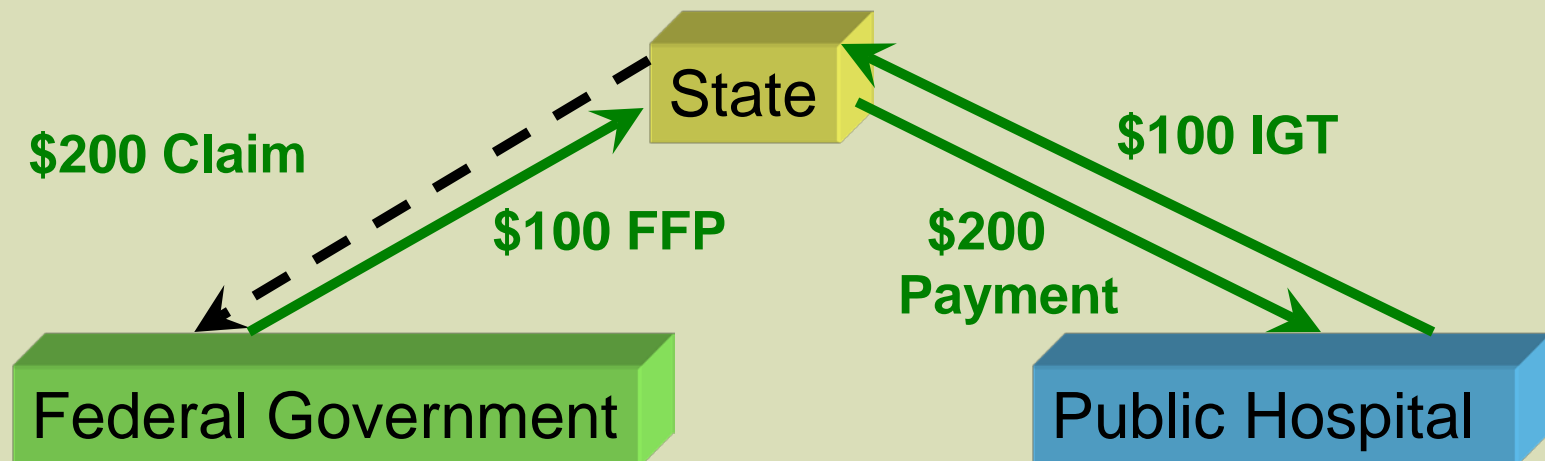


Intergovernmental Transfers (IGTs)

- **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)



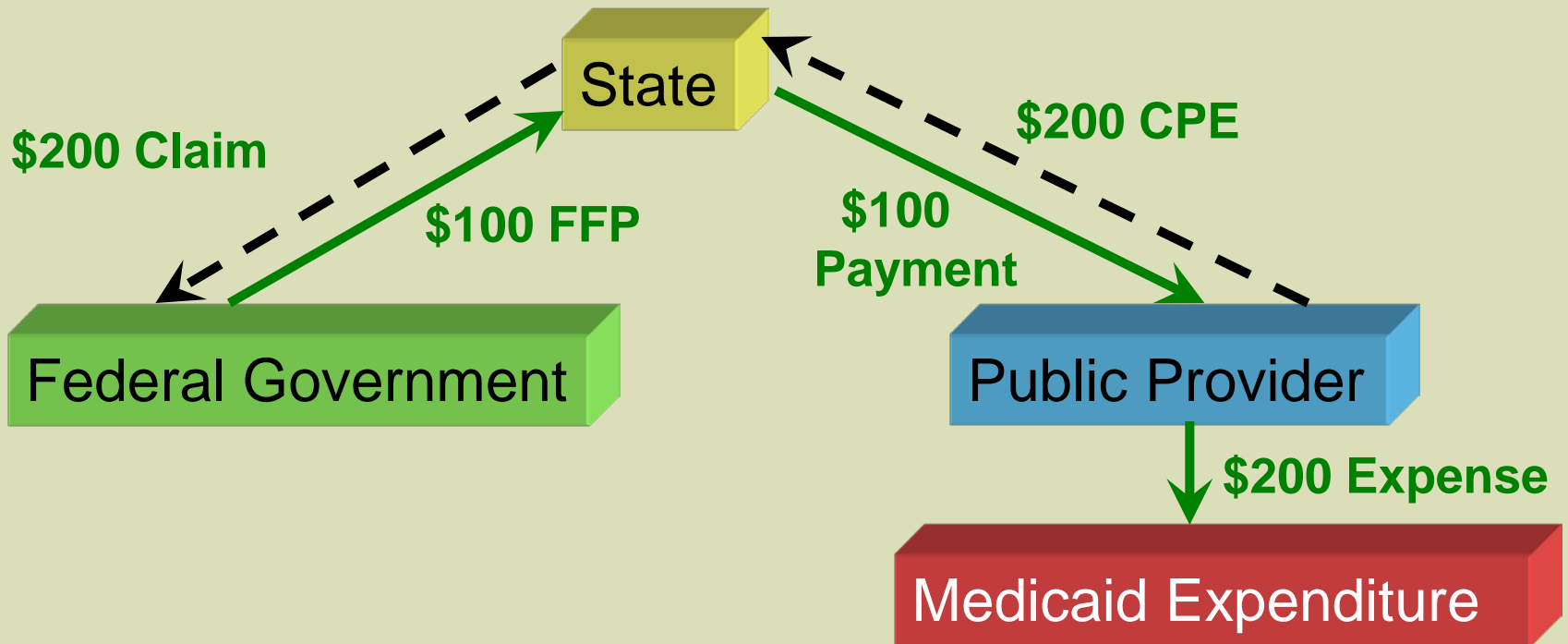
- \$200 Medicaid payment includes \$100 from public hospital and \$100 from CMS
- No state general revenues
- **Public provider nets \$100 (but is credited with receiving \$200)**

Certification of 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

CPE Mechanics

(Assumes 50% FMAP)



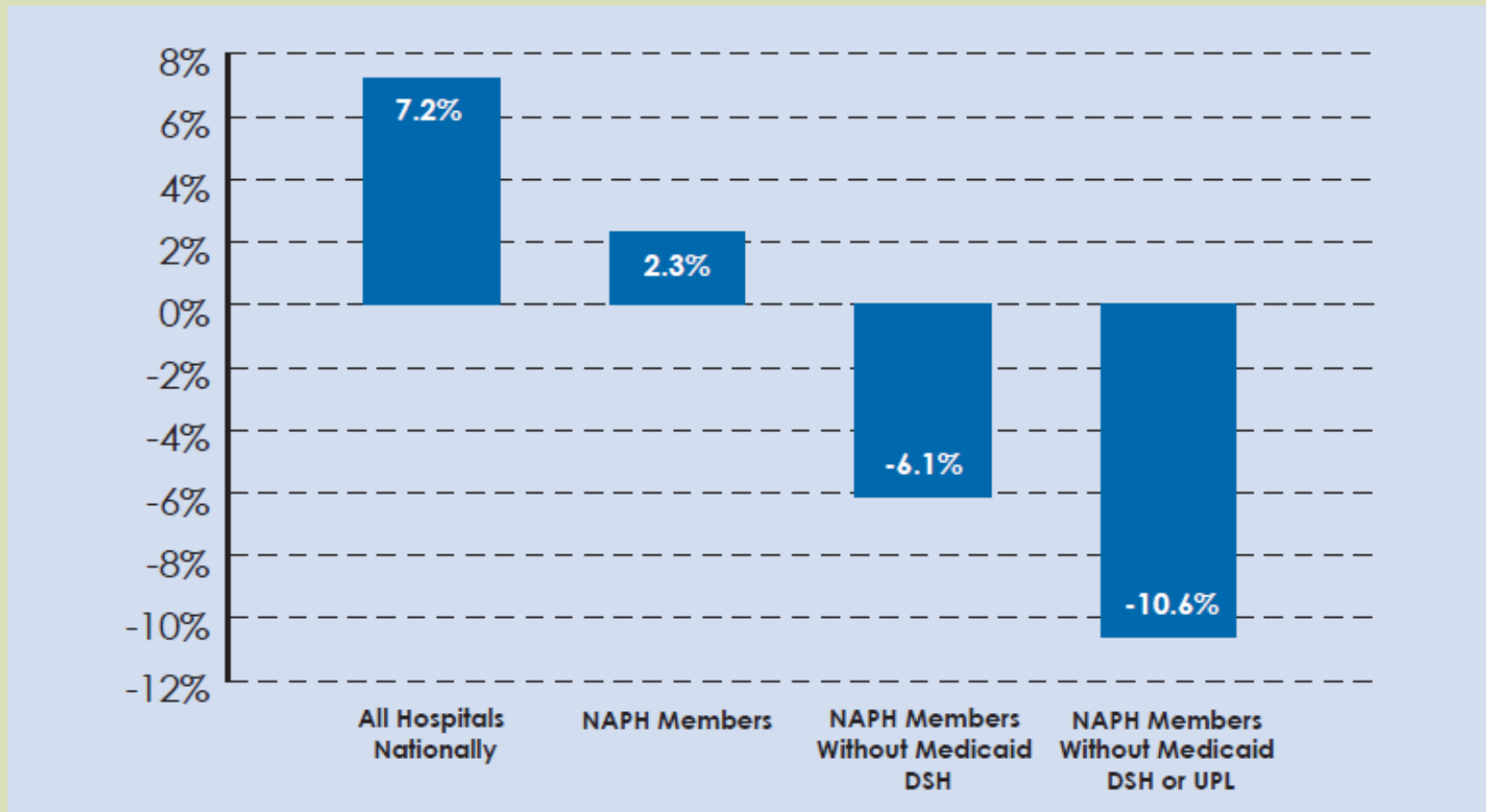
- Public provider incurs \$200 Medicaid expense
- Federal Government provides \$100 FFP
- State passes \$100 FFP to provider
- Public provider nets \$100 (but is credited with receiving \$200)**

Safety Net Financing Under Increasing Regulatory and Transparency Requirements

- 1991 Voluntary Contribution and Provider-Specific Tax Amendments (includes DSH allotments)
- 1993 Omnibus Budget Reconciliation Act "OBRA '93" (hospital-specific DSH caps)
- 1997 Balanced Budget Act (lower DSH allotments)
- 2001 Upper Payment Limit Regulations
- 2002 More UPL Regulations
- 2003 Medicare Modernization Act (DSH cliff relief; DSH audit requirement)
- 2003-current CMS steps up oversight of financing mechanisms
- 2007 Medicaid regulations (public provider cost limit/IGT rule, GME rule, outpatient rule, provider taxes, etc.)
- 2008 DSH Audit Rule finalized
- 2009 Recovery Act (DSH bump; IGTs must be voluntary)
- 2010 Affordable Care Act (DSH cuts)

Importance of DSH and UPL Payments

Hospital Margins, 2010



Source: NAPH Hospital Characteristics Survey, 2010 Data

Ongoing Challenges to the Safety Net

- Sequestration cuts
- Deficit reduction vulnerabilities (E&M, IME, bad debt, DSH rebasing, broader entitlement reform)
- Coverage expansion – net benefit or loss?
 - Lingering uninsured
 - Ongoing disproportionate UC burden
 - Adequacy of Exchange payment rates
 - Medicaid & Medicare DSH cuts/other cuts
- Persistent Medicaid underpayment
- Increasing reliance on provider financing sources
- CMS shift to incentive-based funding
 - No free lunch
- Safety net financing remains critical!

NAPH as a Resource

- Designing policy proposals centered around preserving federal support in changing environment
 - And to protect NAPH member interests as legislative proposals emerge (particularly around deficit reduction and entitlements)
- Government relations calls to inform you about current federal issues and learn about your most pressing concerns
- Knowledge of state-level issues and solutions across states and membership
- Facilitating dialogue with other members like you

Questions?

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