Safety Net Hospital Financing 201

National Association *of* Public Hospitals *and* Health Systems

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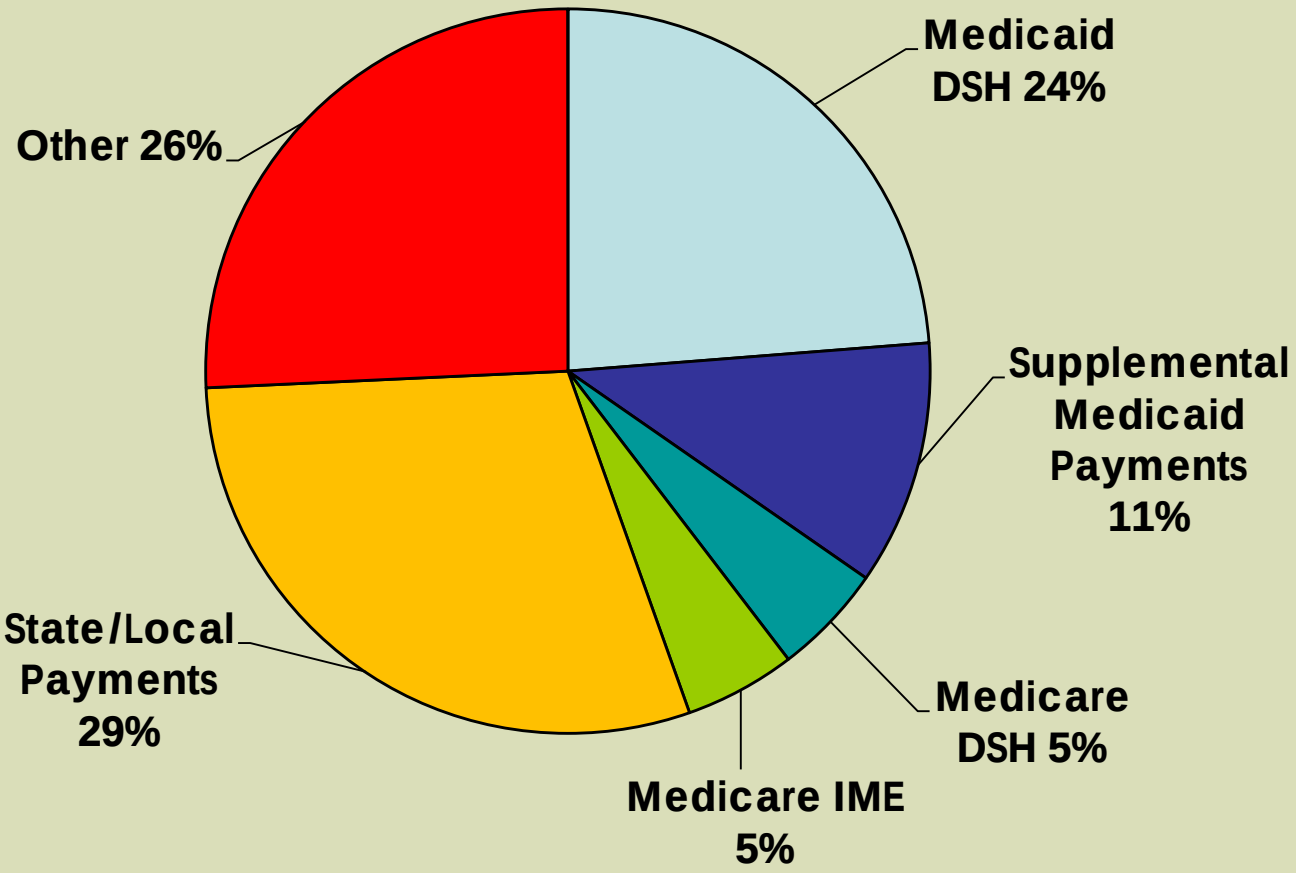
Agenda

- **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

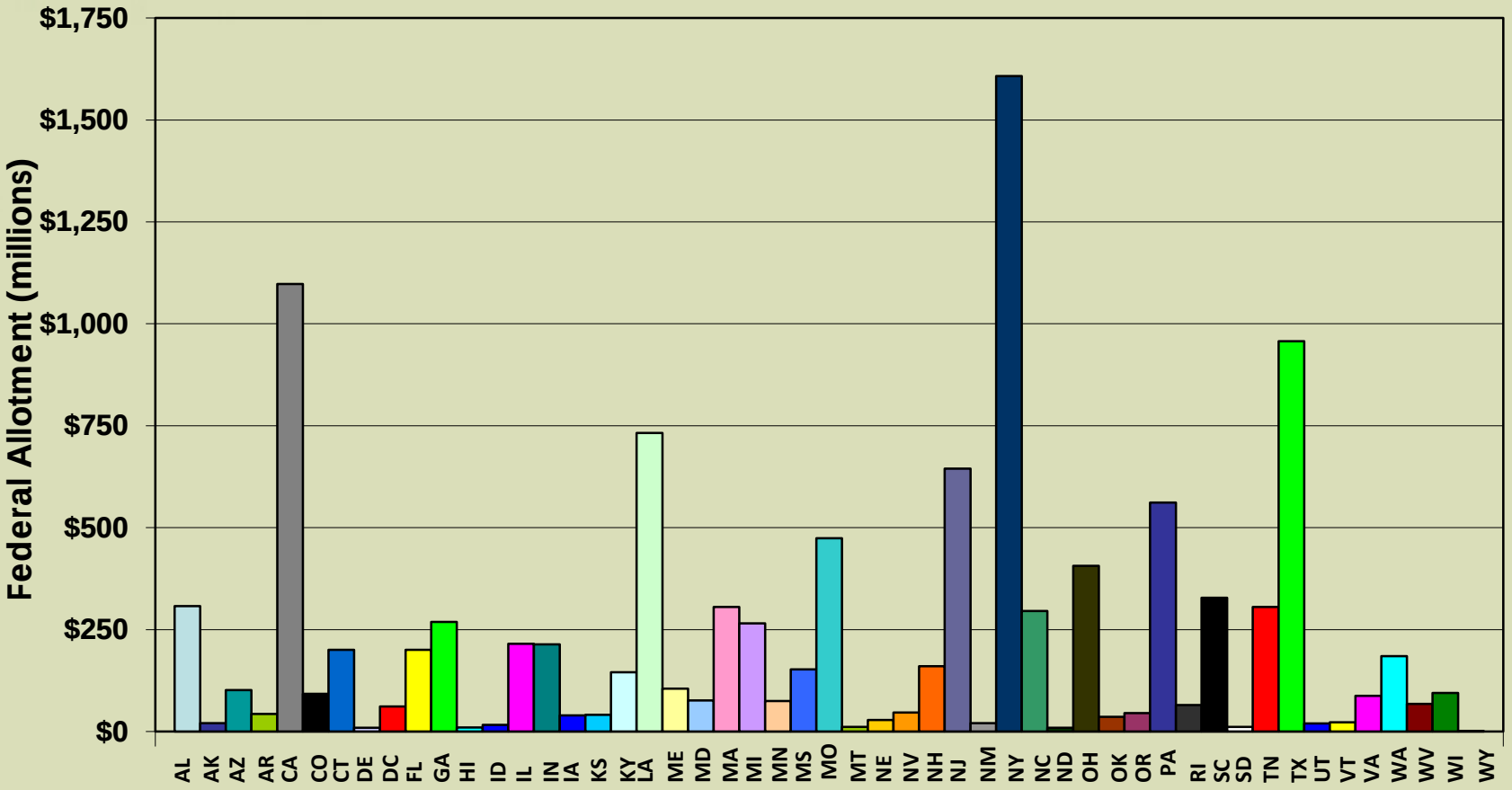
Medicaid DSH

- **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

Source: Federal Register , Jan. 3, 2011.

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

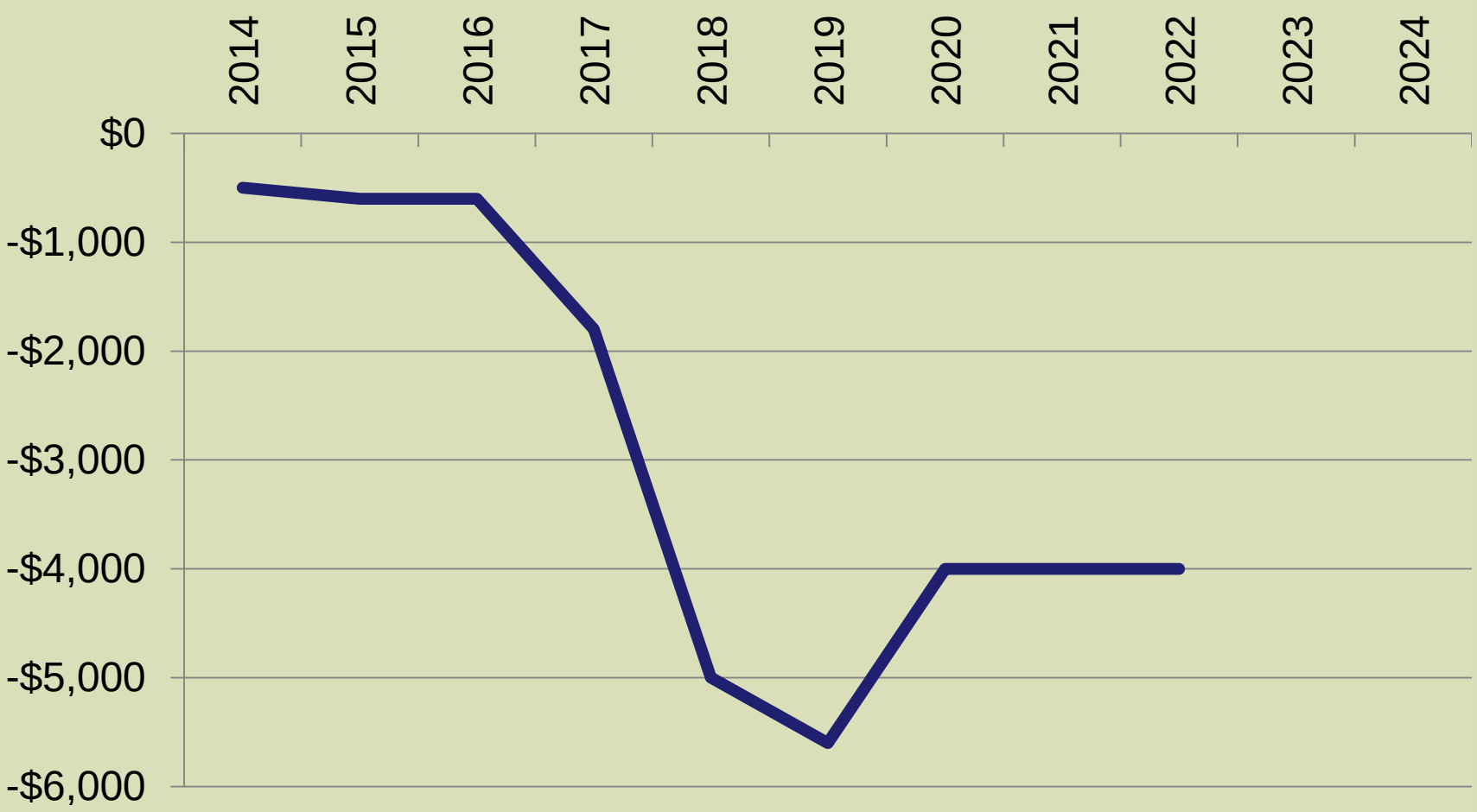
- **Payments reduced in ACA to fund expanded coverage**
- **But 29 million uninsured remain in 2019 (after Supreme Court decision)**
- **Amount of DSH cuts baked into the law**

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

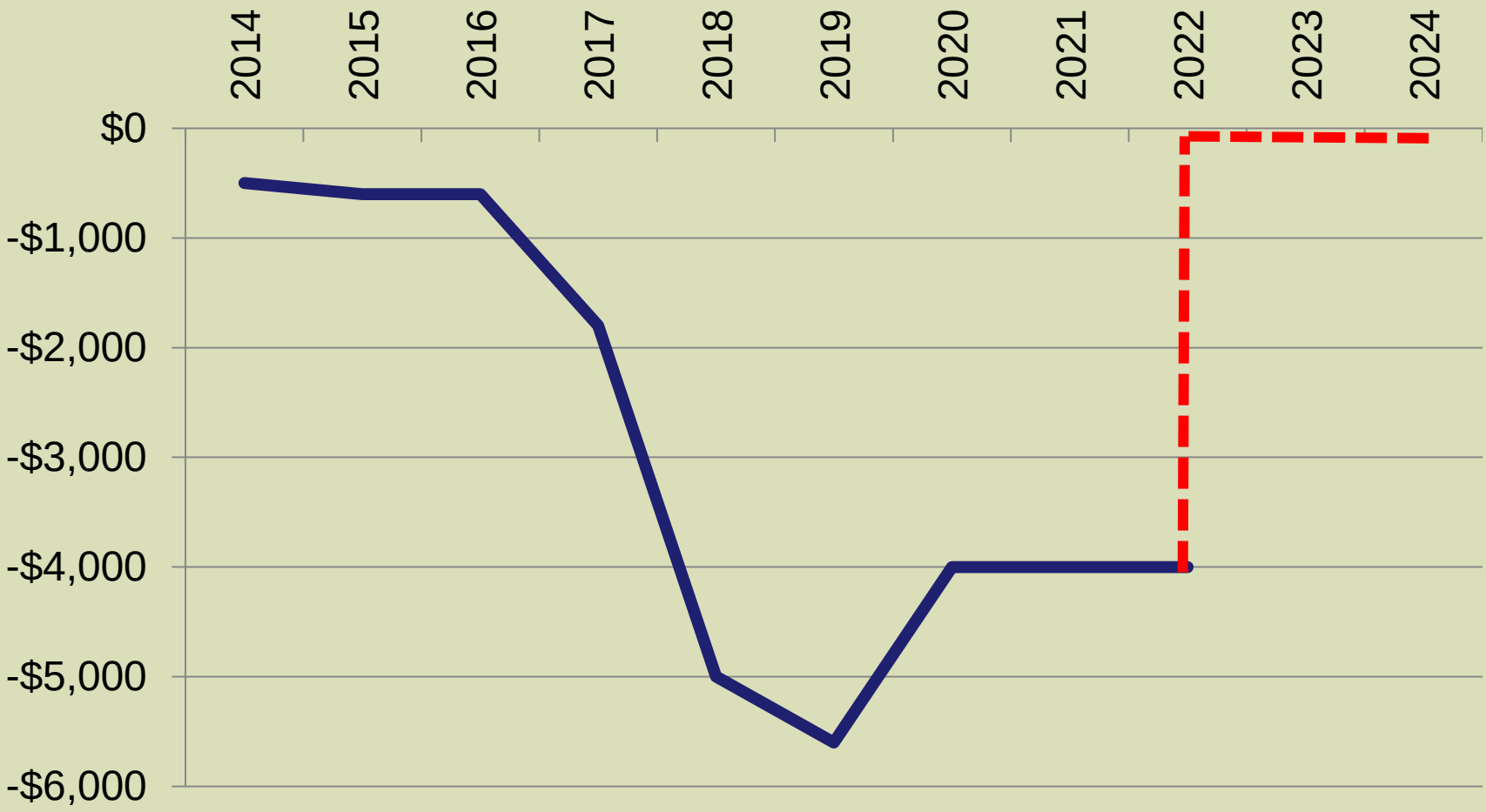
DSH "Rebasing"

- 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

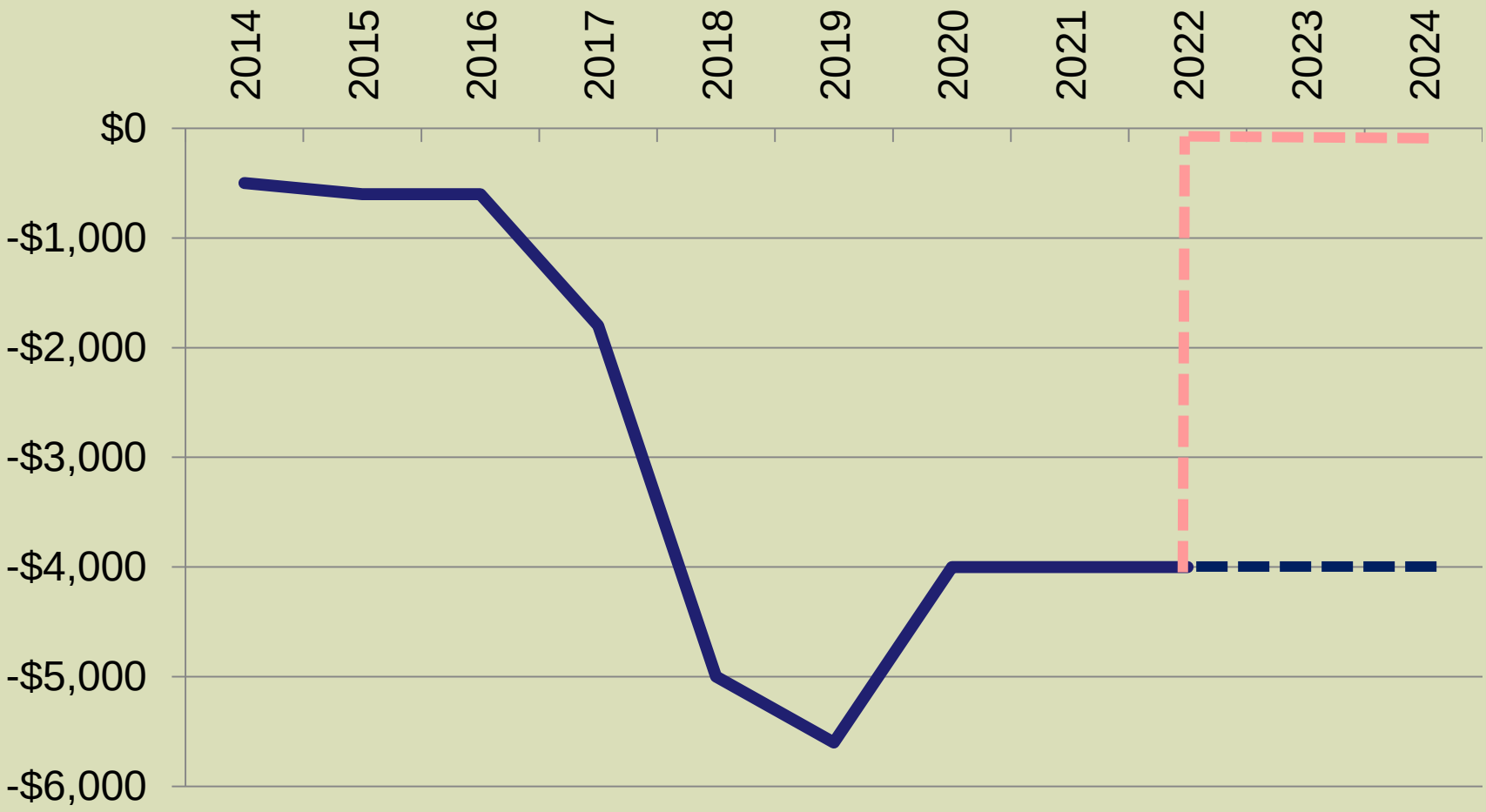
DSH Allotment Cuts



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

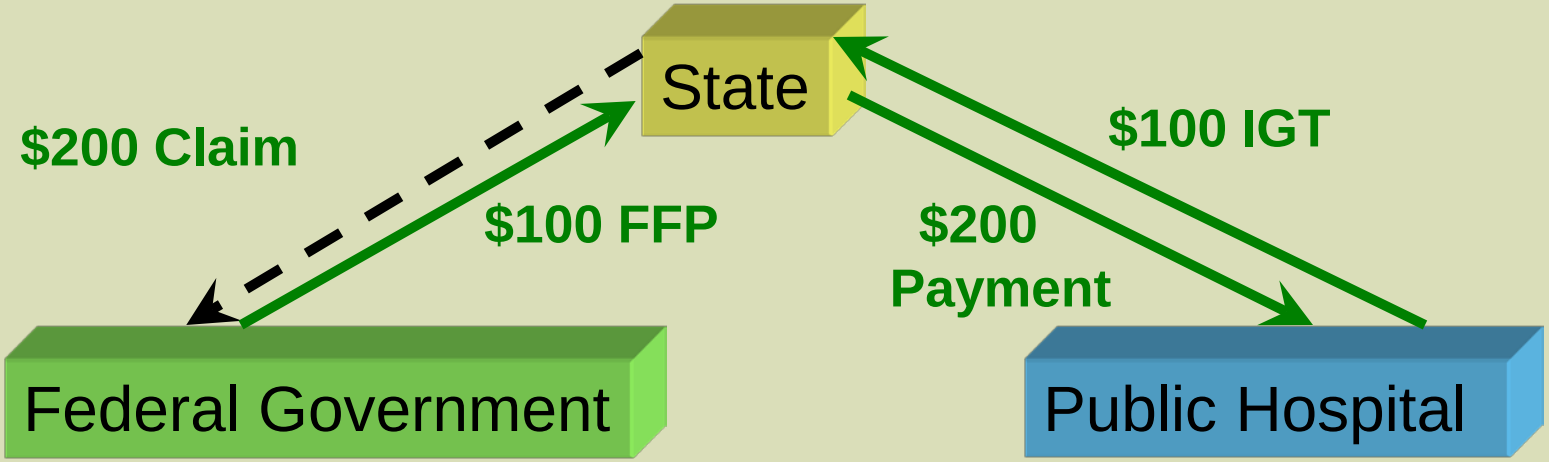
- **Provider Taxes have been on the chopping block for deficit reduction**
  - Less tax revenue to fund Medicaid= lower federal matching costs
  - Lingering concerns about financing "schemes"
- **No Immediate threat in Congress**
  - Admin/Dems don't want to take away financing option for expansion
  - 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)



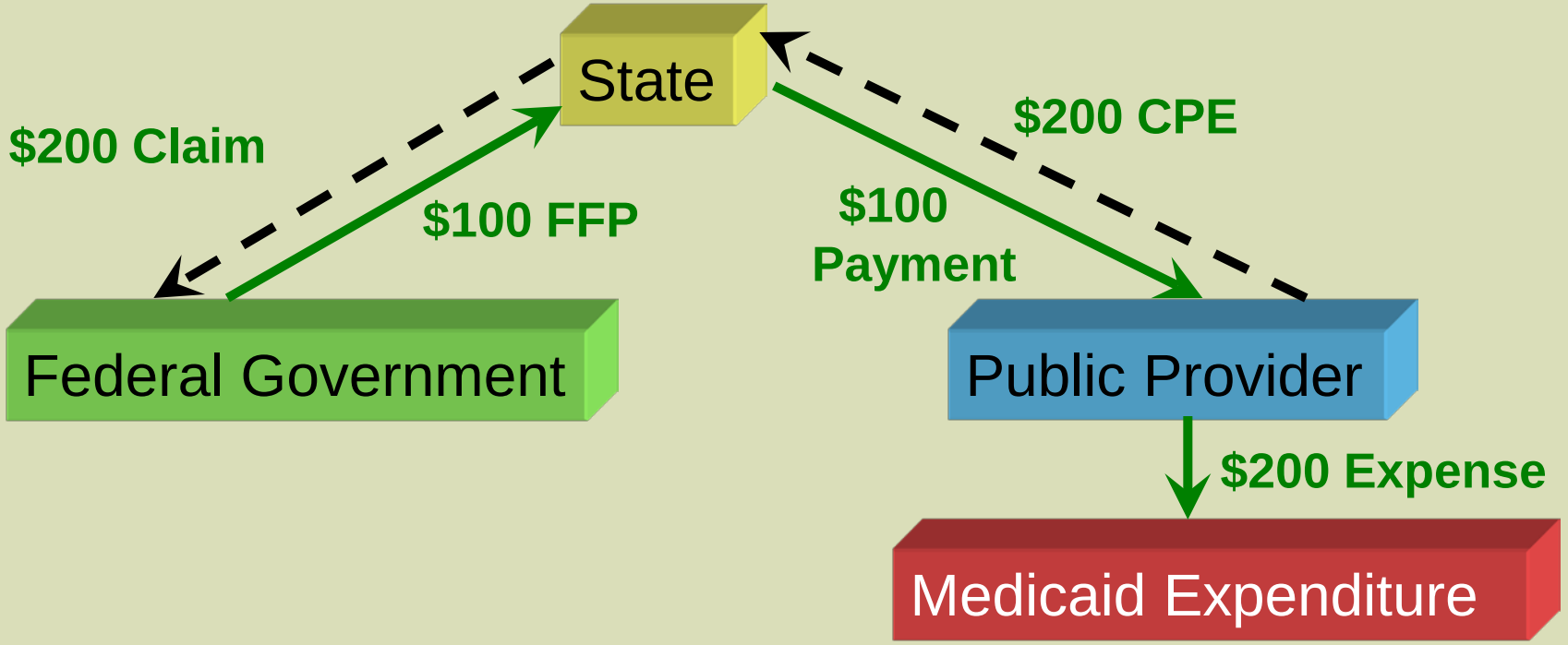
- $200 Medicaid payment includes $100 from public hospital and $100 from CMS
- No state general revenues
- **Public provider nets $100 (but is credited with receiving $200)**

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)



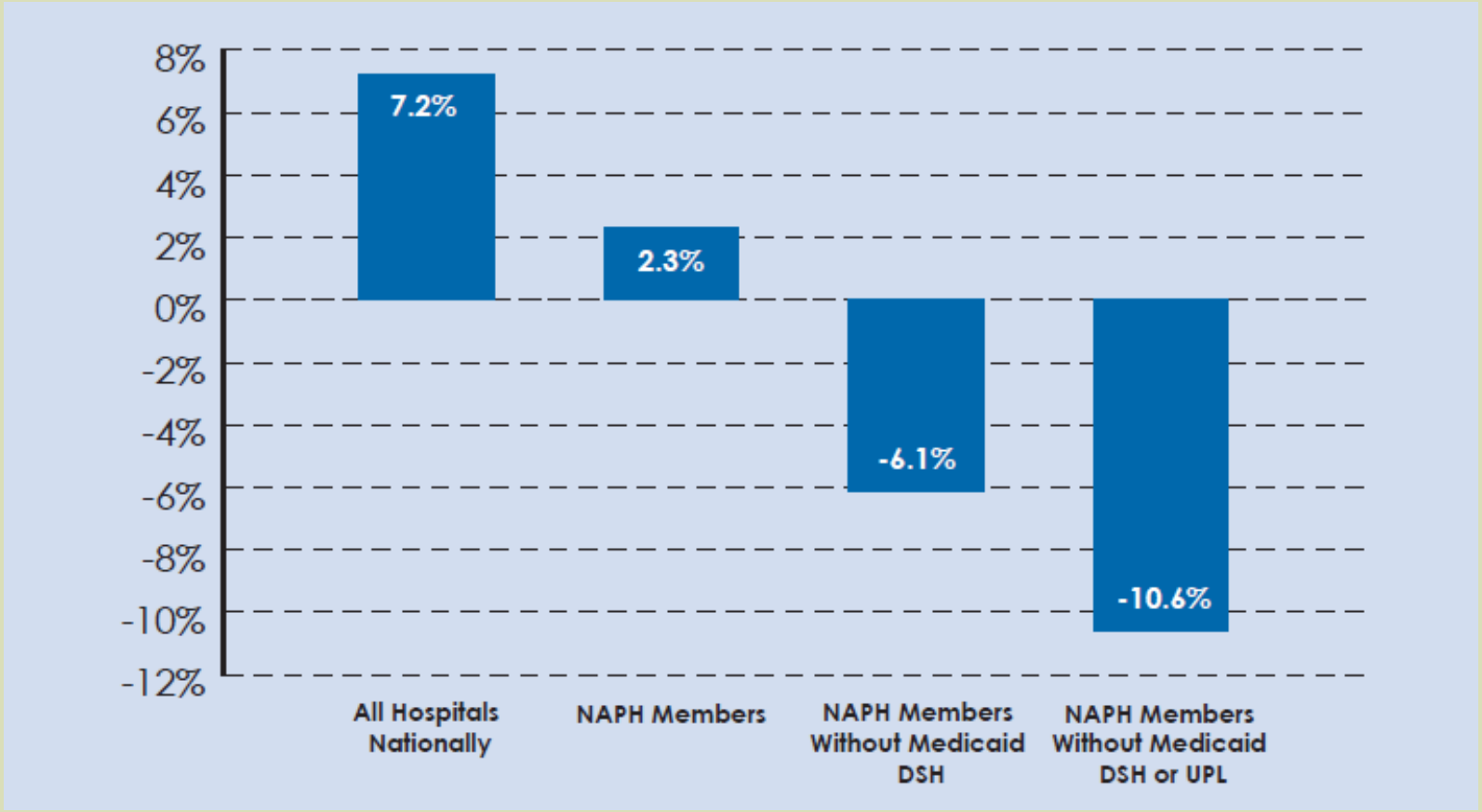
- Public provider incurs $200 Medicaid expense
- Federal Government provides $100 FFP
- State passes $100 FFP to provider
- **Public provider nets $100 (but is credited with receiving $200)**

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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