Foundations of Essential Hospital Financing

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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

OH *%&#! NEVER GONNA MAKE IT...
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

- Medicaid 35%
- Medicare 28%
- Commercial 16%
- Uninsured 16%
- Other 5%

Outpatient Utilization

- Medicaid 27%
- Medicare 18%
- Commercial 20%
- Uninsured 29%
- Other 6%

PATCHWORK OF SUPPORT FOR MISSION

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

340B Drug Discount Program (savings)
FINANCIAL CHALLENGES OF SERVING THESE ESSENTIAL MISSIONS

National Operating Margins
Members of America’s Essential Hospitals vs. All Hospitals Nationwide FY2013

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

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
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

- \approx $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

ACA CUTS SUCCESSFULLY DELAYED, BUT SIGNIFICANT CUTS LOOM

"rebasing"
IMPLEMENTING THE MEDICAID DSH CUTS

Platform factors to allocate among states
- Decrease in state’s uninsured 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

(Hospital’s Medicare SSI Days + Medicaid Days)

(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

REDUCTIONS IN TOTAL DSH (IN BILLIONS)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total DSH without ACA</th>
<th>Reduction in Total DSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$12.7</td>
<td>$0</td>
</tr>
<tr>
<td>2015</td>
<td>$12.2</td>
<td>$2</td>
</tr>
<tr>
<td>2016</td>
<td>$13.3</td>
<td>$4</td>
</tr>
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</table>

REDUCTIONS IN UC POOL (IN BILLIONS)

<table>
<thead>
<tr>
<th>Year</th>
<th>UC Pool Before Reduction</th>
<th>UC Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$12.2</td>
<td>$9.03</td>
</tr>
<tr>
<td>2015</td>
<td>$10.9</td>
<td>$7.65</td>
</tr>
<tr>
<td>2016</td>
<td>$13.3</td>
<td>$6.37</td>
</tr>
</tbody>
</table>

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
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

DSH

UPL

Providers

MCO

UPL

Providers

DSH

UPL

DSH
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
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)

- IG Ts 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 Claim

$100 FFP

State

$100 IGT

$200 Payment

Public Hospital

Federal Government

$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

(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)
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)
<table>
<thead>
<tr>
<th>Provider Class Taxed</th>
<th># of states</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>38</td>
<td>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</td>
</tr>
<tr>
<td>ICF</td>
<td>37</td>
<td>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</td>
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<tr>
<td>Nursing Facility</td>
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<td>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</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>AL, AR, CA, DC, IL, KY, ME, MD, MA, MN, MS, MO, NH, NJ, NM, NY, PA, RI, TN, TX, VT, WV, WI</td>
</tr>
</tbody>
</table>

(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 “Lose rs”
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
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- True Uncompensated Costs
  - IGT, CPE, Provider Tax
- DSH Payments
- UPL Payments
- Base Payments
  - Medicaid Costs
  - Uninsured Costs
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

<table>
<thead>
<tr>
<th>Year</th>
<th>FMAP for Newly Eligible</th>
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<tbody>
<tr>
<td>2014</td>
<td>100%</td>
</tr>
<tr>
<td>2015</td>
<td>100%</td>
</tr>
<tr>
<td>2016</td>
<td>100%</td>
</tr>
<tr>
<td>2017</td>
<td>95%</td>
</tr>
<tr>
<td>2018</td>
<td>94%</td>
</tr>
<tr>
<td>2019</td>
<td>93%</td>
</tr>
<tr>
<td>Thereafter</td>
<td>90%</td>
</tr>
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DIFFERING FMAP RATES BY POPULATION

- Children: 133%
- Pregnant Women: 50% FMAP
- Parents: 100% FMAP
- People with Disabilities: 50% FMAP
- Adults w/o Children: 200%
Over time, more adults meeting traditional Medicaid eligibility criteria become part of expansion population, shrinking traditional Medicaid.
Conclusion
SHARE D 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
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