South Carolina
Medicaid Disproportionate Share

2018 Reimbursement Summit
March 21, 2018

Agenda

- Federal DSH Policy
- SC DSH Policy
- DSH Distributions
- DSH Audit Guidelines
- Affordable Care Act

Federal DSH Policy

Federal Medicaid DSH Qualification Policy

- The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate or;
- The hospital's low-income utilization rate exceeds 25%

and

- The hospital must have a Medicaid inpatient utilization rate of at least one percent.
- At least two obstetricians with staff privileges who treat Medicaid enrollees.

Actual OB deliveries are not audited. The availability of two physicians credentialed to practice OB is the only requirement.

Physician office visits are also not audited. The physician has to agree to accept OB patients if they present.

SCDHHS Medicaid DSH Qualification Policy

Under federal law, States are given authority to designate hospitals as DSH eligible under its prescribed qualification criteria. However, the minimum 1% Medicaid inpatient hospital utilization rate and the OB requirement must still be met. The SCDHHS DSH qualification criteria is as follows:

- Be a licensed SC general acute care hospital that contracts with the SC Medicaid Program or;
- Be a SC psychiatric hospital that is owned by the SC Department of Mental Health that contracts with the SC Medicaid Program or;
- Be a general acute care border hospital that received SC Medicaid DSH payments during FFY 2017 or any SC non-general acute care hospital as long as either class meets the Federal Medicaid DSH qualification criteria.

Federal DSH Qualification Policy

- *Certain hospitals are not required to have at least two obstetricians with clinical privileges on the hospital's medical staff, if:*

  - (1) the hospital serves patients that are predominantly under 18 years of age, or
  - (2) the hospital did not offer non-emergency obstetric services to the general population as of December 22, 1987,

    or
  - (3) the hospital is a rural hospital with at least two non-obstetrical physicians with clinical privileges on the hospital's medical staff permitting them to provide non-emergency obstetric services.

Federal DSH Policy

Hospital Participation in DSH Varies by State

	Number of Hoslitals-All	Number of DSH Hoslitals	
		Number	Percent
Total	**6,000**	**2,743**	**46%**
Massachusetts[1]	108	0	0%
Arkansas	100		
Maine			
Iowa			
Wisconsin			
North Dakota			
Delaware	12		
Indiana	164	16	
California	415	43	10%
Oregon	63	8	13%
Alaska	21	4	19%
Illinois	208	48	23%
Virginia	112	31	28%
South Dakota	60	17	28%
New Mexico	45	13	29%
Florida	242	71	29%

	Number of Hoslitals-All	Number of DSH Hoslitals	
		Numbe	Percent
Nebraska	96	29	30%
Mississippi	112	49	44%
Idaho	49	22	45%
Hawaii	26	12	46%
Tennessee	144	79	55%
District of Columbia	13	8	62%
Washington	98	63	64%
Minnesota	143	94	66%
Michigan	169	118	70%

	Number of Hoslitals-All	Number of DSH Hoslitals	
		Numb	Percent
Missouri	146	108	74%
	54	40	74%
	125	94	75%
	95	73	77%
		64	78%
		137	79%
	98	79	81%
	42	34	81%
	223	183	82%
Montana	62	52	84%
Vermont	15	13	87%
West Virginia	61	53	87%
Pennsylvania	234	205	88%
New York	217	191	88%
New Hampshire	30	27	90%
Kentucky	115	104	90%
Rhode Island	15	14	93%

South Carolina: 100% of Acute Care Hospitals

Federal DSH Policy

- DSH payments to states are limited annually by fixed federal DSH allotments to each state
- These allotments vary widely and are based on states' historical DSH spending prior to the establishment of federal limits in 1993
- These amounts are adjusted annually for anticipated increases in costs of care

Federal DSH Policy - State Limitations

- Allotments to state DSH programs cannot exceed the cost of caring for the uninsured and Medicaid patients
- DSH, being a Medicaid-based program, is funded via Federal Financial Participation (FFP) dollars applied to state matching funds

Federal DSH Policy-Hospital Specific DSH Limit

The Federal statute also limits the amount of DSH payments that a state can make to any individual hospital

In general, DSH payments may not exceed a hospital's unreimbursed cost of providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals. This amount is referred to as the Hospital Specific DSH Limit. The following class of payors are included in this computation:

- Medicaid FFS
- Medicaid MCO
- Uninsured
- ~~Dual Eligibles (FFS and MCO)~~
- ~~Commercial/Medicaid~~

The Court finds that the agency (CMS) *acted outside of the scope of its statutory authority under the Medicaid Act* by removing Dual and Commercial payments from DSH. No official guidance from CMS has been issued.

Emmet G. Sullivan
United States District Judge
March 6, 2018

State and Federal Funding

State/Federal Funding

- Medicaid DSH program is jointly funded by the federal government and states
- Federal government pays states for a specified percentage of program expenditures, called Federal financial participation (FFP), often referred to as the "state match"
- States pay CMS the state match for DSH and CMS then returns the state and federal funds together to the state
- FFP varies by state based on criteria such as per capita income
- FFP ranges from 50% to 75% in states with lower per capita incomes
- Average FFP is 57% for all states
- SC's FFP in 2017 was 71%
- SC's FFP in 2018 is 72%

State/Federal Funding

South Carolina's state matching funds for the SC Medicaid and SC Medicaid DSH programs are comprised of SC state appropriated funds and funds generated from a **provider tax** on all SC general acute care hospitals.

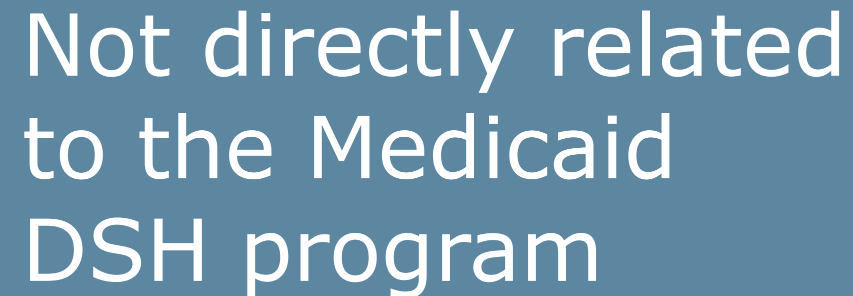
SECTION 12-23-810. *Tax on licensed hospitals*

(C) Total annual revenues from the tax, exclusive of penalties and interest, in subsection (A) of this section initially <u>must equal two hundred sixty-four million dollars</u>. The amount of a general hospital's tax must be deri ed from Schedule B, Part 1 of the hospital's cost report. The initial annual t must be collected, beginning July 1, 2006, based upon the reconciled acc of a general hospital subject to this article, considering partia ollected portion of the previous assessment pursuant to year ending June 30, 2006. Upon notification from the Department of Revenue, on behalf of and based on calculations performed by the Department of Health and Human Services, a general hospital shall remit the balance due based on a payment schedule as determined by the Department of Health and Human Services.

$264 million

SECTION 12-23-840. Disposition of tax revenues

Revenues derived under the provisions of this article must be deposited in the Medicaid Expansion Fund created by Section 44-6-155. In addition to the purposes specified in Section 44-6-155, monies in the Medicaid Expansion Fund must be used to provide health care coverage to the Medicaid-eligible and uninsured populations in South Carolina.



South Carolina State and Federal Funds

SC DSH State and Federal Funds			
DSH Year	Federal Allocation	State Match	Total DSH
2006	$308	$137	$445
2007	$308	$136	$444
2008	$308	$134	$442
2009	$329	$142	$471
2010	$338	$143	$481
2011	$328	$140	$468
* 2012	$321	$136	$457
* 2013	$337	$141	$478
2014	$349	$146	$495
2015	$355	$147	$502
2016	$356	$145	$501
2017	$359	$145	$504

In millions

* Total DSH allotment was not spent during 2012 and 2013. Total DSH allotment was $477 in 2012 and $488 in 2013.

South Carolina Medicaid DSH Distributions

Medicaid DSH Distributions

- SCDHHS collects historical base year data from DSH eligible hospitals and determines **interim** DSH payments for the DSH payment period
- An audit is required to be conducted on the DSH payment period three years later which determines the **audited** hospital specific DSH limit
- SCDHHS **recalculates** the final DSH payments for the DSH payment period using the audited hospital specific DSH limits and the CMS approved DSH payment methodology in effect during the DSH payment period. This results in either an additional payment or recoupment of DSH funds from each hospital.

Medicaid DSH Distributions

- The statewide aggregate hospital specific DSH limit exceeds the total Medicaid DSH allotment amount each year. Therefore, each DSH hospital receives DSH payments based upon its hospital specific DSH limit as a percentage of the statewide available funds
- DSH payments usually constitute between 50% to 60% of the hospital specific DSH limit for each hospital

Percent of Uninsured Covered By DSH

(All Acute Hospitals)

	CMS DSH Allotment			Total Allowed Costs		
DSH Year	Hospital Allotment	Psych Allotment	Total Allotment	Allowed Hospital and Psych Cost Net of Normalization	DSH Shortfall to Allowed Uninsured	Percent Reimbursed
2006	$392	$53	$445	$483	-$37	92%
2007	$391	$53	$444	$494	-$50	90%
2008	$383	$59	$442	$566	-$124	78%
2009	$418	$53	$471	$637	-$179	74%
2010	$426	$55	$481	$691	-$233	70%
2011	$431	$37	$468	$735	-$267	64%
2012	$415	$52	$468	$780	-$312	60%
2013	$415	$52	$478	$844	-$355	58%
2014	$446	$49	$495	$849	-$374	58%
2015	$450	$52	$502	$891	-$389	56%
2016	$440	$61	$501	$874	-$373	57%
2017	$443	$61	$504	$805	$301	63%

Percent reimbursed could be impacted beginning in 2014 due to marketplace (exchange) plans

Medicaid DSH Distributions

Any change made by any individual hospital impacts every other hospital. For example, increases/decreases in cost to charge ratios, service utilization, or payor mix from year to year can result in payment shifts.

"Squeezing the balloon"

- When one hospital gets more, other hospitals may get less
- When one hospital gets less, other hospitals may get more

DSH Federal and State Availability Calculations

DSH Carve Outs and Distribution

SCDHHS-Defined Rural Hospitals

- Qualifying burn intensive care unit hospitals
- Critical access hospitals
- Isolated rural
- Small rural
- Certain hospitals with less than 90 licensed beds, defined by Rural/Urban Commuting Area (RUCA) classes that are in a Health Professional Shortage Area (HPSA)
- Hospitals located within a "persistent poverty county" that are not otherwise eligible for higher reimbursement

Percentage of Costs Paid

- 100% paid to hospitals in the program prior to October 1, 2014
- 90% paid to hospitals added on or after October 1, 2014
- 80% paid to persistent poverty county hospitals

100% Uninsured Costs

- Abbeville County Hospital
- Allendale County Hospital
- Chester County Hospital
- McLeod Health - Cheraw
- Clarendon Memorial Hospital
- Coastal Carolina
- Colleton Medical Center
- Edgefield County Hospital
- Fairfield Memorial Hospital
- GHS/Laurens County Hospital
- Hampton Regional Medical Center
- Lake City Community Hosp
- Marion County Medical
- McLeod Reg Med (Dillon)
- Newberry County Hospital
- Williamsburg Regional Hospital

90% Uninsured Costs

- Cannon Memorial Hospital
- McLeod/Loris Seacoast Hospital
- Union Medical Center (Wallace Thompson)

80% Uninsured Costs

- The Regional Medical Center - Orangeburg

2017 Preliminary Medicaid DSH Distribution

2017 Distribution			
Facility Type	Unreimbursed Costs	Available DSH	Percent
Non-Rural Acute	621	338	54%
Rural Acute	77	73	95%
SCDMH	71	61	86%
Out of State	37	12	32%
Total Provider Payments	806	484	60%
Transformation	-	20	
Total DSH	806	504	63%

DSH Audit Guidelines

2008 DSH Audit Rule

- Implemented December 19, 2009
- Accordingly, state plan years 2005–2010 were designated **transition years** to allow CMS, states, hospitals, and auditors time to develop and refine their procedures without financial penalties.
- Beginning with the results for Plan Year 2011, DSH audited payments **exceeding hospital-specific limits** were considered overpayments.
  - States were required either to return the federal share or,
  - If specified in the state plan, to redistribute it to other hospitals below their limits.
- Beginning in 2012, based on a state plan amendment, SCDHHS redistributed the entire DSH allotment based on the new findings rather than to simply make individual hospital adjustments

DSH Audits Became A Major Concern

Audit Year	*Audit Process*
2010	No redistribution
2011	Redistribution of any amount paid in excess of a hospital's specific DSH limit. Amount overpaid distributed proportionately to all hospitals. Five hospitals paid back **$3** million.
2012	Complete redistribution with **$34** million redistributed
2013	Complete redistribution with **$50** million redistributed
2014	Complete redistribution with **$52** million redistributed

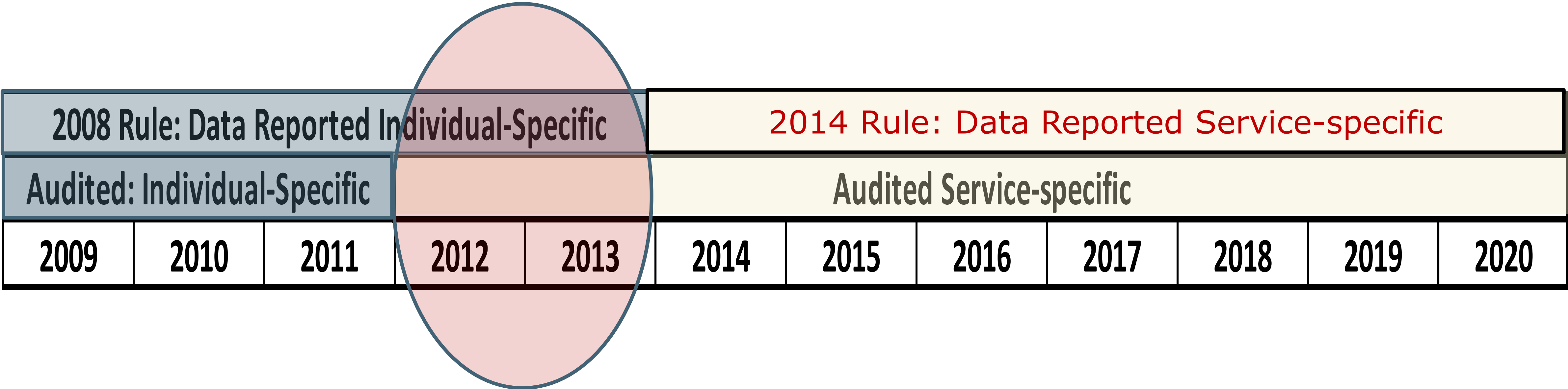
DSH Audit

- In 2003, Congress added statutory requirements for states to submit annual reports and to submit for each hospital an annual independent certified audit of DSH payments
  - The annual reports for each DSH hospital must include the following:
  - The hospital-specific DSH limit
  - The Medicaid inpatient utilization rate
  - The low-income utilization rate
  - The state-defined DSH qualification criteria
  - All Medicaid payments

Discrepancy in 2008 and 2014 Audit Rule Settlements

- Bad timing: Individual-specific vs. Service-specific
  - Individual-specific:
    - 2008 CMS Final Rule: Commercially insured is considered insured, even if coverage did not apply to the service the patient received
  - Service-specific:
    - 2014 CMS Clarification: Commercially insured considered uninsured, even if the patient had coverage, but the coverage does not apply to the service the patient received. For example deductibles in excess of service charges and exhausted lifetime benefits

Discrepancy in 2008 and 2014 Audit Rule Settlements



Data reported Individual-Specific, but audited Service-specific

DSH Audit Difficulties

- Subject to the impact of other hospitals-both positively and negatively
  - Incorrect information
  - Corrections hospitals make going forward
  - Myers and Stauffer audit determination of cost is much more detailed than SCDHHS’s application of cost to charge ratio
  - Estimating receivables and liabilities accurately
  - Having documentation for auditors to allow recording adequate reserves

Ways to Minimize Audit Adjustments

- Compare audit detail results to your preliminary data supplied to SCDHHS and investigate additions and removals
- Compare each year's audit results to prior year audit results
- Refine your data accumulation process after each audit
- Annual Myers and Stauffer audit training webinar and clarity of audit procedures

Audit Completion

At the request of the SCHA Finance Council, SCDHHS has agreed to expedite DSH audits. Rather than the full 3 year requirement:

- 2015 will be completed by June 2018
- 2016 will be completed by March 2019
- 2017 will be completed by March 2020
- The same pattern going forward

SCHA Recommendations to SCDHHS

- Allow hospitals 30 days to provide detail account information
  - Currently hospitals are only allowed 10 days
- Conduct additional audit procedures that have statistically material variance in their DSH distribution from prior year
- Auditors should be rotated every three to five years and be more transparent in providing helpful information to hospitals
- Auditors should conduct individual hospital exit conferences with hospitals

The Affordable Care Act

Patient Protection and Affordable Care Act of 2010

Congress reduced federal DSH allotments beginning in 2014, to account for the decrease in uncompensated care anticipated under Medicaid expansion and health insurance coverage expansion.

Legislation Has Delayed the ACA Reduction Schedule:

- *Middle Class Tax Relief and Job Creation Act of 2012* ***extended the reductions to FY 2021***
- *American Taxpayer Relief Act of 2012* ***extended the reductions to FY 2022***
- *Bipartisan Budget Act of 2013* ***delayed reductions until FY 2016*** *and* ***added the FY 2015 reduction to FY 2016 and extended the reductions to FY 2023***
- *Protecting Access to Medicare Act of 2014 enacted April 1, 2014* ***extended reductions until FY 2017, increased amounts, and extended them to FY 2024***
- *Medicare Access and CHIP Reauthorization Act* ***delayed the reductions until FY 2018, adjusted amounts, and extended them to FY 2025***
- *The Bipartisan Budget Act of 2018* ***eliminated DSH allotment reductions for FY 2018 and FY 2019*** *and* ***increased the amount of reductions scheduled for FYs 2021–2023***

Current Reduction Schedule

The current schedule and amounts for the Medicaid DSH reductions are as follows:

- $4.0 billion in FY 2020;
- $8.0 billion in FY 2021;
- $8.0 billion in FY 2022;
- $8.0 billion in FY 2023;
- $8.0 billion in FY 2024; and
- $8.0 billion in FY 2025.

Health and Human Services reductions must meet these requirements:

- *The largest reductions are imposed on states that:*
  - have the lowest percentages of uninsured individuals, or
  - do not target DSH payments on hospitals with high volumes of Medicaid inpatients or uncompensated care;
- *Smaller percentage reductions are imposed on low DSH states*
- *Takes into account the extent to which DSH funds were used to expand coverage through an 1115 demonstration.*

Questions

Resources

- CMS 2008 DSH Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30000.pdf
- CMS 2014 DSH Final Rule: https://www.federalregister.gov/documents/2014/12/03/2014-28424/medicaid-program-disproportionate-share-hospital-payments-uninsured-definition
- SCHA Timeline
- Myers Stauffer webinar at URL: https://webinar.mslc.com/?meeting=8959959
- Board/Legislative Whitepaper and Q&A

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