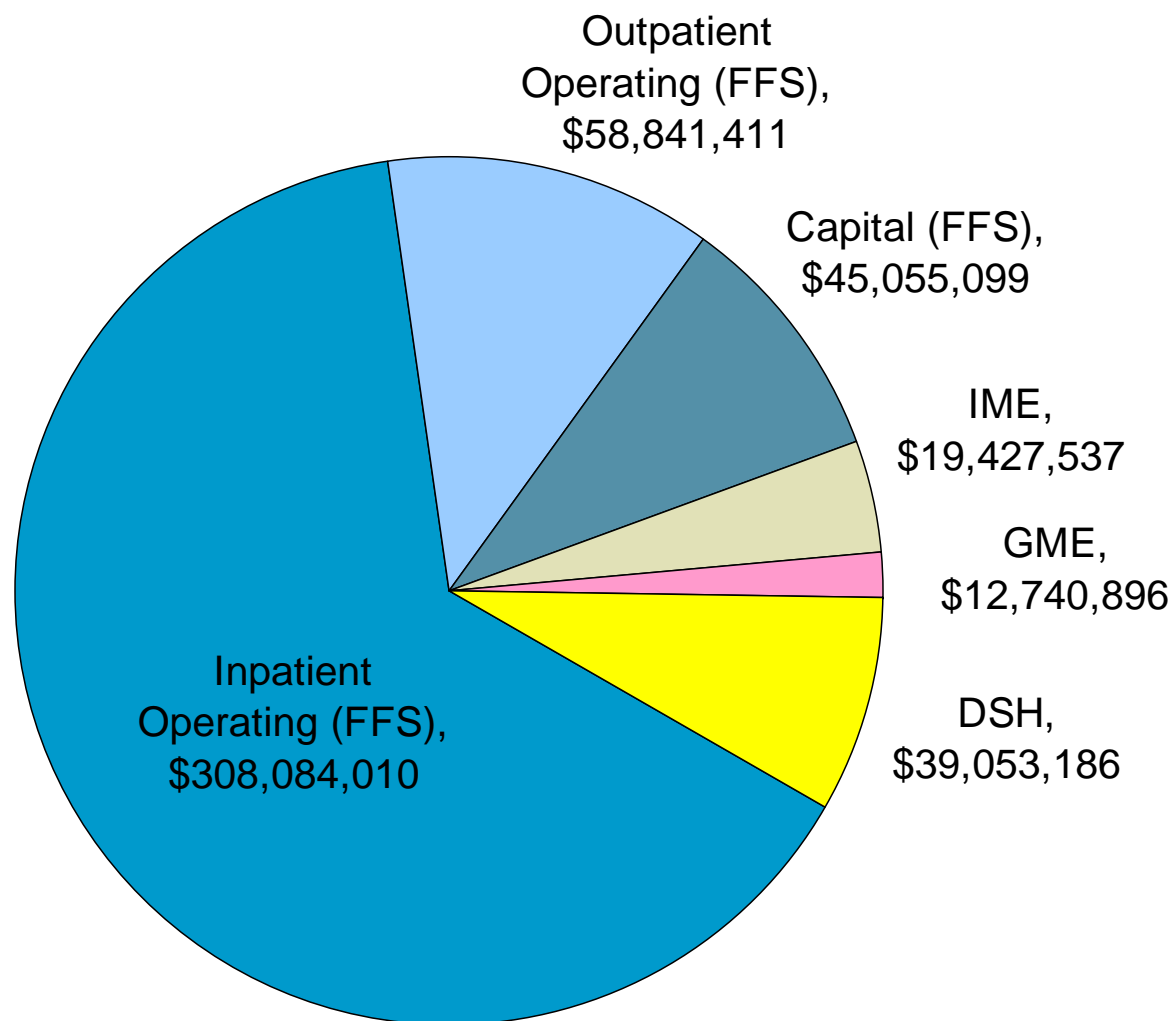

Special Hospital Payments Under Medicaid: GME, IME and DSH

Presentation to the:
Senate Finance Committee
Health and Human Resources Subcommittee

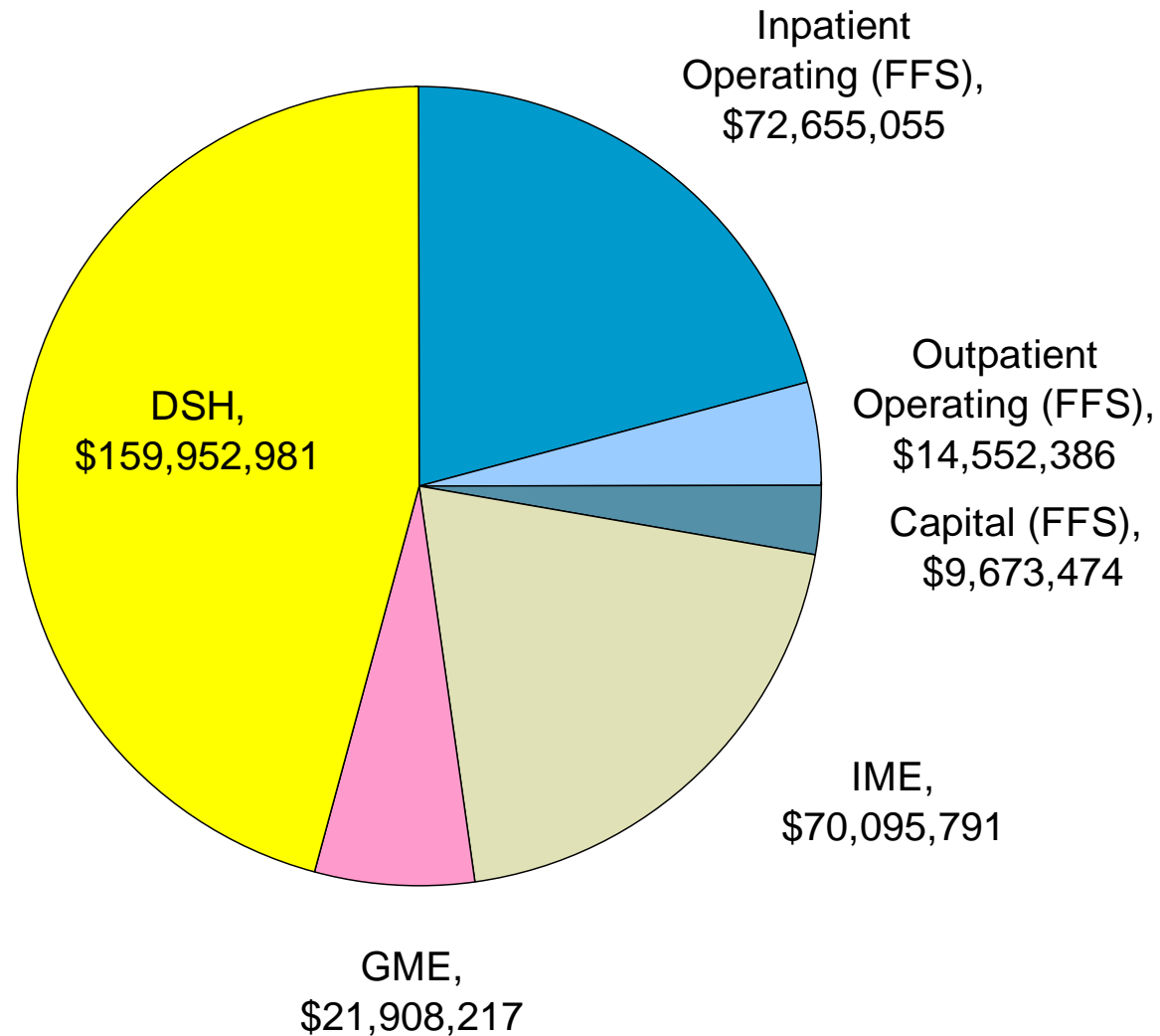
Background

- GME: Graduate Medical Education
- IME: Indirect Medical Education
- DSH: Disproportionate Share Hospital
- All three are special payment streams to hospitals
- Medicare has a methodology to pay each
- Medicaid required to pay DSH but not IME or GME
- Virginia Medicaid pays all three
- Medicaid's methodology not required to (and doesn't) mimic Medicare's
- All three subject to different federal limits

FY2008 Payments for Hospital Services: “Type Two” Hospitals (other than UVA and VCU)



FY2008 Payments for Hospital Services: “Type One” Hospitals (UVA and VCU)



Graduate Medical Education (GME) Payments

- Purpose – Support cost in hospitals of training health professionals (residents/interns and allied health professionals)
- 39 Hospitals receive GME (10 are out-of-state (OOS))
- 4,212 Resident/Intern FTEs in GME hospitals in 2009
 - 1,859 in VA hospitals
 - 2,353 OOS
- Methodology
 - Residents/Interns - Medicaid cost per resident/intern (FFS and MCO) from a base year inflated forward
 - Allied Health Professionals – cost-based
- Recent changes - no inflation in FY10-FY12
- Impact of Health Reform - none

GME Payments in FY2010

(continued)

Hospital Type	Residents/ Interns	Allied Health Professions	Total
Type 1 (UVA & VCU)	\$20,877,265	\$412,247	\$21,289,512
Type 2	\$11,354,712	\$1,626,526	\$12,981,238
Total	\$32,231,977	\$2,038,773	\$34,270,750

IME Payments

- Purpose – recognize higher operating costs at hospitals with teaching programs (increased diagnostic and treatment costs related to educational mission)
- 33 Hospitals received IME payments in FY10 (10 OOS)
- Payments to Type Two Hospitals = \$21,750,852
- Methodology
 - IME factor (formula based on ratio of residents to beds)
 - Multiplied by inpatient operating payments (FFS and MCO)
- Special IME Payments for some NICU hospitals – Since 2005, \$2 million divided among CHKD, Inova Fairfax and Johnson City
- Type One Hospital IME - discussed later

IME Payments (cont.)

■ Recent changes

- No inflation since 2009
- Reduction to hospital inpatient rates (7/1/10 – if no stimulus) affects IME payments
- Changed eligibility for NICU IME (only CHKD still eligible) and reduced amount to \$1.9 million (7/1/10)
- 6 out-of-state hospitals with low Virginia Medicaid utilization no longer eligible for IME payments (7/1/10)

■ Impact of Health Reform

- No direct impact
- More persons with Medicaid could mean more IME

Joint Commission on Health Care Requested Study

Request, by letter of the Chairman, that the Department of Medical Assistance Services develop and report, by August 30, 2011, on a methodology and cost estimate for providing enhanced direct medical education (DME) and indirect medical education (IME) payments to graduate medical programs in Virginia that train physicians in primary care, general surgery, geriatrics, psychiatry, and emergency medicine.

DSH Payments

- Federal requirement of DSH payments began 1989
- Purpose is to “take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs”
- Federal law provides for:
 - Minimum criteria for qualifying as “DSH” hospital
 - Minimum criteria for DSH “payment adjustment”
- States have latitude to be more expansive in defining DSH hospitals and in setting the DSH adjustment

DSH Payments in Virginia

- Type Two Hospitals (other than UVA or VCU)
 - Medicaid utilization <14% - no DSH
 - Medicaid utilization 14% or more - DSH amount based on projected operating payments and the extent utilization exceeds 10.5%
 - Medicaid utilization 21% or more – each percent over 21% yields double the DSH amount of the percents below 21%
- 35 Type Two DSH hospitals in FY2011 (10 OOS)
- DSH in FY2011 to Type Two hospitals = \$41,027,824
 - \$18,681,929 of this for CHKD - same formula, much higher Medicaid utilization
- Type One Hospitals - discussed later

DSH Payments in Virginia (cont.)

- Recent Changes
 - No inflation in total expenditures in FY10-FY12
 - Eligibility threshold reduced from 15% to 14% in FY11
 - Pay only 50% of normal DSH payment to 6 out-of-state hospitals with low Virginia Medicaid utilization
- Impact of health reform – discussed later

Teaching Hospital Indigent Care

- Each year's Appropriation Act says:

“Included in this appropriation is ... (a dollar amount)... to reimburse the ... (VCU and UVA) ... Health System for indigent health care costs. This funding is comprised of ... DSH payments, ... IME payments, and any Medicaid profits realized by the Health System.”

- Indigent care at the teaching hospitals includes:

- Losses on Medicaid FFS and MCO payments
- Losses on patients who meet the state's indigent care criteria
- Similar losses for physician practice plans

- Recent changes

- Half-inflation in FY10, 11, and 12
- 3% reduction in indigent care funding (7/1/09)
- 6% reduction if federal stimulus not extended (7/1/10)

Teaching Hospital Indigent Care (cont.)

- Strategy to pay indigent care with Medicaid funds
 - Pay the most possible through non-DSH Medicaid hospital reimbursement
 - Type One hospital IME formula is “enhanced”
 - IME can be paid for FFS and Managed Care Medicaid
 - IME is subject to overall “Medicare Upper Payment Limit” (UPL) so payments are made up to this limit
 - Make physician “supplemental payments” to UVA and VCU practice plans – allowable under federal rules
 - Pay remaining amounts through “enhanced” DSH formula
 - FY2008 Amounts
 - IME - \$70.1 million
 - DSH - \$160.0 million

GME, IME, and DSH Amounts (SFY2008)

Reimbursement Category	Type One (UVA & VCU)	Type Two	Total
IME	\$ 70,095,791	\$ 19,427,537	\$ 89,523,328
GME	\$ 21,908,217	\$ 12,740,896	\$ 34,649,113
DSH	\$ 159,952,981	\$ 39,053,186	\$ 199,006,167
Total for SFY 2008	\$ 251,956,989	\$ 71,221,619	\$ 323,178,608

Health Reform Legislation and DSH

- Health Reform reduces DSH allotment to states beginning in FFY14
- Total reductions are specified in law
- Formula for allocating reductions to states left up to HHS Secretary
 - Target largest reductions to states with low rate of uninsured or DSH formula that does not target hospitals with Medicaid and uninsured (not Virginia)
 - Target smallest reductions on low DSH states (not Virginia)

Health Reform Legislation and DSH (cont.)

- Virginia's FY10 DSH allotment is \$172 million total funds
- If national reduction is proportional, Virginia's allotment would be reduced by:
 - FFY14 - \$7.8 million (total funds)
 - FFY15 - \$9.3 million (total funds)
 - FFY16 - \$9.3 million (total funds)
 - FFY17 - \$27.9 million (total funds)
 - FFY18 - \$77.5 million (total funds)
 - FFY19 - \$86.8 million (total funds)
 - FFY20 - \$62.0 million (total funds)
- Actual reduction to be determined

DSH Reductions - Implications for Hospitals

- Assumption of Health Reform – less need for DSH if more people are insured
- Underlying assumption - DSH pays for uninsured/uncompensated care
- In Virginia, for most DSH hospitals, DSH pays only a portion of losses on Medicaid patients
- Except for UVA, VCU and CHKD, DSH does not pay for uninsured/uncompensated care

DSH Reductions - Implications for Hospitals (continued)

- What does this mean for hospitals in Virginia?
 - If expanded health coverage means hospitals simply get paid for more of the existing patient volume:
 - Revenue increases
 - Cost remains constant
 - Net gain for hospitals, so less DSH may not mean a net loss
 - If expanded coverage increases demand for services:
 - Revenue increases
 - Cost increases correspondingly
 - Increased revenue may not offset increased costs - remember half of expanded coverage is Medicaid, which pays less than cost
- Conclusion: Expanded coverage plus DSH reduction may or may not leave hospitals unharmed

DSH Reductions – Implications for States

- Federal Government will reduce states' DSH "Allotment"
- Spending (GF and NGF) on DSH must be reduced
- This does not necessarily force reduction in total spending on hospitals
- States are not barred from increasing other payments to hospitals even while they reduce DSH
- Federal rules related to DSH are sufficiently complex that it is unlikely each hospital's DSH loss could be exactly restored through other payment streams, even if the state wished to

Conclusions

- We don't yet know how much Virginia's DSH allotment will be reduced
- We don't yet know the impact expanded coverage will have on hospital uninsured/uncompensated care
- There are likely to be options available if the state wishes to restore losses of Type One and/or Type Two hospitals resulting from these changes
- It is unlikely available options will enable the state to fully hold harmless all hospitals, so there will likely be difficult decisions to be made