



Department of Medical Assistance Services



Medicaid DSH and Indigent Care

Presentation to the:

Senate Finance Committee
Subcommittee on Health and Human Resources

January 27, 2014



<http://dmas.virginia.gov>

What is DSH?

- Federal requirement that states provide for “Disproportionate Share Hospital” (DSH) payments to hospitals that serve a “disproportionate” number of Medicaid patients.
- Federal rules set:
 - Minimum criteria for which hospitals must qualify
 - A minimum payment adjustment for those hospitals
- As long as a state satisfies the federal minimum criteria, it has wide latitude to craft its own DSH payment policy
- Each state has an “allotment” of federal DSH funds
 - DSH spending is separately reported
 - Federal funds are not available beyond the allotment

Virginia DSH Policy

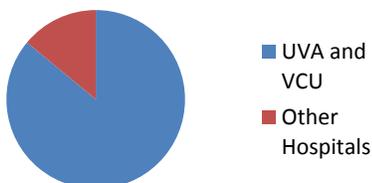
- Two distinct objectives
 - Partial financial relief to private hospitals that have a high proportion of Medicaid patients (except Children’s Hospital of the King’s Daughters, which is paid all of its uncompensated care costs)
 - Maximize use of federal funds to support indigent care at state teaching hospitals (UVA and VCU)
 - Gradually replaced GF-only funding for indigent care beginning in 1991
 - In FY14, DMAS estimates \$207 million (\$104 million in federal funds) in DSH payments to UVA and VCU

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Who Gets DSH and How Much

- Hospitals with >14% Medicaid utilization
 - 33 private hospitals (including 11 out-of-state hospitals)
 - CHKD
 - Catawba and Piedmont
 - UVA and VCU
- The majority of DSH goes to UVA and VCU

DSH in 2014



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Indigent Care Trends

Year	Indigent Care Costs	Percent Increase
2007	\$154 million	
2008	\$175 million	14%
2009	\$199 million	13%
2010	\$208 million	4%
2011	\$228 million	10%
2012	\$245 million	8%
2013	\$254 million	4%
2014	\$271 million (estimate)	7%
2015	\$291 million (estimate)	7%
2016	\$311 million (estimate)	7%

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“DSH Cliff”

- Virginia has anticipated someday reaching a “DSH cliff”
 - Private hospital DSH went from \$10 million in 2005 to \$24 million in 2014
 - Indigent care costs at UVA and VCU are expected to grow at 7%
 - DSH allotment was growing at only 2.5% even before DSH reductions mandated by the ACA
 - DMAS has “maxed out” other non-DSH Medicaid funding for UVA and VCU
- Two policy alternatives when the “DSH cliff” is reached
 - Less than full funding for indigent care at UVA and VCU
 - GF would have to be substituted for federal funds to fully fund indigent care at UVA and VCU

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Federal Allotment and Reductions

FFY	Pre ACA DSH	ACA Reductions	Reduced DSH
2014	93,430,890	-	93,430,890
2015	95,766,662	-	95,766,662
2016	98,160,829	10,477,492	87,683,337
2017	100,614,850	15,716,238	84,898,612
2018	103,130,221	43,656,217	59,474,004
2019	105,708,476	48,894,963	56,813,514
2020	108,351,188	34,924,973	73,426,215
2021	111,059,968	34,924,973	76,134,995
2022	113,836,467	34,924,973	78,911,494
Total Reduction		223,519,829	

Reductions in FFY14 and FFY15 were eliminated and reductions in FFY16 were increased by the Bipartisan Budget Act of 2013
Federal DSH allotment is matched by state general funds

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Proposed DSH Changes

Item 301 WWW of the Introduced Budget

- DMAS worked with the VHHA and the Hospital Payment Policy Advisory Council to develop a sustainable DSH policy for private hospitals:
 - Designates \$24 million in DSH funds for private non-children’s hospitals beginning in 2015 based on historical DSH for private non-children’s hospitals
 - Establishes an equitable distribution of those funds among private non-children’s hospitals
 - Adjusts funding automatically consistent with changes in the allotment (including ACA reductions to DSH)
 - Authorizes non-DSH reimbursement increases to replace any ACA reductions to DSH for private hospitals
- Continues to use the remaining DSH to fund indigent care at UVA and VCU but does not address the “DSH Cliff”

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Over the “DSH Cliff”

- DSH funding expected to be adequate in 2014-2016 biennium
- Assumes insurance from the marketplace reduces some of the indigent care needed at UVA and VCU
- DSH Shortfall beginning in 2017

SFY	Federal Funds
2017	\$10 million
2018	\$75 million
2019	\$83 million
2020	\$75 million
2021	\$84 million
2022	\$92 million
Total	\$418 million

- \$224 million of the \$418 million shortfall is due to ACA reductions

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Indigent Care Shortfall at UVA and VCU

- DMAS assumes DSH reductions to private hospitals will be offset by non-DSH payments

SFY	DSH Shortfall	Private DSH (Replaceable)	Shortfall at UVA and VCU
2017	\$10 million	\$1 million	\$9 million
2018	\$75 million	\$6 million	\$67 million
2019	\$83 million	\$6 million	\$77 million
2020	\$75 million	\$6 million	\$69 million
2021	\$84 million	\$6 million	\$77 million
2022	\$92 million	\$7 million	\$85 million
Total	\$418 million	\$32 million	\$386 million

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Alternate Possibility: Closing the Coverage Gap

- Coverage of persons <138% of poverty would reduce indigent care cost to the state
 - Indigent care is 50% GF funded
 - Alternate coverage is 0% to 10% GF funded
- DMAS has made two different estimates of the possible reduction in GF cost through 2022
 - 2012 estimate - \$637 million
 - 2013 estimate - \$1,096 million

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Basis of Two Estimates

- 2012
 - Less information available
 - Used conservative assumptions to avoid overstating savings
- 2013
 - Obtained and analyzed data on indigent care trends and population
 - Estimates are based on data and experience

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Comparison of Two Estimates

2012 Estimate	2013 Estimate
Began with assumption of 2014 indigent care cost of \$290 million	Began with assumption of 2015 indigent care cost of \$291 million
Assumed I/C cost growth of 2% per year (assumption)	Assumed I/C cost growth of 7% per year (based on actual trends)
Assumed 5% of I/C replaced by Exchange insurance	Assumed 7.8% of I/C replaced by Exchange insurance
Assumed 50% of remaining I/C would be replaced if coverage gap were closed (assumption)	Assumed 80% of remaining I/C would be replaced if coverage gap were closed (based on analysis of I/C population)
Possible GF savings = \$637 mil	Possible GF savings = \$1,096 million

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Department of Medical Assistance Services



Questions?