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Disproportionate Share Hospital Payments (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 260, #10]

CURRENT LAW

Wisconsin's medical assistance (MA) program reimburses hospitals for services they provide to MA recipients through several mechanisms that vary depending upon the type of hospital. Specialty hospitals, including psychiatric hospitals, rehabilitation hospitals, and long-term acute care hospitals, receive a hospital-specific daily rate, tied to a percentage of their average costs. General medical/surgical (GMS) hospitals receive a base payment for services provided, but may also receive supplemental payments. Base payments for GMS hospitals are generally based on the diagnosis and acuity of the patient for inpatient services and for the group or bundle of services provided for outpatient services. Base payments also depend on whether a GMS hospital qualifies as a critical access hospital, meaning it has fewer than 25 beds and is typically located in a rural area or far from other general hospitals.

Supplemental payments take several forms and can be either broadly or narrowly targeted. The two major supplements are hospital access payments and disproportionate share hospital (DSH) payments. The state share of access payments is funded with segregated revenue collected from assessments on hospitals, while the state share of DSH payments is funded with general purpose revenue (GPR). Several other smaller hospital supplemental payments are funded with assessment revenue.

The state makes DSH payments to hospitals for which at least 6% of inpatient days are attributable to MA patients and which meet other criteria related to emergency and obstetrical services. For each qualifying hospital, the DSH payment is calculated using an add-on percentage, multiplied by the hospital's base inpatient payment for services provided on a fee-for-service (FFS) basis. The add-on percentage is determined by the share of a hospital's patient days that are attributable to MA, such that those hospitals with a higher proportion of MA patients generally

have a higher add-on percentage. However, the maximum payment that a hospital may receive in a year is subject to a cap, which results in some hospitals receiving an add-on percentage that is lower than it would otherwise be based on MA inpatient utilization alone.

By statute, DHS is required to allocate $27,500,000 GPR annually for DSH payments, although the 2019-21 biennial budget act, as modified by partial veto, temporarily increased the state share of payments. Under the corresponding state plan approved by the federal Medicaid authority, the state share of DSH payments during 2019-21 was set at $47,500,000 each year. Since this increase applies only during the 2019-21 biennium, the state allocation will return to $27,500,000 in 2021-22 and thereafter.

The state receives federal matching funds on the state funds allocation, so the total amount of DSH payments is determined by the applicable federal matching rate. In the 2019-21 biennium, in addition to the increase in the state share of payments, the total amount distributed was also affected by a temporary 6.2 percentage point increase to the state's federal matching rate under provisions of the federal Families First Coronavirus Response Act of 2020. This increase, which first applied in January of 2020 and will remain in effect through at least the end of the 2019-21 biennium, has the effect of increasing total payments since the state share remains fixed. With the combination of the temporary increase to the amount of state funds allocated for payments and the COVID-19-related increase to the federal contribution rate, total DSH payments (state and federal funds) increased from $67.7 million in 2018-19 to $127.5 million in 2019-20 and $132.7 million in 2020-21.

The maximum DSH payment that any one hospital may receive is capped. By statute, the DSH cap is set at $4.6 million, but to account for the temporary increase in the state funds allocation the cap was temporarily increased to $7.95 million by the 2019-21 budget act. However, the Department adjusted this cap to $8.67 million in 2019-20 and to $9.02 million in 2020-21 to account for the higher total payment resulting from the temporary increase to the federal matching rate.

DISCUSSION POINTS

1. Because the increase in the state share of DSH payments provided by the 2019-21 budget was temporary, the $20,000,000 GPR provided for this portion of the payment is not included in the GPR appropriation base for the 2021-23 biennium. Therefore, maintaining the same level of state funding for DSH payments in the 2021-23 biennium would require an increase to the base. Assembly Bill 68/Senate Bill 111, conditioned on the adoption of full Medicaid expansion, would provide $20,000,000 GPR annually to maintain the total state funding allocation at $47,500,000, and would establish this amount as the ongoing, annual statutory allocation. The federal matching funds associated with this GPR increase would be estimated at $33,835,800 FED in 2021-22 and $29,925,100 FED in 2022-23. The bill would establish the maximum DSH payment at $7,950,000.

2. Hospital payments, including both base payments and supplements, account for one of the largest expenditures categories in MA. Through the combination of base reimbursements and supplements, MA paid approximately $2.0 billion on an all funds basis for hospital services in 2019-20, excluding the state mental health institutions. Base rate reimbursements made up approximately

59% of this total, access payments accounted for 33%, DSH payments contributed 6%, and other supplements made up the remaining 2%.

3. MA reimbursement impacts the overall fiscal health of hospitals, which varies widely between facilities in the state. The Wisconsin Hospital Association reports that the median operating margin (the difference between income and expenses, expressed as a percent of income) for hospitals in 2019 was 5%, although 40 hospitals (out of 152 in the state) reported negative margins and some reported significantly higher margins, in excess of 10%. In 2012 the median operating margin was also approximately 5%, although it grew to a peak of almost 8% in 2015 before declining back to the current level.

4. Sustaining negative operating margins for several years may cause hospitals to close or reduce their capabilities. Data compiled by the University of North Carolina Cecil G. Sheps Center shows that 180 rural hospitals have closed nationwide since 2005, and that the rate of closures is increasing, although only one has closed in Wisconsin (Franciscan Skemp Medical Center in Arcadia). A nationwide study published in *Health Affairs* in June, 2020, reports that median profit margins for non-profit critical access hospitals improved from 2.5% in 2011 to 3.2% in 2017, while median profit margins for non-CAH non-profit hospitals decreased from 3.0% to 2.6%. Profit margins decreased for for-profit hospitals as well over the study period.

5. The COVID-19 pandemic and response have also impacted hospital's finances. The Epic Health Research Network documented a 30% drop in hospital admissions nationwide in March and April of 2020, with patient volume returning to approximately normal by July. A second, smaller, dip brought admissions down to 15% below pre-pandemic levels in January and February of 2021. One factor contributing to this trend, the postponement of elective and non-emergent procedures, had particularly large impact on hospital revenues, since these are typically profitable. COVID-19 precautions also necessitated that hospitals make changes to procedures, facilities, and supplies such as personal protective equipment. The Wisconsin Hospital Association estimates that COVID-19 resulted in approximately $2.5 billion in losses for hospitals in the state. The pandemic has affected different hospitals differently, and the Kaiser Family Foundation reports some share of hospitals nationwide have remained profitable.

6. Several state and federal programs have provided funding to hospitals intended to offset these losses. The federal provider relief fund, created by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and expanded by subsequent legislation, has provided $1.99 billion to 5,429 healthcare providers in Wisconsin as of May, 2021, including hospitals. Wisconsin businesses have also received $14.26 billion in forgivable loans under the paycheck protection program; nationally, healthcare providers received approximately 13% of these loan funds, per the Kaiser Family Foundation. The Wisconsin Hospital Association estimates that hospitals will receive a total of $1.2 billion in federal COVID-19 aid from these and other sources.

7. At the state level, the administration allocated $44 million to hospitals out of the approximately $2.0 billion received by the state under the federal coronavirus relief fund (CRF) program. This comprised $4 million allocated to the Medical College of Wisconsin and the remaining $40 million distributed to other hospitals in proportion to their share of combined inpatient and outpatient Medicaid revenue compared to other facilities around the state, offset by certain other relief

payments. Distribution of these relief payments by the state began in mid-July, 2020.

8. Several different points of comparison offer useful measures of the adequacy of MA hospital payments. These benchmarks include the rates paid by Medicare, the actual costs incurred by hospitals to provide care to MA patients, and the rates paid by commercial insurers. MA payments are lower than each of these.

9. Including all supplements, MA reimbursed hospitals at approximately 90% to 95% of the rates paid by Medicare in 2019, although a direct comparison is difficult given the significant differences in the enrolled populations and mix of procedures between the two programs. Nationwide, this relationship is reversed, with Medicaid programs paying on average slightly more than Medicare (about 103%) in 2019, per the American Hospital Association.

10. On an aggregate basis, DHS estimates that commercial insurance payment rates are two to three times higher than rates paid by MA. Because the prices charged to commercial insurers vary considerably by type of service, by hospital, and even by insurer within the same hospital, this ratio will also vary. Generally this ratio is higher for outpatient services than inpatient services.

11. The fact that MA payments are considerably less than commercial insurance payments means that hospitals receive less revenue per inpatient stay or outpatient service when the patient has MA coverage than if the coverage is provided through a commercial insurance policy. This may have implications for hospital revenues and the services that a hospital can offer to all patients. The higher the share of MA patients are of a hospital's total patient population, the greater that these impacts will be.

12. In addition to being below commercial insurance payment rates, the total of all MA payments to hospitals, including base rate reimbursement and supplements, is less than the hospitals' aggregate cost of care attributable to MA patients. On a statewide basis, the Wisconsin Hospital Association estimates that MA hospital payments cover approximately 66% of hospital costs attributable to MA patients (including a proportionate share of capital and fixed costs). This calculation can vary depending on methodological choices as to which costs and which revenues to consider. Nevertheless, just as there is no dispute that MA pays below commercial insurance rates, there is wide agreement that total MA payments are below average MA costs.

13. Disproportionate share hospital payments are intended to provide supplemental reimbursement for hospitals that serve relatively high numbers of MA recipients and uninsured, low-income patients. The rationale for DSH payments is that publicly-funded programs, such as Medicaid and Medicare, tend to have lower reimbursement rates than private insurance, putting a hospital that has a large number of patients with coverage under these public programs is in a weaker financial position than a hospital that has fewer of these patients. The DSH payments are intended to reduce this imbalance.

14. The Department adjusts hospital base reimbursement rates annually based on a hospital inflation index. The cost of these rate increases, along with anticipated changes in hospital service utilization, are reflected in the MA cost-to-continue reestimate. Increases to the DSH payment have been provided as separate budgetary decisions, outside of this base reimbursement rate adjustment. The following table shows funding provided by DSH payments since 2013-14, when the current

program was first established.

Disproportionate Share Hospital Payments by Fiscal Year and Fund Source
($ in Millions)

Fiscal Year	GPR	FED	Total
2013-14	$15.0	$21.9	$36.9
2014-15	15.0	21.9	36.9
2015-16	15.0	21.0	36.0
2016-17	15.0	21.5	36.5
2017-18	27.5	39.3	66.8
2018-19	27.5	40.2	67.7
2019-20	47.5	80.0	127.5
2020-21	47.5	85.2	132.7

15. Because the GPR portion of the DSH payments is fixed by statute (or nonstatutory provision), the total amount of the payment varies with changes in the federal matching rate. With the temporary increase in the matching rate provided under federal COVID-19 relief legislation, total DSH payments were higher in the 2019-21 biennium than they otherwise would have been, by approximately $10.5 million in 2019-20 and $14.6 million in 2020-21.

16. Because the enhanced federal matching rate is expected to continue through at least the end of calendar year 2021, the total DSH payment in 2021-22 will also be higher than it would be with the standard matching percentage. With a return to the state's standard matching rate, and with a state share set at $47.5 million per year (as proposed by the Governor), total DSH payments would be approximately $118 million to $120 million per year.

17. While hospitals have benefited from a higher DSH payment due to the enhanced federal matching rate, most hospitals have likely experienced an increase in the proportion of their patients who are enrolled in MA, as opposed to commercial insurance, during the COVID-19 pandemic. Total enrollment in full benefit MA eligibility groups has increased by approximately 250,000 since the beginning of the 2019-21 biennium, which is equivalent to just over 4% of the state's population. The shift from commercial insurance to MA coverage likely has affected hospital revenues.

18. Of the 152 hospitals in Wisconsin, 89 qualified for DSH payments in 2020-21 and 63 hospitals, with an MA inpatient percentage below 6.0%, did not qualify. For the hospitals that did qualify, the MA inpatient percentage varies widely. For 58 of the qualifying hospitals, MA patients accounted for less than 16% of total inpatient days, 33 hospitals had an MA percentage between 16% and 36%, and for three hospitals in Milwaukee County MA patients accounted for between 52% and 55% of patient days (Ascension St. Joseph's, Aurora Sinai Medical Center, and Children's Hospital of Wisconsin). The table below shows the distribution of hospitals by their MA share of inpatient days, and the total DSH payments made to the hospitals in each interval.

Distribution of 2020-21 DSH Payments by Share of MA Inpatient Days

MA Share of Inpatient Days	Number of Hospitals	Total DSH Payments
0.0% to 5.9%	63	$0
6.0% to 11.9%	36	11,168,200
12.0% to 17.9%	30	46,728,800
18.0% to 23.9%	11	26,975,100
24.0% to 29.9%	3	7,018,800
30.0% to 36.0%	4	14,212,300
Over 50%	3	26,594,800

19. Upon introduction of the bill, the administration indicated that the GPR increase that would be provided for DSH payments would be an allocation of GPR savings associated with adopting the full Medicaid expansion, and the statutory increase was made contingent upon implementation of full expansion. Because the Committee has excluded full Medicaid expansion from the bill, the state will not realize the GPR savings. If the primary justification for providing hospital supplement increases is tied to full MA expansion, the Committee could now determine that the DSH increase is no longer warranted (Alternative 5).

20. The Committee could make the DSH increase permanent, as in AB 68/SB 111, but without making the increase contingent on the state adopting full Medicaid expansion (Alternative 1). As under AB 68/SB 111, this alternative would establish in statute the level of GPR funding for DSH payments ($47,500,000 per year) and payment cap ($7,950,000) that are currently in effect on a temporary basis. The FED funding amount in Alternative 1 has been adjusted to reflect updated forecasts of the federal matching rate. To account for the fact that total DSH payments may be affected by the temporary increase to the federal matching rate, the Department could be authorized to make a proportional adjustment to the payment cap.

21. Alternatively, the Committee could provide a smaller increase. Alternative 3 illustrates the cost of increasing permanent DSH levels by only half of the temporary amount currently in effect, setting the GPR share at $37,500,000 and adjusting the maximum payment proportionately, to $6,280,000. With standard federal matching rate, total DSH payments would be approximately $94.0 million per year.

22. Alternative 2 and 4 provide the same level of funding as Alternatives 1 and 3, respectively, but on a temporary basis for the 2021-23 biennium only.

ALTERNATIVES

1. Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to permanently establish the GPR share of DSH payments at $47,500,000. Set the maximum payment at $7,950,000, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 1	Change to Base
GPR	$40,000,000
FED	64,239,000
Total	$104,239,000

2. Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to temporarily maintain the GPR share of DSH payments at $47,500,000 for the 2021-23 biennium only. Set the maximum payment at $7,950,000 for the biennium, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 2	Change to Base
GPR	$40,000,000
FED	64,239,000
Total	$104,239,000

3. Provide $26,917,900 ($10,000,000 GPR and $16,917,900 FED) in 2021-22 and $25,201,600 ($10,000,000 GPR and $15,201,600 FED) in 2022-23 to permanently establish the GPR share of DSH payments at $37,500,000. Set the maximum payment at $6,280,000, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 3	Change to Base
GPR	$20,000,000
FED	32,119,500
Total	$52,119,500

4. Provide $26,917,900 ($10,000,000 GPR and $16,917,900 FED) in 2021-22 and $25,201,600 ($10,000,000 GPR and $15,201,600 FED) in 2022-23 to temporarily establish the GPR share of DSH payments at $37,500,000 for the 2021-23 biennium. Set the maximum payment at $6,280,000 for the biennium, but authorize the Department to make a proportionate adjustment to the cap during the 2021-23 biennium if the state is eligible for an enhanced matching rate under the federal Families First Coronavirus Response Act.

ALT 4	Change to Base
GPR	$20,000,000
FED	32,119,500
Total	$52,119,500

5. Take no action. This would return the GPR share of DSH payments to $27,500,000 and the maximum payment to $4,600,000.

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