Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

May 21, 2015 Joint Committee on Finance Paper #348

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

[LFB 2015-17 Budget Summary: Page 205, #4]

CURRENT LAW

2013 Wisconsin Act 20 (the 2013-15-biennial budget act) increased medical assistance (MA) benefits funding by $36,792,000 ($15,000,000 GPR and $21,792,000 FED) in 2013-14 and by $36,728,700 ($15,000,000 GPR and $21,728,700 FED) in 2014-15 to fund, in the 2013-15 biennium only, supplemental payments to disproportionate share hospitals (DSHs), which are hospitals that serve a high number of MA recipients and low-income patients. Hospitals with at least 6% of inpatient days attributable to MA patients were eligible for payments. The amount of the payment each hospital received depended on the number of MA inpatients the hospital served and the hospital's MA patients as a share of all patients. The maximum payment was capped at $2,500,000.

Federal law limits DSH payments to any hospital to the amount of uncompensated costs that the hospital incurs for providing inpatient and outpatient services to Medicaid patients and uninsured patients.

GOVERNOR

Provide $35,910,900 ($15,000,000 GPR and $20,910,900 FED) in 2015-16 and $35,842,300 ($15,000,000 GPR and $20,842,300 FED) in 2016-17 to fund one-time disproportionate share hospital (DSH) payments in the 2015-17 biennium.

Direct the Department of Health Services (DHS) to distribute DSH payments in the amounts provided under this item according to a formula, as described below, if approved by the U.S. Department of Health and Human Services (HHS), or according to alternative formula

negotiated with HHS, subject to approval by the Joint Committee on Finance under a 14-day passive review process.

Specify that a hospital may qualify for a DSH payment if it meets the following criteria: (a) it is located in Wisconsin; (b) it provides a wide array of services, including services provided through an emergency department; (c) the number of inpatient days for MA recipients at the hospital was at least 6% of total inpatient days at that hospital during the most recent year for which such information is available; and (d) it meets all applicable requirements under federal law relating to eligibility for DSH payments.

Require the Department, subject to federal approval, to distribute the total amount of DSH funding available in each year by utilizing a fee-for-service add-on percentage that increases as the hospital's percentage of MA recipient inpatient days increases, subject to a limit established so that at least one of the following is true: (a) no single hospital receives more than $2,500,000; and (b) the amount of the payment is in accordance with federal rules concerning the hospital-specific limit.

Specify that if the Department needs data to calculate the DSH payments other than data available from the Medicaid Management Information System, the fiscal survey data, or the federal Centers for Medicare and Medicaid Services public records, the Department shall collect the necessary data from hospitals.

Require DHS to seek any necessary federal approval for the DSH payment methodology described above, and to implement the methodology if such approval is received. In addition, in the event DHS negotiates a DSH payment methodology that differs from that described above, require DHS to submit the terms of that methodology to the Joint Committee on Finance for approval under a 14-day passive review process before DHS can implement that payment methodology.

DISCUSSION POINTS

1. 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 because publicly-funded programs, such as Medicaid and Medicare, tend to have lower reimbursement rates than private insurance, 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 compensate for this imbalance.

2. The bill would continue, for an additional two-year period, the DSH payment program established by the 2013-15 biennial budget. The DSH payment distribution formula under the bill would be similar, although not identical, to a payment made during the two years of the 2013-15 biennium. Although the amount of GPR funds provided for the payments would be the same ($15,000,000 annually), the total amount of the payments would be slightly lower, reflecting a lower anticipated federal medical assistance matching percentage (FMAP) received on the state

funds.

3. While states receive MA federal matching funds for DSH payments, the total federal funding available to each state is capped. However, since Wisconsin has traditionally not relied heavily on DSH payments in its MA hospital reimbursement policies, the proposed use of federal DSH funds is within the state's allotment (approximately $100.8 million in federal fiscal year 2013-14).

4. The hospitals that the Department has determined are eligible for DSH payments can be classified in the following categories: (a) acute care hospitals; (b) critical access hospitals; and (c) psychiatric hospitals. Like general acute care hospitals, critical access hospitals provide general surgical-medical services, but have fewer than 25 inpatient beds and are generally in rural areas or areas with few other hospitals. DHS has determined that, in addition to these hospitals, psychiatric hospitals that have an emergency room are also eligible for DSH payments.

5. In 2014-15, DSH payments totaled $36.7 million. Of this amount, DHS distributed $33.3 million to acute care hospitals (90.6%), $2.2 million to critical access hospitals (6.0%), and $1.3 million to psychiatric hospitals (3.4%). Sixty of the state's 86 acute care hospitals received a DSH payment, while 35 of the state's 58 critical access hospitals and four of the state's 13 psychiatric hospitals received a payment. The appendix to the paper shows the estimated 2014-15 DSH payments, by hospital.

6. While the formula established for the 2013-15 biennium specified that the payment would increase at a 0.75 proportionate rate with the MA inpatient day percentage, the bill would specify only that the add-on percentage used for the 2015-17 biennial distribution must increase as the MA inpatient day percentage increases, without establishing a specific coefficient. Assuming that the Department would use a coefficient of 1.0, this change would result in a slight shift in payments, from hospitals with a lower MA utilization rate to hospitals with a higher utilization rate. If the 2014-15 DSH payments had been distributed in accordance with the bill's proposed formula, 23 hospitals would have had a higher payment and 71 hospitals would have received a lower payment. Five hospitals that received the $2,500,000 maximum would receive the same payment. The hospitals with a higher payment all had a MA inpatient utilization rate of over 15.5% and those that would have received a lower payment had a MA utilization rate below that level.

7. Subsequent to the introduction of the bill, the Department of Administration submitted an errata letter to the Joint Committee on Finance requesting two technical modifications to the DSH payment formula language. First, the letter requested that language describing the payment as an "addition to the supplemental funding" be deleted, on the grounds that DSH payments are a supplement. Second, the letter requested that a provision pertaining to two requirements pertaining to the maximum DSH payment be modified to specify that both conditions must be true, rather than one or both be true. These changes could be made if the Committee adopts the Governor's basic formula structure [Alternative C1].

8. Wisconsin hospitals have long claimed that low MA reimbursement rates require them to offset their losses by charging more to patients covered by commercial insurance policies. The Wisconsin Hospital Association (WHA) estimates that in 2013 the difference between the cost of

providing inpatient and outpatient services to MA patients and the amount that the MA program reimbursed hospitals for those services was $960 million, a loss that WHA claims is passed on to other payers. To the extent that hospitals are forced to shift costs to commercial payers as the result of MA program losses, a policy that reduces those losses (such as providing DSH payments) should result in lower charges to commercial insurance.

9. Some economists have disputed the claim that low reimbursement rates paid to healthcare providers by public programs (including both Medicaid and Medicare), result in cost shifts to commercial insurance payers. They assert that the rates charged to commercial insurers by a hospital are affected primarily by market factors that are independent of the rates paid by public programs. That is, a hospital generally seeks to maximize net revenues, regardless of the mix of its commercially insured and publicly-funded patients. The extent to which hospitals increase or decrease prices charged to commercial insurers is dependent upon their market power in relation to those insurers and competing hospitals. By contrast, the idea that a hospital charges higher rates to commercial insurers in response to lower public program reimbursement rates implies that the hospital has the market power to dictate a higher price to commercial insurers that it would not otherwise exercise in the absence of low public program reimbursement rates. In support of this view, these economists cite evidence that suggests that hospitals either reduce costs in response to constrained revenues from public programs, or attempt to attract a larger pool of commercially-insured patients by reducing the price charged to commercial insurers.

10. Regardless of whether or not a cost shift occurs as the result of lower reimbursement rates for services provided to MA patients, hospitals that see a high proportion of MA patients will generally have more constrained revenues than those that see a lower proportion, which may affect those hospitals' financial viability. It is possible that continued erosion of MA reimbursement rates in relation to costs may affect those hospitals' ability to continue to provide care for MA patients.

11. For most hospitals, MA is a smaller source of revenues than Medicare and commercial insurance. In its Guide to Wisconsin Hospitals (Fiscal Year 2013), the Wisconsin Hospital Association's Information Center indicated that MA accounted for approximately 13.5% of hospitals' total gross patient revenues (billed charges), while Medicare accounted for 43.6% and commercial insurance or other payment sources accounted for the remaining 42.9% of hospitals' total gross patient revenues.

12. It is widely acknowledged that MA reimbursement rates fall well below the usual and customary charges for non-institutional providers, such as physicians, dentists, psychologists, physical and occupational therapists, home health care and personal care providers. In contrast to the decision in the 2013-15 budget to provide supplemental funding for DSH payments for hospitals, no state funding has been provided for payment increases to these MA providers since 2008, when the Legislature approved a 1% rate increase. The bill would continue to provide the supplemental hospital payments, but would not provide funding to increase the reimbursement rate for non-institutional providers.

13. In contrast to the funding to continue DSH payments, the bill would reduce reimbursement for federally qualified health centers (FQHCs). These clinics, because they serve primarily MA and uninsured low income patients, are far more dependent on MA for total

operations than most hospitals.

14. In addition to low MA reimbursement rates, another purpose of DSH payments is to compensate states for care provided to uninsured persons. However, with the expansion of health coverage under the Affordable Care Act, as well as the state's decision to extend MA coverage to childless adults with income up to 100% of the federal poverty level, the number of uninsured patients has likely decreased since 2013. It is too soon to see the impact using available hospital data, but a decrease in the uninsured may reduce hospitals' uncompensated care costs.

15. A case could be made that providing supplemental payments for hospitals is not justified, since the bill would continue to freeze reimbursement rates for non-institutional providers and would decrease the reimbursement rate for FQHCs. Furthermore, in an environment in which funding for many GPR-funded state programs may be reduced or constrained, the Committee may decide it is necessary to reduce funding for some programs, such as DSH payments, as these payments were provided on a one-time basis in the 2013-15 biennium.

16. For these reasons, and in light of other GPR-funded priorities, the Committee could delete the Governor's recommendation, resulting in GPR reductions of $15,000,000 annually [Alternative A4].

17. Alternatively, the Committee could adopt a modification that provides a smaller DSH payment. A commitment of $10,000,000 GPR annually would produce payments (including federal matching funds) of $23,946,400 in 2015-16 and $23,900,600 in 2016-17 [Alternative A2], whereas a commitment of $5,000,000 GPR annually would result in total payments of $11,973,200 in 2015-16 and $11,950,300 in 2016-17 [Alternative A3].

18. The purpose of DSH payments is to target supplements to those hospitals that have a high percentage of MA patients (as well as uncompensated care associated with charity care and bad debt) since these patients can place financial stress on hospitals. Yet, most hospitals have a MA inpatient utilization rate above the 6% minimum threshold, which means that most hospitals that meet the categorical qualifications receive a payment. In 2014-15, 70% of acute care hospitals received DSH payments and only eight of the 26 acute care hospitals that did not received a payment were disqualified because of their MA inpatient utilization percentage. [The others had a MA utilization percentage above the 6% threshold, but were disqualified because of categorical exclusions.]

19. If the Committee decides to reduce the amount of DSH payments (or even if it does not), the distribution formula could be modified to more narrowly target payments to hospitals with the highest percentage of MA inpatients. For instance, the minimum percentage could be increased to 10% [Alternative B2]. This would reduce the number of acute care hospitals that would have received a payment (using 2014-15 formula inputs) from 60 to 40, and the number of critical access hospitals receiving a payment from 35 to 16. The four psychiatric hospitals would continue to receive a payment.

20. The Committee could further target DSH payments by setting a minimum threshold of 15% [Alternative B3]. In this case (again using 2014-15 formula inputs), the number of acute care

hospitals receiving a payment would decrease from 60 to 20. The number of critical access hospitals receiving a payment would decrease from 35 to six, and the number of psychiatric hospitals would decrease from four to three.

21. Another alternative to target the hospitals that experience the greatest MA program underpayments, would be to exclude critical access hospitals from the distribution [Alternative C2]. Critical access hospitals are reimbursed using a methodology designed to pay the hospital's actual cost of providing services to MA patients. Although these hospitals may experience some of the same financial stresses associated with bad debt and providing services to the uninsured as do other hospitals, they do not experience the MA payment shortfall that is the principal rationale for making DSH payments. Eliminating critical access hospitals from the distribution would direct additional funds ($2.2 million from the 2014-15 distribution) to other hospitals that do not receive a cost-based reimbursement under the MA program.

22. If the Committee determines that making disproportionate share payments should be the state's policy on an ongoing, annual basis, rather than just in the 2015-17 biennium, the bill could be amended to require annual payments. Since the amount of the total payment will vary from year to year, depending upon the state's Medicaid matching percentage, the total payment could be set at the amount equal to the state funds budgeted for payments ($15,000,000 annually under the bill), plus the corresponding amount of federal matching funds [Alternative C3].

ALTERNATIVES

A. Disproportionate Share Hospital Payment Funding

1. Approve the Governor's recommendation to provide $35,910,900 ($15,000,000 GPR and $20,910,900 FED) in 2015-16 and $35,842,300 ($15,000,000 GPR and $20,842,300 FED) in 2016-17 to fund one-time disproportionate share hospital (DSH) payments in the 2015-17 biennium

2. Modify the Governor's recommendation by reducing funding allocated for DSH payments by $11,964,500 (-$5,000,000 GPR and -$6,964,500 FED) in 2015-16 and by $12,010,300 (-$5,000,000 GPR and -$7,010,300 FED) in 2016-17 to provide a total DSH payments of $23,946,400 in 2015-16 and $23,900,600 in 2016-17.

ALT A2	Change to Bill
GPR	- $10,000,000
FED	- 13,974,800
Total	- $23,974,800

3. Modify the Governor's recommendation by reducing funding allocated for DSH payments by $23,937,700 (-$10,000,000 GPR and -$13,937,700 FED) in 2015-16 and by $23,960,600 (-$10,000,000 GPR and -$13,960,600 FED) in 2016-17 to provide a total DSH payments of $11,973,200 in 2015-16 and $11,950,300 in 2016-17.

ALT A3	Change to Bill
GPR	- $20,000,000
FED	- 27,898,300
Total	- $47,898,300

4. Delete provision.

ALT A4	Change to Bill
GPR	- $30,000,000
FED	- 41,753,200
Total	- $71,753,200

B. Disproportionate Share Hospital Payment Minimum Medicaid Inpatient Percentage

1. Approve the Governor's recommendation to distribute DSH payments to hospitals with an MA inpatient percentage of at least 6%.

2. Modify the Governor's recommendation by increasing the minimum MA inpatient percentage to qualify for a DSH payment from 6% to 10%.

3. Modify the Governor's recommendation by increasing the minimum MA inpatient percentage to qualify for a DSH payment from 6% to 15%.

C. Other Modifications

[The Committee may adopt none, one, or more than one of these alternatives.]

1. Adopt technical modifications to the formula language as requested by the Department of Administration in an errata letter to the Joint Committee on Finance and as described in Point #7.

2. Modify the DSH payment criteria to specify that critical access hospitals are not eligible for payments.

3. Modify the DSH payment requirement to specify that payments are to be made annually on an ongoing basis. Require the Department to make total payments equal to the amount of GPR allocated annually in the 2015-17 biennium [dependent on the Committee's decision under Part A] plus the amount of federal matching funds received on the GPR funds.

Prepared by: Jon Dyck

APPENDIX

2014-15 Disproportionate Share Hospital Payments

Acute Care Hospitals

Hospital	City	MA Inpatient Percentage	Payment
Appleton Medical Center	Appleton	6.4%	$166,144
Aspirus Wausau Hospital	Wausau	9.0	311,372
Aurora Baycare Medical Center	Green Bay	15.3	473,243
Aurora Lakeland Medical Center	Elkhorn	10.4	123,798
Aurora Medical Center - Grafton	Grafton	6.1	127,539
Aurora Medical Center - Kenosha	Kenosha	9.7	128,951
Aurora Medical Center - Summit	Summit	8.7	49,497
Aurora Medical Center of Manitowoc Co Inc.	Two Rivers	9.8	61,621
Aurora Medical Center of Oshkosh	Oshkosh	16.3	111,339
Aurora Memorial Hospital - Burlington	Burlington	6.2	53,526
Aurora Metro Hospital Corp.	Milwaukee	52.5	2,500,000
Aurora Sheboygan Memorial Medical Center	Sheboygan	16.8	165,028
Aurora West Allis Medical Center	West Allis	15.8	400,081
Bay Area Medical Center	Marinette	8.3	138,188
Beaver Dam Community Hospitals Inc.	Beaver Dam	10.0	51,359
Bellin Memorial Hospital	Green Bay	9.8	272,332
Beloit Memorial Hospital Inc.	Beloit	13.5	154,111
Children's Hospital Of Wisconsin	Milwaukee	51.9	2,500,000
Children's Hospital Of Wisconsin - Fox Valley	Neenah	43.5	411,888
Columbia St. Mary's Hospital - Milwaukee	Milwaukee	29.0	2,068,276
Divine Savior Healthcare Inc.	Portage	8.6	41,075
Fort Healthcare	Fort Atkinson	9.3	73,756
Froedtert Memorial Lutheran Hospital	Milwaukee	18.7	2,500,000
Gundersen Lutheran Medical Center Inc.	La Crosse	15.8	774,826
Holy Family Memorial Medical Center	Manitowoc	9.2	49,888
Howard Young Medical Center Inc.	Woodruff	9.6	110,348
Lakeview Medical Center	Rice Lake	14.4	68,905
Mayo Clinic Health System - Eau Claire Hospital	Eau Claire	10.8	387,860
Mayo Clinic Health System - Franciscan Healthcare	La Crosse	12.5	279,405
Mercy Health System Corporation	Janesville	14.2	448,487
Mercy Medical Center of Oshkosh	Oshkosh	9.1	183,422
Meriter Hospital Inc.	Madison	21.3	1,588,124
Mile Bluff Medical Center	Mauston	14.5	59,671
Oconomowoc Memorial Hospital	Oconomowoc	6.4	60,951
Riverview Hospital Association	Wisconsin Rapids	13.8	57,914

2014-15 Disproportionate Share Hospital Payments (continued)

Hospital	City	MA Inpatient Percentage	Payment
Sacred Heart Hospital	Eau Claire	16.0%	$599,515
Saint Joseph's Hospital	Marshfield	17.0	1,261,969
Saint Mary's Hospital Inc.	Rhinelander	16.1	132,656
Saint Michael's Hospital	Stevens Point	11.6	103,581
St. Agnes Hospital	Fond du Lac	9.3	166,654
St. Clare Hospital And Health Services	Baraboo	11.9	106,051
St. Clare's Hospital of Weston Inc.	Weston	10.6	164,333
St. Elizabeth Hospital	Appleton	18.4	483,016
St. Joseph's Community Hospital	West Bend	6.0	61,456
St. Joseph's Hospital	Chippewa Falls	12.1	89,704
St. Luke's Medical Center	Milwaukee	12.9	2,368,916
St. Mary's Hospital - Janesville	Janesville	13.6	221,097
St. Mary's Hospital Medical Center	Green Bay	13.4	176,552
St. Mary's Hospital Medical Center	Madison	16.2	1,223,671
St. Nicholas Hospital	Sheboygan	7.2	65,462
St. Vincent Hospital	Green Bay	18.2	835,190
The Monroe Clinic	Monroe	7.8	34,249
Theda Clark Medical Center	Neenah	11.2	272,272
United Hospital System Inc.	Kenosha	12.1	351,630
University Of WI Hospital & Clinics Authority	Madison	11.9	2,500,000
UW Health Partners - Watertown Regional Med Center	Watertown	13.5	72,035
Waukesha Memorial Hospital Inc.	Waukesha	6.6	454,915
Wheaton Franciscan Healthcare - All Saints	Racine	17.2	1,177,831
Wheaton Franciscan Healthcare - St. Francis	Milwaukee	22.9	900,605
Wheaton Franciscan St. Joseph's	Milwaukee	42.2	2,500,000
	Acute Care Hospital Total		$33,276,281

Critical Access Hospitals

Hospital	City	MA Inpatient Percentage	Payment
Amery Regional Medical Center	Amery	6.6%	$55,540
Waupun Memorial Hospital	Waupun	6.2	24,735
Baldwin Area Medical Center Inc.	Baldwin	8.4	35,347
Berlin Memorial Hospital	Berlin	9.2	57,898
Black River Memorial Hospital	Black River Falls	10.9	74,924
Burnett Medical Center Inc.	Grantsburg	11.7	17,319
Cumberland Memorial Hospital	Cumberland	9.6	62,891
Grant Regional Health Center Inc.	Lancaster	12.2	18,058
Hayward Area Memorial Hospital	Hayward	18.8	104,578
Hudson Hospital	Hudson	10.6	129,335

2014-15 Disproportionate Share Hospital Payments (continued)

Hospital	City	MA Inpatient Percentage	Payment
Ladd Memorial Hospital	Osceola	7.1	32,564
Langlade Memorial Hospital	Antigo	14.4	60,930
Mayo Clinic Health System - Northland	Barron	9.9	30,512
Mayo Clinic Health System - Red Cedar	Menomonie	11.6	71,939
Memorial Health Center Inc.	Medford	17.1	28,088
Memorial Hospital Inc.	Neillsville	11.3	27,315
Memorial Hospital of Lafayette County	Darlington	8.5	17,309
Memorial Medical Center	Ashland	24.1	405,915
Mercy Walworth Hospital and Medical Center	Lake Geneva	13.8	32,262
Ministry Door County Medical Center	Sturgeon Bay	7.5	77,597
New London Family Medical Center	New London	6.1	21,959
Prairie Du Chien Memorial Hospital	Prairie du Chien	8.0	20,654
Reedsburg Area Medical Center	Reedsburg	10.7	76,122
River Falls Area Hospital	River Falls	9.1	89,924
Rusk County Memorial Hospital & Nursing Home	Ladysmith	9.4	26,064
Shawano Medical Center	Shawano	15.7	147,471
Southwest Health Center	Platteville	16.5	56,897
The Richland Hospital Inc.	Richland Center	9.3	65,843
Riverside Medical Center	Waupaca	6.9	42,843
Spooner Health System	Spooner	8.3	12,787
St. Croix Regional Medical Center	St. Croix Falls	11.8	84,556
Tomah Memorial Hospital Inc.	Tomah	16.0	74,569
Upland Hills Health Inc.	Dodgeville	9.2	30,141
Vernon Memorial Hospital	Viroqua	7.7	29,405
Westfields Hospital	New Richmond	7.7	40,866
	Critical Access Hospital Total		$2,185,155

Psychiatric Hospitals

Hospital	City	MA Inpatient Percentage	Payment
Bellin Psychiatric Center	Green Bay	31.3%	$330,003
Brown County Community Treatment Center	Green Bay	13.5	36,257
Milwaukee County Behavioral Health	Milwaukee	19.7	791,446
North Central Health Care Facilities	Wausau	19.2	108,194
	Psychiatric Hospital Total		$1,265,900
	Total Disproportionate Share Hospital Payments		$36,727,336