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Health, Education and Human Services Division

B-278942

January 28, 1998

The Honorable John R. Kasich
Chairman, Committee on the Budget
House of Representatives

The Honorable David L. Hobson
House of Representatives

Subject: Medicaid: Managed Care and Individual Hospital Limits for Disproportionate Share Hospital Payments

The Balanced Budget Act of 1997 contains an estimated $17 billion in Medicaid reductions over 5 years, including $10.4 billion from disproportionate share hospital (DSH) payments.[1] DSH payments are made in addition to other Medicaid reimbursements to hospitals that serve large numbers of low-income patients. These payments are based on formulas devised by the states, subject to certain federal requirements. Some states, such as Ohio, do not consider the costs and revenues associated with Medicaid recipients enrolled in managed care when calculating hospital DSH payments. This has created some concern that DSH funds are not being distributed equitably and that some state formulas could adversely affect children's hospitals, which typically have high Medicaid utilization.

Because of these concerns, you asked us to determine (1) whether state formulas vary in their inclusion of managed care costs and revenues when calculating the maximum amount a specific hospital can receive, (2) whether such variation is allowed by the Medicaid program, and, if so, (3) HCFA officials' views on setting a uniform policy in this area.

To address your questions, we talked with HCFA officials and state Medicaid program officials in Ohio and six other states where we had ongoing work related to DSH payments. We also contacted representatives of several hospital

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[1]Because of increases in other parts of the Medicaid program, total budget savings are estimated to be $7.3 billion.

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associations.[2] In addition, we reviewed relevant documents–including some state Medicaid plans–as well as applicable Medicaid statutes and regulations. We performed our work between September 1997 and January 1998 in accordance with generally accepted government auditing standards.

In summary, we found that state formulas for calculating maximum DSH payments to specific hospitals vary in whether or not they include Medicaid managed care costs and revenues. The rules of the Medicaid program allow this variation. HCFA officials told us that different state circumstances may warrant different state approaches and HCFA does not plan to impose new requirements to eliminate this variation.

BACKGROUND

The total amount of federal funds a state can expend in DSH payments is determined by federal statute. In allocating its DSH funds, a state must first designate the hospitals in the state that will be eligible to receive DSH payments. Federal rules require the states to make DSH payments to hospitals meeting criteria for the numbers of Medicaid or low-income patients they serve. These rules also set parameters for determining minimum DSH payments to these hospitals. In addition, these rules allow the states to select additional hospitals to receive DSH payments if they meet other federal requirements.

While the states also have broad discretion when determining the amount of Medicaid DSH payments to individual hospitals, there is a facility-specific limit on the maximum DSH payment an individual hospital can receive. The Omnibus Budget Reconciliation Act of 1993 essentially defines this maximum DSH payment amount as the sum of (1) the cost of services to Medicaid patients less the amount paid by Medicaid prior to DSH payments and (2) the cost of services to uninsured patients less any payments made on their behalf to the hospitals. The states are free to use different methods to determine the payments for different hospitals, paying some only a small portion of their maximum and paying others the maximum allowed.

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[2]The seven states we contacted were Kansas, Maryland, Michigan, New Hampshire, North Carolina, Ohio, and Texas. The hospital associations we contacted included Ohio's Association for Hospitals and Systems, the Association of Ohio Children's Hospitals, and the National Association of Children's Hospitals.

STATES VARY IN TREATMENT OF MANAGED CARE WHEN SETTING HOSPITAL DSH LIMITS

Of the seven states we contacted, three included the costs and revenues for Medicaid beneficiaries enrolled in managed care plans when calculating individual hospital maximum DSH payment amounts and three states did not. The remaining state is changing its system to include managed care costs and revenues when calculating its maximum DSH payments. Although HCFA does not track these state practices nationwide, HCFA officials told us that they knew of a few states that were changing their Medicaid state plans to include Medicaid managed care costs and revenues when determining hospital maximum DSH payment amounts.

A concern about whether a state includes managed care costs and revenues in calculating its hospital maximum DSH payment amounts centers on the effect on children's hospitals. In essence, some argue that by ignoring Medicaid managed care costs and revenues in some states, some children's hospitals are being inordinately hurt because they tend to have high Medicaid utilization from both fee-for-service and managed care recipients. When costs and revenues from the Medicaid managed care population are not included in the formula, the hospitals' maximum DSH payment amounts may not be as high as they otherwise could be, and the hospitals may not receive as large a DSH payment as they otherwise could by law.

While 10 of 13 children's hospitals in the states we contacted were paid their hospital specific maximums in 1996, we found that hospital maximum DSH payment amounts do not always determine the DSH payment a hospital receives. For example, Michigan, which includes Medicaid managed care costs and revenues when calculating its maximum DSH payments, made a DSH payment in 1996 of about $9.5 million to a children's hospital whose maximum DSH payment amount was $33 million. In contrast, Ohio, which does not include managed care costs and revenues when determining maximum DSH payments, paid its children's hospitals their upper limits in 1997. Some of these hospitals reported to their state association losses from caring for Medicaid managed care patients. If Ohio's policy had been to include this shortfall when calculating their maximum DSH payments, these hospitals could have received higher DSH payments.[3] However, other hospitals with Medicaid managed care

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[3]Because Ohio spent its total DSH allocation, any increase in DSH funding to one hospital would have resulted in a decrease for others.

losses would also have had their maximum DSH payment amount increased, potentially by a greater amount than that of the children's hospitals.

Currently, Medicaid statutes do not address how the states should treat Medicaid managed care costs and revenues in setting individual hospital maximum DSH payment amounts. HCFA has not issued a formal policy in this area and accepts state Medicaid plans using either method.[4] A state's recognition of Medicaid managed care costs and revenues in determining maximum DSH payment amounts affects not its designation as a DSH hospital but only its maximum DSH payment amount. Similarly, hospital maximum DSH payment amounts often do not determine the DSH payment a hospital receives. The states are still required to include all persons who qualify for Medicaid, including Medicaid managed care enrollees, when determining whether a hospital is designated to receive DSH payments under federal rules.

HCFA IS NOT PLANNING TO REQUIRE UNIFORM TREATMENT OF MANAGED CARE IN DSH LIMITS

We found that HCFA has no plans to set a uniform policy in this area. HCFA officials told us that they defer to the states on issues such as this because different state circumstances may warrant different state approaches. HCFA officials told us that there may be situations in which states would believe it is appropriate to include managed care costs in setting the DSH upper limit, such as where hospitals provide care for many Medicaid managed care enrollees. They told us that in such cases they would not want to preclude the states from setting a policy that Medicaid managed care costs and revenues be included in the calculation of hospital maximum DSH payment amounts. In contrast, HCFA officials did express concern that allowing hospitals the possibility of recouping losses from their Medicaid managed care business might reduce the hospitals' incentives to negotiate adequate rates with managed care plans. They added that, in these cases, they would not want to set a policy that required the states to include Medicaid managed care shortfalls in DSH maximum calculations.

[4]Similarly, HCFA allows the states the option of including outpatient costs and payments in addition to inpatient costs and payments when determining a hospital's DSH upper payment limit.

AGENCY COMMENTS

We provided a draft of this correspondence to the HCFA Administrator for review and comment. While HCFA was unable to provide formal comments in time for us to include them, HCFA program officials who reviewed the report told us that it is accurate. They also provided technical comments, which we included as appropriate.

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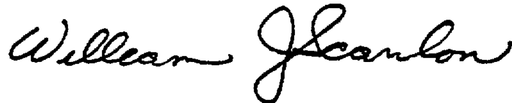
Please call Paul Alcocer at (312) 220-7709 or me at (202) 512-7114 if you or your staff have any questions about the information in this letter. Other contributors to this document were Dan Meyer and Barbara Mulliken.



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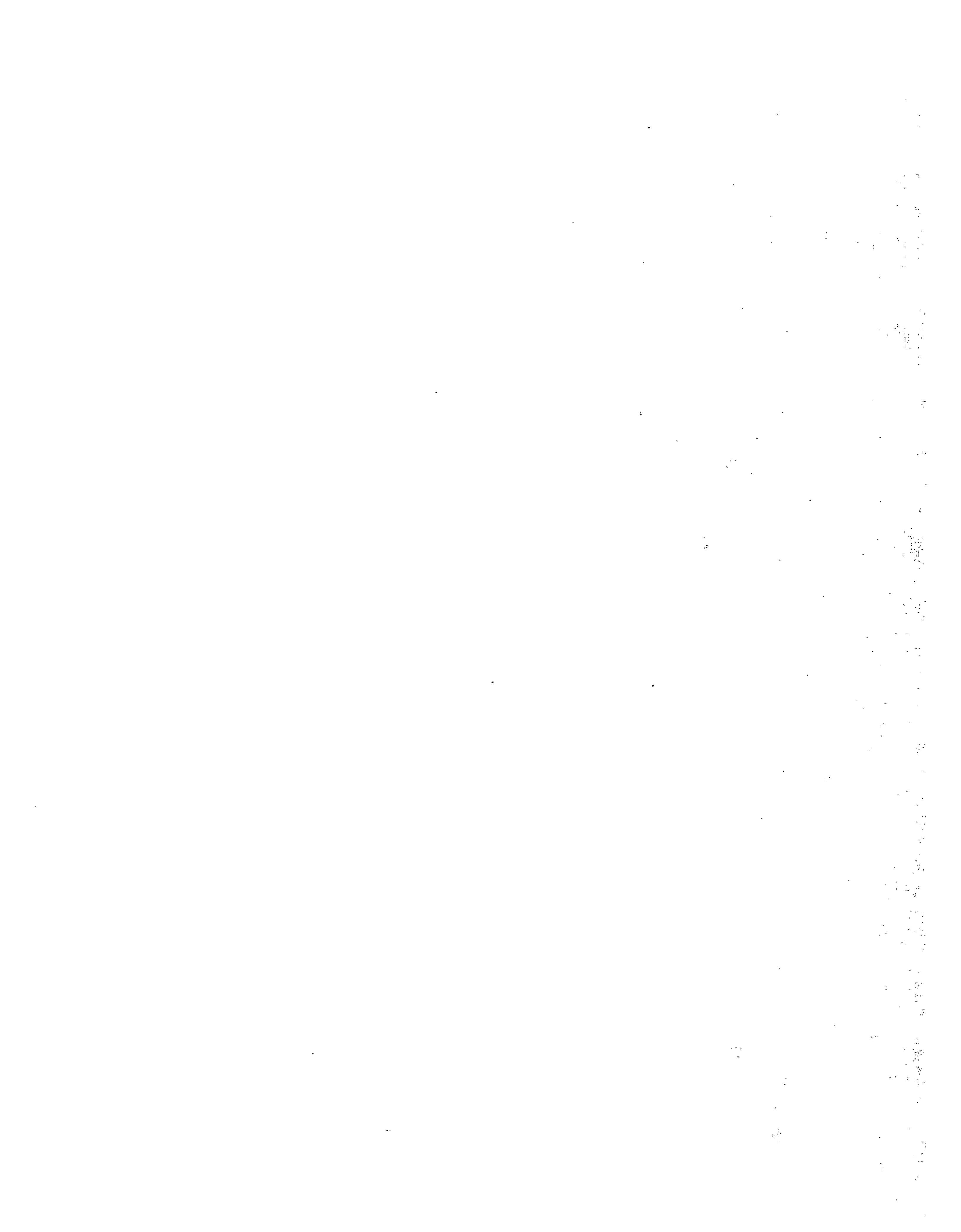

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