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Kansas Health Policy Authority
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Draft Methodology to Reform DSH Payments in Kansas

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Overview

- DSH reform process
- Background on present method
- Concerns with present method
- Key reform objectives
- Draft methodology
- Discussion and feedback

DSH reform process

DSH reform process

- Concerns about existing methodology raised by hospitals
- All hospital meetings in September and December 2006
- Formation of advisory workgroup of hospital financing officials, consultants, KHA and KHPA staff
- Development and vetting of multiple models with workgroup and individual hospitals January to July 2007
- Presentation of draft methodology to all hospitals August 14, 2007
- Presentation of proposed methodology to KHPA Board August 20-21, 2007
- Submission to CMS during September 2007 of State Plan Amendments for DSH formula and Critical Access Hospital fee-for-service payment rates.
- Application of new methodology FY 2008

Background on present methodology

Present methodology

- In Kansas, the current Medicaid DSH program allows hospitals to **qualify** for DSH funding in two ways:
  - MUR: The proportion of inpatient Medicaid days to total inpatient days is greater than one standard deviation above the mean for all hospitals that do business with Kansas Medicaid. This is the Medicaid Inpatient Utilization Ratio (MUR).
  - LIUR: Total Medicaid and other public revenue is at least 25% of total hospital revenue. This is the Low Income Utilization Ratio (LIUR), and includes both inpatient and outpatient revenue. Public revenue represents state and local subsidies, not Medicare, VA, etc.
- After significant discussion with multiple hospital stakeholders, KHPA recommends maintaining this set of qualifications for DSH payments.

Present methodology

- In Kansas, the current Medicaid DSH program **reimburses** qualifying DSH hospitals according to two separate formulas:
  - LIUR payment typically reimburses 100% of inpatient losses (for both Medicaid and the uninsured), and between 30% and 50% of outpatient losses, subject to the state's overall Federal DSH allotment.
  - MUR hospitals receive up to 2.5% of their Medicaid inpatient payments (*not* losses) plus another percentage of these payments equal to half of the amount by which their MUR exceeds the MUR qualification threshold.

Concerns with present methodology

Existing concerns

- **Under-spending.** The current methodology does not always result in fully expending all payments allowed by Federal DSH regulations ($42 million for community hospitals). In 2007, $6 million went unallocated (approximately $4 million Federal funds, $2 million SGF).

- **Instability.** Very large disparities between hospitals that do and do not qualify for DSH payments, and very large changes in DSH payments from one year to the next for any given hospital.
  - Three hospitals would change payment class in 2008, two would lose eligibility, and five would become eligible.
  - Total DSH-eligible losses increased from $37 million to $59 million in FY 2008, creating some big increases and many decreases.
  - Without reform, there would be 21 hospitals with higher payments and 30 hospitals with lower payments in FY 2008.

- **Inequity**. Medicaid losses are treated differently in hospitals qualifying as MUR versus LIUR. Inpatient and outpatient losses are treated unequally by the DSH formula.

Key reform objectives

DSH reform objectives

- **Support KHPA vision principles.** The overall goal of DSH reform is to provide financial support for hospitals providing care to those in need, including Medicaid beneficiaries and the uninsured.
- **Spend available funds.** Maintain the state's support for the DSH program and devise a formula that always expends the maximum amount allowed by Federal regulations.
- **Adopt single formula.** Direct resources consistently and equitably towards hospitals that provide a high level of services to Medicaid beneficiaries and the uninsured by abandoning the existing two-formula strategy applied to LIUR and MUR hospitals.
- **Introduce dis-proportionality.** Increasing the percentage of losses reimbursed for hospitals with proportionally higher losses.
- **Include all losses**. Treat losses equally whether attributable to outpatient, inpatient, Medicaid, or uninsured services.
- **Predictability**. Create more predictability and stability in DSH payments over time, lessening the payment "cliff" that faces marginal DSH hospitals.

Draft methodology

Draft methodology: formula

- **Focus on hospital losses**. The draft methodology begins with each facility's percentage of losses to total costs. Losses include those attributable to Medicaid, the uninsured, outpatient and inpatient services.
- **Rank facilities by proportional losses.** This burden rate is then normalized (i.e., rebased) between 0% and 100% to determine each facility's percentage rank, a measure of disproportionate burden. Roughly speaking, this percentage rank is equal to each hospital's loss ratio expressed as a percentage of the highest observed loss ratio.
- **Adjust ranking to obtain percentage of losses reimbursed**. To obtain the proportion of losses covered, a base percentage is added to each percentage rank. This base percentage serves as a means to ensure that the federal allotment is neither under-spent nor exceeded. The resulting DSH payment for each facility is literally this proportion of their qualifying Medicaid and uninsured losses.
- **Resulting payments emphasize proportional losses.** The facilities with the highest burden of uncompensated costs relative to their peers will have the highest percentage of its allowable losses covered. Conversely, the facilities with the lowest burden of uncompensated costs will receive the lowest percentage of loss coverage

Draft methodology: additional reforms

- **Change the base Medicaid reimbursement for Kansas Critical Access Hospitals** (CAH) to cover costs (cost based reimbursement, consistent with how Medicare pays CAHs). By removing these small rural hospitals -- crucial to providing services across a rural state such as Kansas -- from the DSH pool, we free up funds to be applied to other hospitals' losses.
- **Limit 10% of Kansas Medicaid DSH payments for out-of-state community hospitals** in order to ensure that the majority of DSH funds pay for losses to Kansas hospitals (excludes payments to state psychiatric facilities).
- **Excluding the Kansas University Hospital Authority from the DSH formula**, given their unique Medicaid payment formula as a public hospital.
- **Provide a smooth three-year transition to the new methodology** in FY 2008-2010 to give DSH hospitals adequate time to adjust to the new DSH formula.
- **Provide one-time 50% payments to multi-year DSH hospitals that lose eligibility** (applies on an ongoing basis).

Discussion and feedback


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