

Preserving the Arkansas Health Care Safety Net through Reasonable Reimbursement for Hospitals:

Follow-up to Studies of Arkansas Medicaid Hospital
Reimbursement of 2002, 2004, 2006 & 2012, using 2013
Data

Fall 2015



Arkansas Hospital Association

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Over a decade ago, the Arkansas Hospital Association first engaged **BKD, LLP** (BKD) to conduct a study to document hospitals' losses attributable to inadequate Arkansas Medicaid reimbursements. That study was based on data for 2002 and was subsequently updated three times, with data for 2004, 2006, and 2011. This year the AHA and BKD performed a similar study to update those findings utilizing 2013 data.

Report Summary

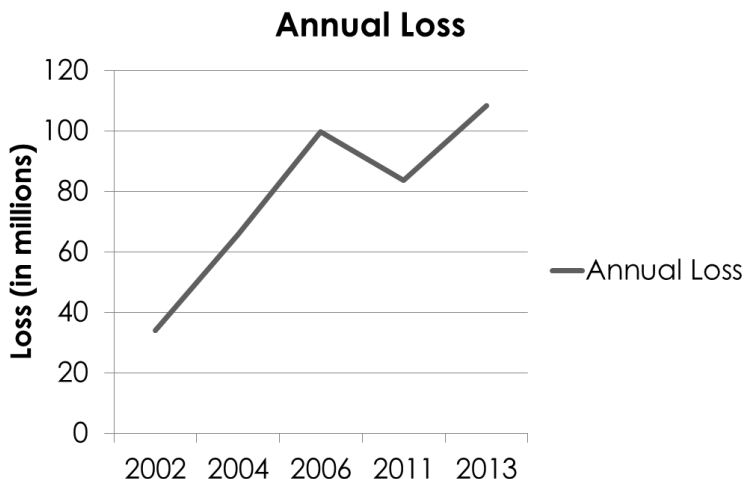
\$108,719,000

That's the unreimbursed cost of services provided in 2013 to Arkansas Medicaid recipients recorded by the 44 Arkansas acute care hospitals included in this study. The balance of Arkansas' 98 licensed hospitals, including UAMS, Arkansas Children's Hospital and Arkansas' critical access hospitals and others, are reimbursed under a different methodology based on cost and are not included in this study, which breaks down the losses by rural and urban location, and bed size.

The unreimbursed Medicaid costs are separate and in addition to the costs of uncompensated care related to uninsured patients who can't afford to pay for the hospital care they receive.

Arkansas hospitals provide state-of-the art health care to thousands of low-income Arkansans each year. The inpatient and outpatient data from the 44 hospitals included in this study shows that these hospitals are significantly underpaid for both inpatient and outpatient services by the Medicaid program and the level of those underpayments has grown steadily over the past decade.

The unreimbursed Medicaid costs are separate and in addition to the costs of uncompensated care related to uninsured patients who can't afford to pay for the hospital care they receive.



If not for the Upper Payment Limit (UPL) and Provider Access reimbursements, losses for 2013 would have been over \$265 million.

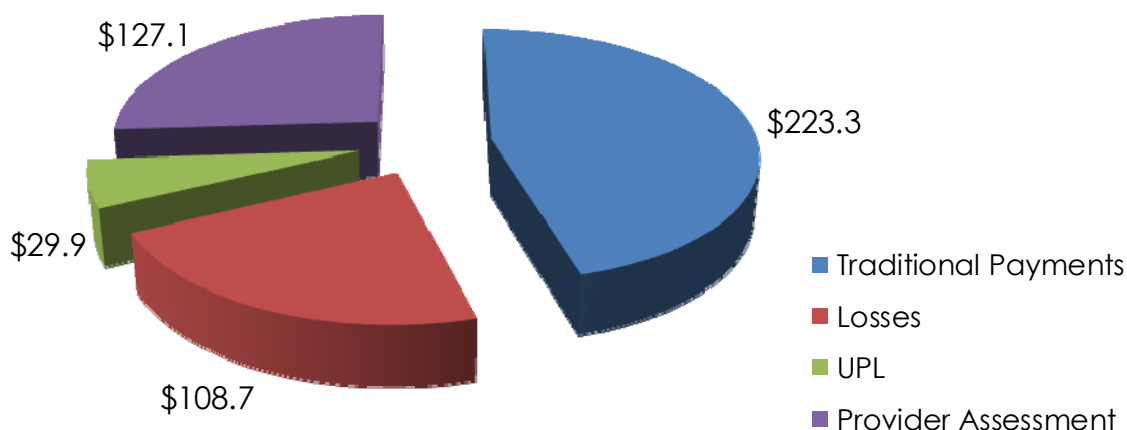
The overall Medicaid payment ratio in 2013 was 89% of costs.

Even after considering supplemental Upper Payment Limit (UPL) and provider access reimbursements, Arkansas hospitals lost over \$108 million in 2013 caring for Arkansas Medicaid patients. This continues a trend of increasing losses only partially tempered by the establishment of the provider access program in 2009.

The Arkansas Medicaid program, on average, reimbursed hospitals included in this study less than 80% of the cost of care which they incurred in 2013 associated with Medicaid beneficiaries. These reimbursements include payments generated from federal matching programs and are not totally funded by the state. These hospitals spent \$488 million caring for Medicaid patients, but were reimbursed only \$223 million under Medicaid’s traditional payment methodology. Most hospitals were able to participate in the state’s UPL and provider access programs and shared in supplemental payments available through those channels, reducing the total losses by \$157 million, resulting in a net loss of approximately \$109 million, (an increase of approximately \$25 million since the most recent study, which included approximately the same number of hospitals).

Arkansas Medicaid Payment Summary

(In millions)



The study identified \$488 million in costs of care to Medicaid recipients; however, hospitals were not reimbursed for nearly \$109 million of these costs.

For outpatient services, Medicaid rates, which are based on a fee schedule that has not been updated in 25 years, cover only 33% of costs.

Based on traditional Medicaid rates alone, Medicaid covered 65% of hospitals' inpatient care costs relating to covered days. When considering inpatient care to Medicaid patients who exceed their 24-day coverage limit (which Medicaid does not pay), the payment ratio drops to 52% of costs. For outpatient services, Medicaid rates, which are based on a fee schedule that has not been updated in 25 years, cover only 33% of costs.

Fortunately, the UPL and Provider Access funds partially offset these losses, bringing the inpatient and outpatient payment ratios to 91% and 52%, respectively, and the overall payment ratio is 78% of costs.

Study Background

This study was commissioned by the Arkansas Hospital Association (AHA) to estimate the difference between the cost of providing hospital services to Arkansas Medicaid beneficiaries and the amount paid by the Arkansas Medicaid Program (Medicaid).

The study is based on cost reports and claims data obtained under the *Freedom of Information Act* from the Arkansas Medicaid Administrative Contractor and Department of Human Services. The study includes inpatient and outpatient data from acute care hospitals in Arkansas that are not paid based on reasonable cost (Critical Access Hospitals, state hospitals and Arkansas Children's Hospital).

History of Medicaid Reimbursement in Arkansas for Inpatient Services

Acute Inpatient Reimbursement – Patients over the Age of One

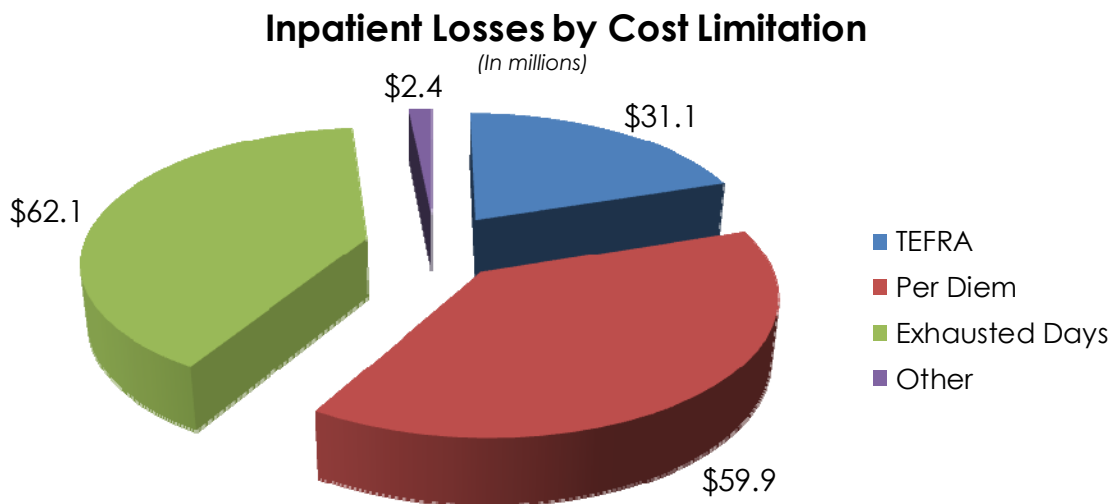
In the early 1990s, Medicaid implemented a hospital reimbursement methodology following Medicare guidelines under the federal *Tax Equity and Fiscal Responsibility Act of 1982* (TEFRA). Under the TEFRA methodology, a participating hospital established a cost per discharge target amount for a base year (generally 1990 or 1991 for Medicaid). In subsequent years, the total cost per discharge paid by Medicaid would not exceed the target amount, updated for a defined inflation rate. If costs fall below the target amount, hospitals would be paid for full cost up to a per diem cap. If costs are above the target amount, reimbursement is further limited.

The target amount is updated each year. Generally, Medicaid has used an inflation factor equal to the Medicare inflation factor. In many years since 1990, in response to Congressional budget reconciliation measures, Medicare has used an inflation factor less than the identified full rate of inflation. As a result, the TEFRA rates have increased at a rate less than inflation, if at all. TEFRA target rates have not kept pace with the costs of providing care since 1990.

In addition to the TEFRA limitations, the Medicaid program imposed an absolute cost per day limitation of \$675 prior to July 1, 2006, and \$850 thereafter. In addition, the Medicaid program currently covers only 24 days of care per state fiscal year for most recipients over age 21. It is not uncommon for patients to require more than 24 days of care in any one year. Hospitals are not reimbursed by Medicaid for days that exceed the 24-day cap, but are allowed to bill patients directly for these “non-covered” days. Unfortunately, these patients are generally not able to pay hospitals for this extra care. Instead, hospitals are forced to write off these balances as bad debts or charity adjustments, often resulting in no payments for days in excess of the 24-day limitation.

We understand that effective January 1, 2016, Arkansas Medicaid will reimburse \$400 per day for the 25th and subsequent days. However, at the same time, the Medicaid program will cease to reimburse for Medicare crossover days for Medicaid beneficiaries.

The following chart shows that a majority of losses incurred by hospitals under the traditional inpatient Medicaid payment method is caused by the 24-day and per diem limits.



To summarize, hospitals are reimbursed the lower of the following under the traditional Arkansas Medicaid inpatient program for patients over the age of one:

- Allowable costs of providing patient services
- Allowable costs reduced by any TEFRA limitation
- Total covered Medicaid days (x) per diem rate

Acute Inpatient Reimbursement – Patients Under the Age of One

Under federal guidelines, hospitals that provide services to Medicaid patients under the age of one are reimbursed at least 100 percent of the allowable costs for providing care to these patients. This reimbursement is not subject to a lower of cost or charges limitation, the TEFRA limitation, the per diem limit or the 24-day annual limit.

Upper Payment Limit Reimbursement

Starting in 2001, the Arkansas Medicaid program implemented an Upper Payment Limit (UPL) provision to the state Medicaid plan to allow for some additional reimbursement to Arkansas hospitals for acute care services. The UPL benefit varies based on a hospital's type of ownership. Hospitals that qualify as "non-state public" hospitals generally receive additional payments of approximately 54% of the difference in what Medicare would have paid for the hospital's Medicaid patients compared to what Medicaid paid under the traditional reimbursement method described previously.

Hospitals that do not qualify as "non-state public" hospitals are considered "private" hospitals and receive much less in the form of supplemental payments under the UPL program. These hospitals receive quarterly payments per Medicaid discharge based on its pro rata share of a pool of funds established by Medicaid each year. The majority of Arkansas hospitals fall into this category.

In 2015, the UPL program for private hospitals ended and the resulting "gap" under the upper payment limit was absorbed by the provider access program, resulting in less payments to hospitals.

The loss of \$109 million reported in this study includes the impact of UPL payments made under these payment formulas. Arkansas hospitals included in this study received approximately \$34 million in UPL payments during 2013, reduced by required matching payments of \$4 million for a net of \$30 million.

Provider Access Program

Starting mid-2009, Arkansas Medicaid amended the state Medicaid plan, establishing a provider access program to increase reimbursement to private hospitals. This program assesses a fee, at initially no more than 1% of the net patient service revenue of private hospitals, to draw down federal matching funds and then allocates the proceeds to private hospitals to supplement Medicaid payments. In February 2011, the program was amended to allow the assessed fee to be no more than 5.5% of net patient service revenue.

The loss of \$109 million reported in this study includes the impact of net provider access payments received by Arkansas hospitals. Arkansas hospitals included in this study received \$127 million in net provider access payments during 2013.

Without the benefit of the provider access program, Arkansas hospitals would have lost \$236 million in 2013 on Medicaid covered services.

Payment for Outpatient Services

The Medicaid program pays hospitals for outpatient services based on a fee schedule. **For most services, payment under the fee schedule is equal to the lesser of the amount billed or 64% of the Blue Cross/Blue Shield fee schedule published in October of 1990. This fee schedule has not been updated in 25 years.**

Most fee schedule payments are well below the costs of providing outpatient care. On average, payments to hospitals were less than 8% of billed charges and 33% of allowable costs.

Development of the Study

The AHA engaged BKD to conduct this study to illustrate hospital reimbursement in relation to the cost of providing patient care. Data used to develop the study results includes:

- Arkansas acute care hospital cost reports for periods ending during 2013.
- Medicaid outpatient claims data for the corresponding periods ending during 2013.

Because there has been a several-year delay in final settlements of cost reports by Medicare Administrative Contractors, the cost reports used by BKD have not been audited by the Medicaid Administrative Contractor.

Critical access hospitals¹ are reimbursed for 100% of allowable costs by the Arkansas Medicaid program. Accordingly, these hospitals have not been included in this study. In addition, the state teaching hospital and children’s hospital were not included in this study, as they are also reimbursed for their allowable costs.

The process for completing a Medicaid cost report in Arkansas is unique. Several instances were noted where the cost reports provided by the hospitals were not prepared in the manner that represents the Medicaid program payment methodology. When possible, these cost reports were adjusted to properly reflect the Arkansas Medicaid completion methodology.

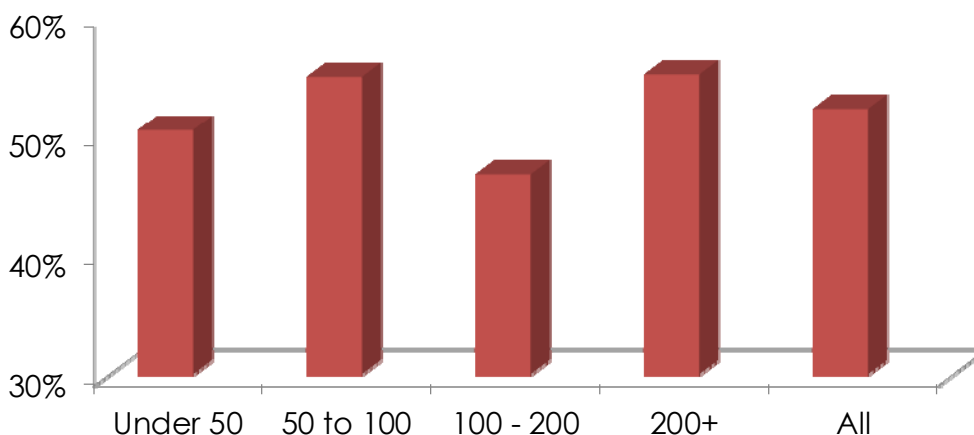
Study Findings

Inpatient

Hospitals continue to be paid far below the cost of providing care to their patients by the Arkansas Medicaid program under the traditional reimbursement process. Further, despite the provider access program, the amount of unreimbursed cost continues to grow.

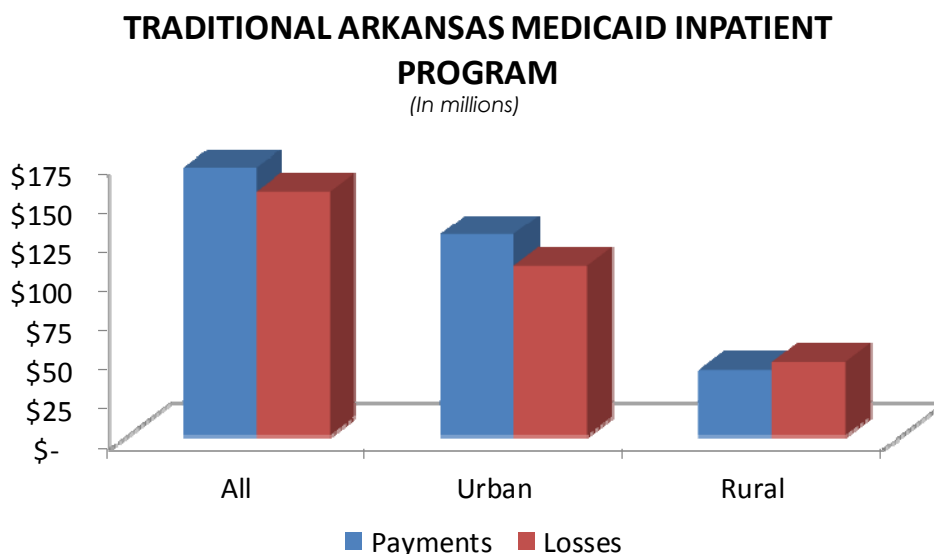
As shown in the following chart, all size ranges of Arkansas hospitals lose money from their provision of services to Arkansas Medicaid beneficiaries.

**TRADITIONAL ARKANSAS MEDICAID PROGRAM
PERCENT OF COSTS COVERED**



¹ Critical access hospitals are limited to 25 total acute care beds and are not permitted to have an acute average length of stay in excess of 96 hours.

The amount of inpatient payments and losses by hospital location type is reflected below:



Hospital inpatient losses vary based on each type of program payment limitation. Under the traditional Medicaid inpatient payment system, \$156 million in losses were caused by the limitations (in millions of dollars) as shown on the following table:

Exhausted days	\$ 62.1
Per diem limit	59.9
TEFRA	31.1
Other	2.4
	\$ 155.5

Supplemental payments related to the Arkansas UPL and provider access programs reduced these Medicaid losses on inpatient services by \$157 million.

Because Medicaid patients are generally indigent, coinsurance amounts are usually not collectible.

The per diem limitation was originally established at the 90th percentile of hospital per diem costs. After its initial implementation at \$584 per day, the limit was increased to \$675 in 1996, and was not increased again until July 1, 2006, to \$850. The per diem limitation remains unchanged through 2013.

When the per diem was first implemented in 1996, one in 10 hospitals would theoretically be limited by the per diem cap. This study revealed that all but two of the 44 hospitals were limited by the per diem cap.

Outpatient

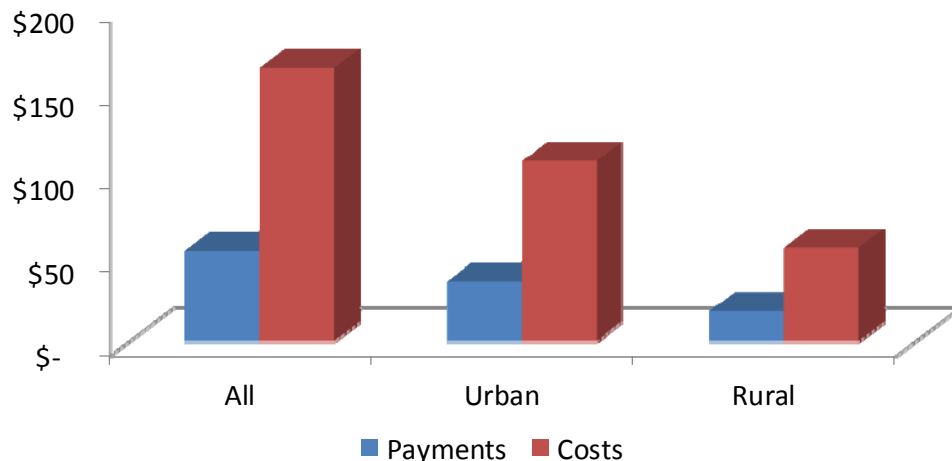
As with inpatient services, hospitals incurred tremendous losses from outpatient services in 2013. Unlike inpatient services, there is no UPL program to reduce this burden except for only four hospitals that are considered “non-state public” hospitals.

34 hospitals incurred more than \$1,000,000 in losses from caring for Medicaid recipients on an outpatient basis.

All Arkansas hospitals included in this study incurred losses from outpatient services provided to Arkansas Medicaid recipients. The losses totaled \$110 million from traditional Medicaid payments. Outpatient payments to hospitals were roughly 33% of the costs of providing care in 2013. The average loss per hospital was over \$2.5 million with 34 of the 44 hospitals experiencing annual losses of more than \$1 million.

The following chart illustrates that losses incurred by Arkansas hospitals for providing outpatient services to Medicaid beneficiaries exceeded the payments for those services.

TRADITIONAL ARKANSAS MEDICAID OUTPATIENT PROGRAM
(In millions)



Supplemental payments related to the Arkansas provider access programs reduced these Medicaid losses on outpatient services by \$32 million.

Many states have cost-based payment methodologies for outpatient services that limit losses to hospitals. While few if any states pay full costs for outpatient services, they do pay up to 85% of costs.

Impact of Upper Payment Limit Program on Inpatient Payments

16 hospitals incurred more than \$2,000,000 in losses from caring for Medicaid recipients.

Arkansas hospitals received much needed partial relief from Medicaid losses starting in 2001 with UPL and again in mid-2009 with provider access. It is important to note that any additional reimbursement due hospitals under these programs did not result in a use of Arkansas' state funds. Until 2014, certain hospitals paid the state matching funds to draw down the supplemental federal UPL Medicaid dollars through their use of inter-governmental transfer payments while others paid an assessment fee to draw down federal matching funds. The Medicaid program kept approximately 20 percent of these amounts (exclusive of the hospital generated state match) to pay administrative costs and supplement other programs.

Without the supplemental UPL and provider access payments, none of the hospitals included in this study had a "positive" margin from Medicaid payments. Including the supplemental payments, only nine hospitals had a "positive" margin on allowable costs. For the remaining 35 hospitals, the average margin was a negative 52%. Sixteen of Arkansas' largest hospitals still incurred losses of over \$2 million each, even after UPL and provider access payments were received, and four of these hospitals incurred losses in excess of \$10 million each.

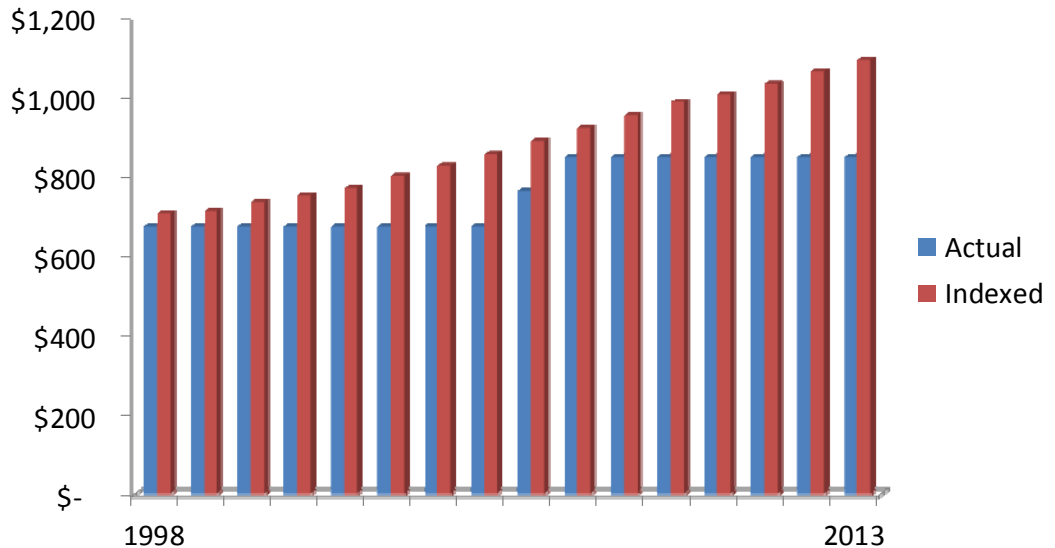
Recommendations

The following items are critical to preserving the future of Arkansas hospitals:

- The inpatient per diem limit for traditional Medicaid payments was increased to \$850 effective on July 1, 2006. While this increase significantly reduced the disparity between the cost of providing care to inpatient Medicaid recipients and payments to Arkansas hospitals, it remains significantly below the initial target of the 90th percentile of per diem costs. The 2013 per diem is less than the 2nd percentile of this study's per diem costs, well below the 90th percentile target intended upon establishment of the per diem limit in 1996. If the per diem cap were set at the 90th percentile, it would have amounted to \$2,386 during 2013. The state should consider increasing the per diem cap to an amount closer to the actual cost, keeping in mind that the current cap is about a third of the cost.

- The per diem limit in future years should be indexed to the Medicare PPS inflation factor.

The following chart shows actual Medicaid per diem rates from 1998 through 2012 as compared to a scenario where the \$675 per diem, set in 1996, is adjusted by annual Medicare inpatient payment updates.



- The state should take all necessary actions to ensure continuity of the UPL and provider access programs in their existing forms in light of federal attempts to limit these gap program benefits.
- Hospitals should be paid a fair amount for caring for outpatients — either on an updated and index fee schedule or as a percent of cost.
- Due to inconsistencies in the completion of some Medicaid cost reports, the state should draft detailed cost report filing instructions and distribute those to each provider to ensure that reports are filed accurately each year. The Arkansas method of filing cost reports is unique and is not currently outlined in Medicaid regulations.
- While the state looks for savings opportunities to offset the cost to the state of the “Private Option” that will be incurred starting in 2017, it should bear in mind that hospitals are already woefully underpaid by traditional Medicaid.