Reducing Hospitals' Reliance on Supplemental Payments: Connecting Uninsured Patients With Health Insurance Coverage

INTRODUCTION

With increasing operating and uncompensated care costs and an uncertain future for supplemental payments, hospitals must maximize their outreach, eligibility screening, and enrollment functions to ensure every health insurance coverage option is fully explored for every uninsured patient.

BACKGROUND

With more than 14 million Americans estimated to lose their jobs – and in many cases also their employer-sponsored health insurance – since the outbreak of COVID-19, the number of uninsured individuals will increase. National estimates are that up to 40 million people could become newly uninsured, according to Health Management Associates. As staggering as that number is, it is also possible that it is an underestimate if the economy continues to founder as the number of COVID-19 cases increases exponentially.

The increase in the number of uninsured will cause commensurate growth in hospitals' uncompensated care costs. These costs, already more than $41 billion a year prior to the pandemic, according to the American Hospital Association, severely constrain hospitals' ability to meet their communities' health care needs. In some cases, hospitals' only option is the elimination of entire service lines, such as labor and delivery, and too often in rural communities, closure altogether. While the economic crisis' full impact on uncompensated care costs is not yet known, one study conservatively estimates the increase in hospital charity care costs at 18 percent.

This increase in uncompensated care costs is on top of hospitals' massive financial losses stemming from COVID-19, including temporary cancellation of surgeries and non-emergent procedures. AHA estimates these losses to be more than $202 billion in just four months, or an average of $50.7 billion per month from March 1 to June 30, 2020. For the rest of 2020, AHA estimates losses of $20.1 billion per month.

The credit markets have taken notice of this dire situation. Moody's Investors Service and Fitch Ratings in March adjusted their outlook for hospitals and the healthcare industry from "stable" to "negative."

This bleak financial picture comes into sharp focus all at a time when the future of hospitals' Medicaid supplemental payments – a critical piece in stemming hospitals' financial losses – already was tenuous.

ROLE OF SUPPLEMENTAL PAYMENTS

Hospitals' Medicaid supplemental payments, broadly described, have two main purposes:

1. Reduce hospitals' cost of care provided to uninsured patients.
2. Supplement base Medicaid payment amounts/reduce the shortfall between the cost of care provided to Medicaid enrollees and reimbursement for that care.

Although referred to as Medicaid payments, supplemental payments are not reimbursement for a

service provided to a particular Medicaid beneficiary. Rather, they are typically lump sum payments and are not tied to a discrete service. They can be broadly categorized as disproportionate share hospital (DSH) payments and non-DSH payments. Examples of the latter include Upper Payment Limit program payments, uncompensated care pool payments, and Delivery System Reform Incentive Payment program payments.

Across all 50 states, on average, supplemental payments constitute 55 percent of hospitals' total Medicaid payments, according to MACPAC. In 13 states, however, supplemental payments constitute more than 55 percent of their total Medicaid payments. Their role in hospitals' financial stability cannot be overstated.

Yet, over the last several years, the federal government has demonstrated increasing interest in tightening control over supplemental payments and reining in spending.

- The Affordable Care Act required annual reductions in Medicaid DSH payments beginning in October 2019. These reductions – $4 billion in federal fiscal year 2020 and $8 billion per year in FFYs 2021 to 2025 – were scheduled in anticipation of a reduction in the number of residents without health insurance due to Medicaid eligibility expansion and availability of subsidized coverage through the marketplace.

  In some states, however, such as Texas and Florida, the reduction in the number of uninsured did not materialize, in part because Medicaid expansion is optional. As a result, the U.S. Congress has delayed these cuts several times, most recently until Dec. 1, 2020, but the cuts have not been repealed, despite vociferous advocacy from hospital groups, and are scheduled to take effect for FFY 2021.

- At least one state had contentious and lengthy negotiations with the federal government over the future of their non-DSH supplemental payments. Texas has a section 1115 Medicaid waiver that, among other things, governs the distribution of uncompensated care payments to hospitals. In late 2017 at the 11th hour, Texas' waiver was finally renewed, but with major changes. Beginning in 2020, uncompensated care pool payments would be subject to a different methodology that no longer allowed for the inclusion of "bad debt" as an allowable expense. The result: reduced uncompensated care payments, despite an increasing number of uninsured residents.

- An April 2019 report from the majority staff of the U.S. Senate Finance Committee concluded that, "[w]ithout oversight of the different federal and state [supplemental] payments and the proper conditions of their use, the Committee is concerned that they can be easily abused."

- Following that report, in November 2019, the Centers for Medicare & Medicaid Services proposed the Medicaid Fiscal Accountability Rule, which if finalized, would severely curtail supplemental payments. The CMS head, Seema Verma, noted the rule is intended to crack

down on Medicaid financing mechanisms that she called “shady recycling schemes.” AHA estimates the rule will reduce hospitals’ Medicaid supplemental payments up to $31 billion, or nearly 17 percent of total hospital program payments.

Taken together, these actions indicate a tenuous future for hospitals’ supplemental payments. In that future, it will be even more important for hospitals to have effective and efficient operations in place to make sure that every uninsured patient is connected to a viable source of health insurance coverage and uncompensated care is minimized.

CONCLUSION

A reduction in supplemental payments combined with an increasing number of uninsured patients and unprecedented financial losses is a perfect storm for hospital finances. The threat to the entire health care system is substantial, putting access to care at risk for everyone.

While hospitals are facing a significant set of short- and long-term challenges, it is critical that leaders look closely at their processes for eligibility screening for and enrollment in available health insurance programs to identify areas for improvement. Prioritizing this function will be key to securing not only better patient outcomes but hospital financial outcomes as well.

Questions to ask to assess your hospital’s eligibility and enrollment function:

1. How many self-patients does your hospital serve annually and what are their associated charges?
2. What are your hospital’s average collection and reimbursement rates?
3. What are your hospital’s enrollment-related workforce expenses?
4. What are your hospital’s self-pay conversion rates?

ABOUT CADRE ENROLLMENT

Cadre Enrollment is deployed in hospitals and leverages technology to screen uninsured patients for eligibility for more than 1600 health insurance and other public health and social services programs nationwide. Over 16 months, the technology identified 81 percent of uninsured patients as eligible for Medicaid in states that expanded Medicaid under the provisions of the Affordable Care Act and 50 percent as eligible in non-expansion states. With an accuracy rate exceeding 95 percent, no other platform on the market can deliver comparable results for hospitals and their patients. More information at cadre.health/cadre-enrollment