New Mexico Hospital Association

Sole Community Provider (SCP)
and
Disproportionate Share Hospital (DSH)
Funding

SCP History

Since 1994, the Sole Community Provider program has been essential to the operation of 28 of New Mexico's hospitals. It is a Medicaid matching program which augments county indigent funding with a federal match to assist hospitals with the burden of caring for indigent patients and the resulting uncompensated cost of care. The 2013 funding level is anticipated to be roughly $250 million. Counties currently provide the full amount of the non-federal share.

SCP under the Centennial Care 1115 Waiver

The historical "Upper Payment Limit" (UPL) calculation which was used as the basis for determining the amount of SCP funding available for a county match will no longer apply in the 100% managed care environment of Centennial Care. UPL calculated the amount by which Medicaid reimbursed hospitals less for like services compared to Medicare. The Human Services Department (HSD) has clearly recognized the need to provide a new basis for replacing vital SCP/UPL payments. The Department is proposing a sufficient *potential overall* funding level (starting at $369 million in 2014) and year-to-year growth for SCP over the 5 years of the waiver. Even though the basis for determining the available funding would change, county funding or other sources would still be needed to pay for the non-federal share.

HSD proposes to convert the SCP program to a "Safety Net Care Pool: comprised of 2 new funding sub-pools:

- Uncompensated Care (UCC) Pool: The definition of UCC has yet to be determined.
- Delivery System Reform Incentive Pool (DSRIP): The qualifying projects and deliverables that would be required of hospitals to earn this funding have yet to be determined.

HSD has begun a series of meetings with hospitals and counties to determine the parameters and definitions of this new approach to SCP.

Hospital funding could be severely reduced if the pool funding methodology is defined in a restrictive way that adds new cost limits that do not currently apply to SCP payments.

Based on one common federal definition of Uncompensated Care, for the 16 out of 28 hospitals with available audit data, *the aggregate impact would be just over $100 million, a 67% reduction.* Conceivably, the UCC payment reduction could be rolled into the DSRIP pool but that would put a major portion of SCP funding at risk for new performance requirements that are not yet defined and may not be defined for several years.

Both Centennial Care and the Affordable Care Act anticipate that with coverage expansion, uncompensated care may decrease but hospitals believe it is important to fully gauge the effects of expansion before making any large adjustments to safety net funding streams like SCP.

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Medicaid DSH History

New Mexico Medicaid makes a quarterly DSH payment to qualifying hospitals to take into account those hospitals that are serving a disproportionate number of low income patients with special needs. There is an annual regulatory formula used to determine which hospitals are eligible. Eligible hospitals are grouped into one of four pools: Teaching Prospective Payment System (PPS) Hospitals, Non-teaching PPS hospitals, PPS-Exempt (TEFRA) hospitals, and a reserve pool which compensates those qualifying DSH hospitals which have had a shift in the delivery of services between low-income and Medicaid covered inpatient days in any given quarter. Payments are based on the number of Medicaid discharges and the University of New Mexico Hospital receives about 85% of the funding.

New Mexico is one of 16 so-called "low-DSH" states – mostly western states. New Mexico hospitals receive less than $30 million in total funding from this program. (HSD provides the non-federal share for this program from general fund appropriations.)

DSH under the Affordable Care Act

"The CBO baseline projects federal DSH spending of $9.9 billion in 2014 growing to $11.0 billion in 2019. Because PPACA will expand coverage, uncompensated care amounts will fall, thus allowing reductions in DSH payments of $0.5 billion in 2014, $0.6 billion in 2015, $0.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019 and $4 billion in 2020. The Department of Health and Human Services will decide how DSH reductions are distributed so state allotments reflect progress covering the uninsured."[1]

There is considerable apprehension in the hospital field about the looming DSH cuts, especially among safety net hospitals that care for large numbers of Medicaid patients.

It remains to be seen how DHHS regulations will address DSH relative to Medicaid expansion. As originally envisioned in PPACA, DSH reduction is based on the assumption of Medicaid expansion. If a state rejects Medicaid expansion, one might assume that states hospitals would experience relief from the DSH reduction. That assumes that the calculations would be done state by state. However, it is conceivable that such decreases in coverage expansion would be accounted for in the aggregate, meaning an opting-out state would not receive the full benefit of DSH reduction relief.

[1] *What is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States?* Policy Paper, Robert Wood Johnson Foundation, June 2010

Presentation to:
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