HFMA Greater Heartland

Medicaid DSH: Updates and Strategies

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Agenda

1. Missouri Medicaid DSH Updates
2. OBBBA (2025 Law) Impacts
3. Strategies

Missouri Medicaid & Hospital Landscape

Expansion & Unwinding

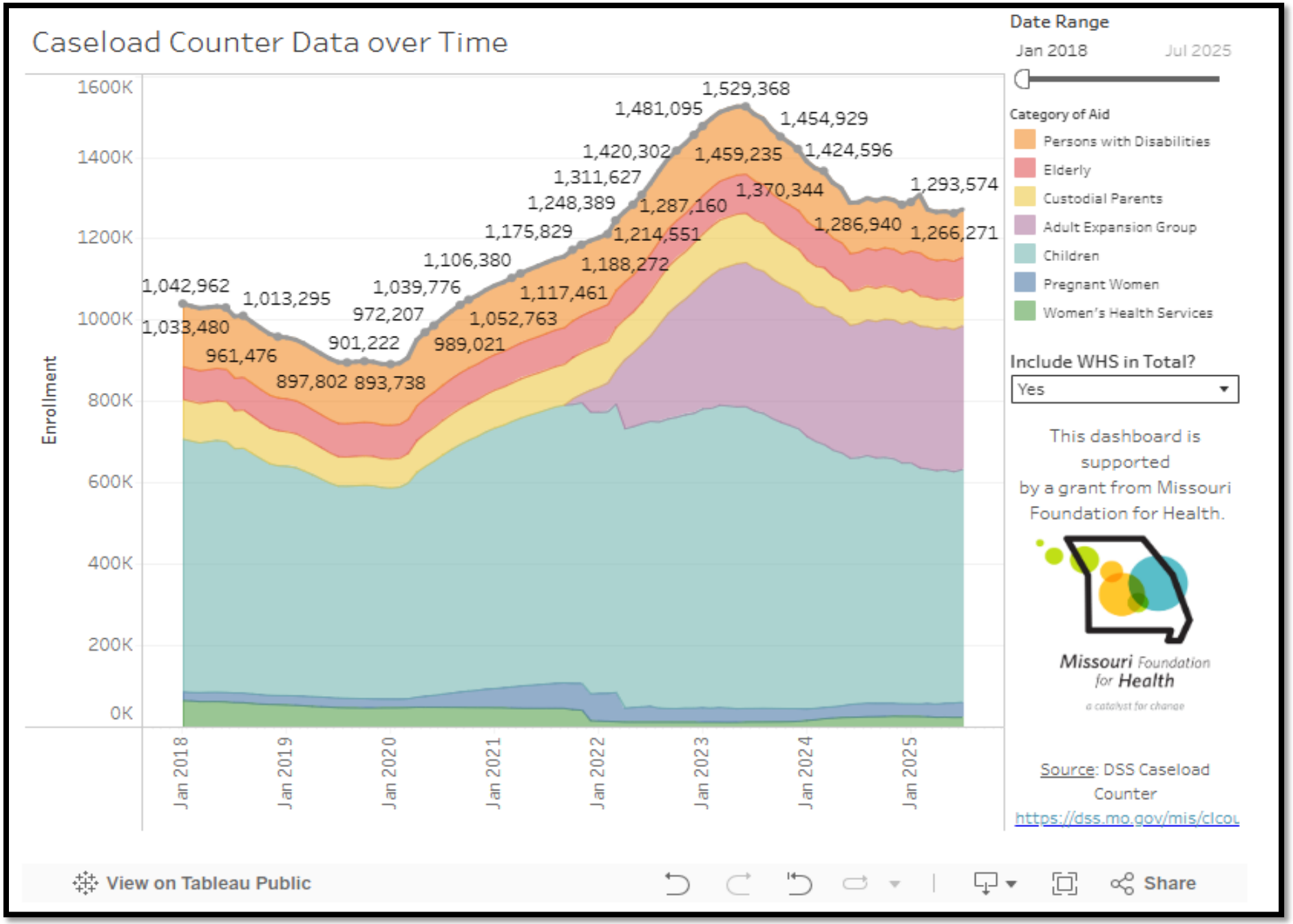
- Medicaid enrollment peaked at ~1.5M in June 2023. Post pandemic eligibility reviews are now reducing the rolls.

Hospital Financial Pressure

- Many hospitals face thin margins post-COVID; some seek partnerships or mergers to remain viable

Policy Changes

- Major policy shifts (state & federal) are underway – todays update will cover how these changes affect hospital reimbursement



- **October 2021** – Expansion
- **June 2023** – Peak enrollment
- **2026 and beyond** – Impacts mostly Expansion population (Purple)

[Caseload Counter Data over Time | Tableau Public]

Medicaid DSH Program - Refresher

Purpose

- Helps hospitals that serve a “disproportionate share” of Medicaid/Uninsured patients by offsetting uncompensated care costs

DSH Payment Limit

- A hospital’s DSH payments **cannot exceed its total Uncompensated Care Costs (UCC)** for Medicaid shortfall + Uninsured care.

Missouri Participation

- MO HealthNet distributes DSH payments to qualifying hospitals using federal allotments and state funds (including provider taxes). Any federal DSH cuts or state funding changes directly impact these payments

Medicaid DSH is a FEDERAL program (Administered by the States)

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients.

The total amount of such payments is limited by annual federal DSH allotments, which vary widely by state.

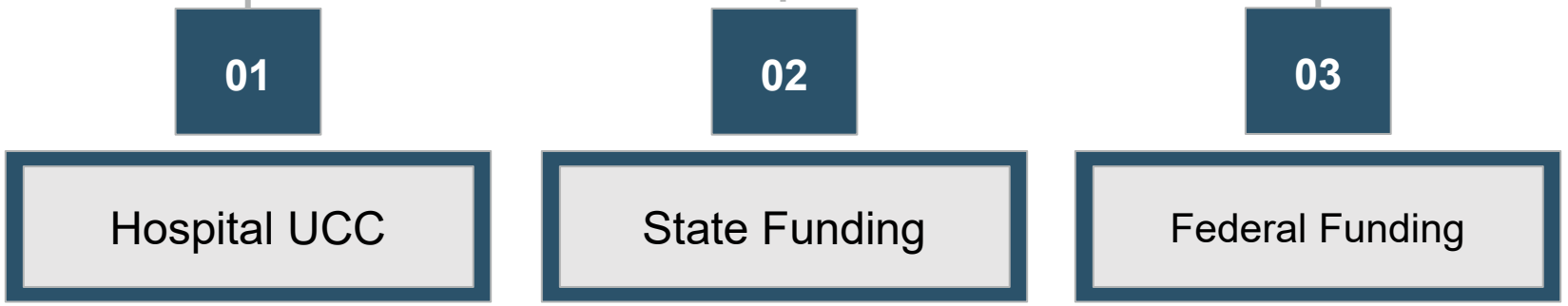
States can distribute DSH payments to virtually any hospital in their state, but total DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides.

Medicaid DSH Program

Established by Congress in 1981

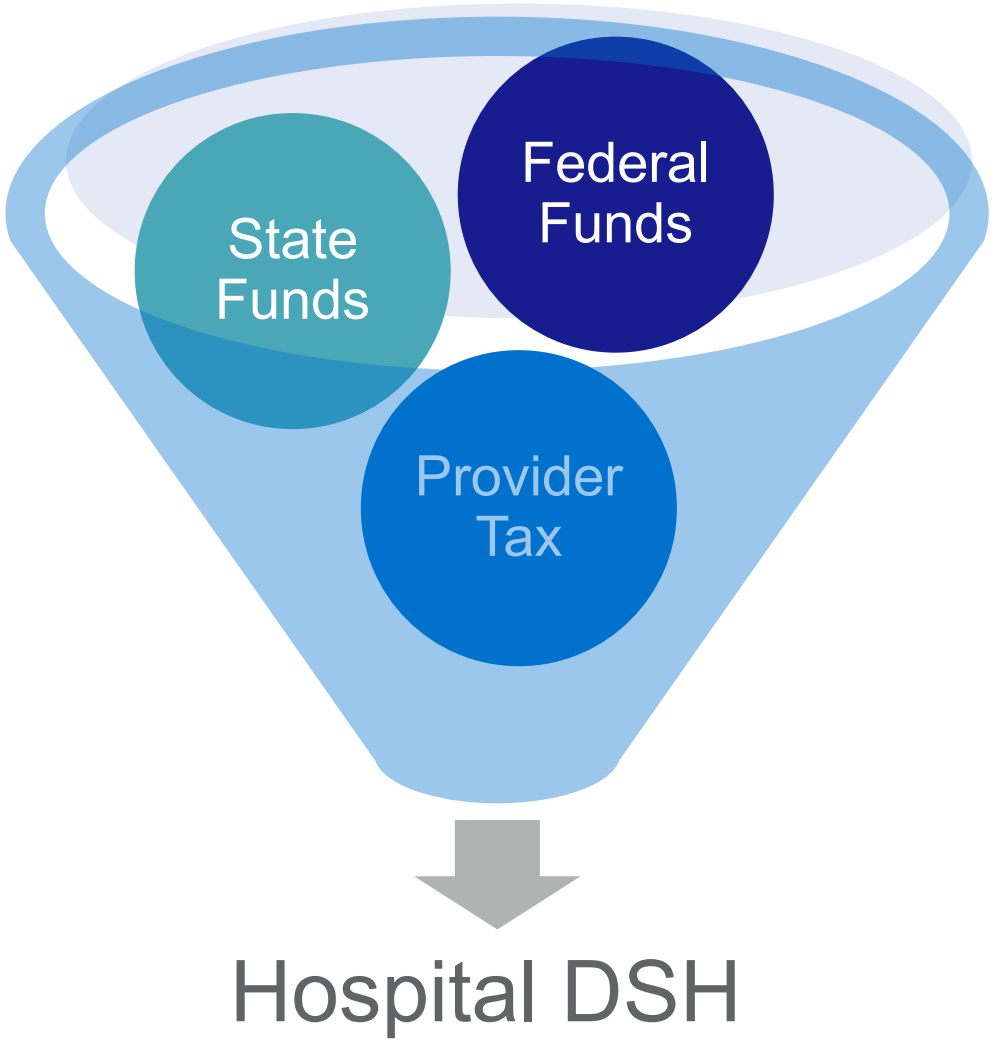
Purpose

To assist Hospitals treating a disproportionate share low-income patients.



Medicaid DSH Program

State's Role



- Federal Financial Participation (FFP) – States submit claim for share of money from government.
- States have some flexibility with guidelines.
- States must address program in their state plan.
- Federal Medicaid DSH funding is capped.

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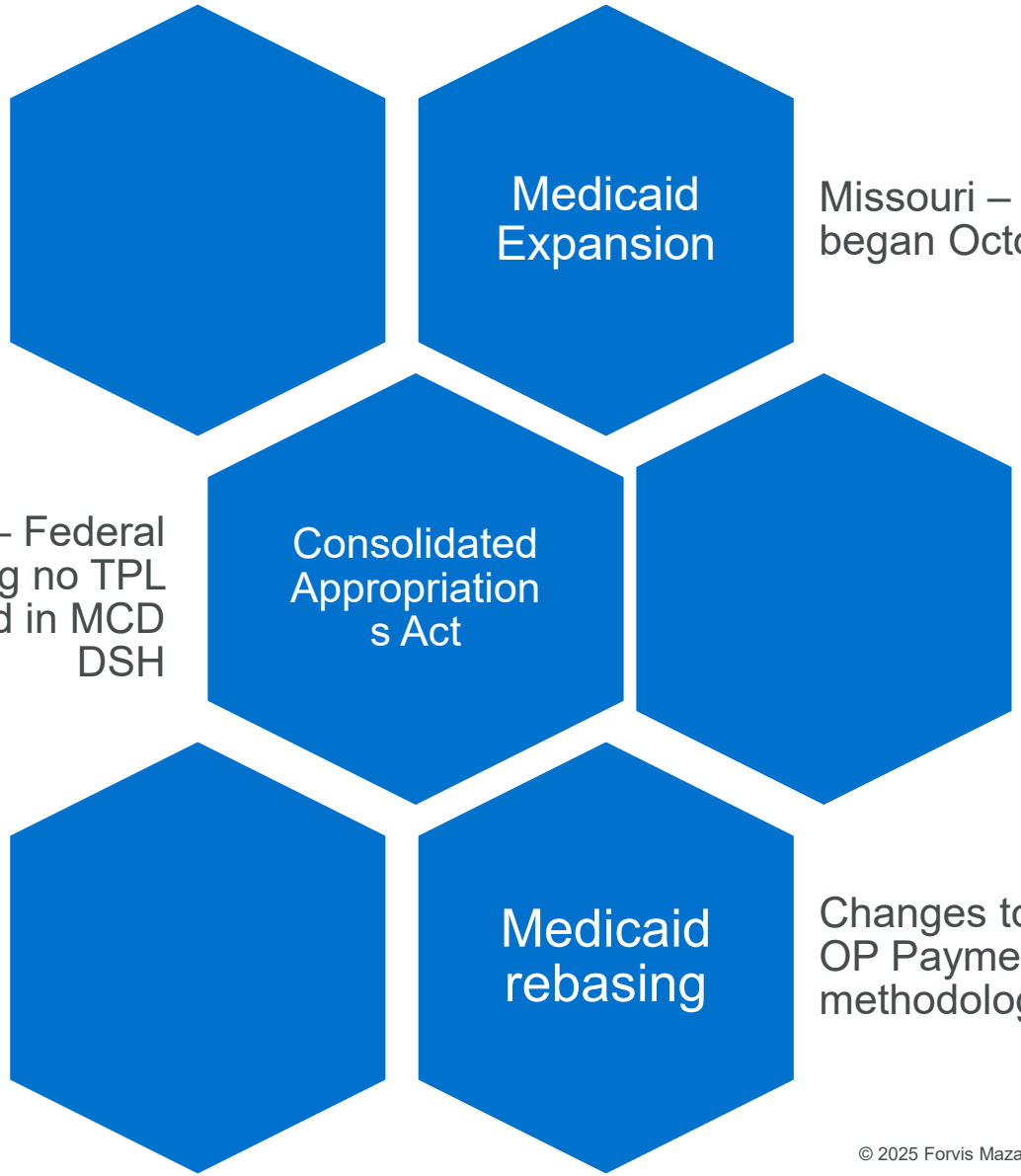
Payment Timeline

Payment Timeline

State FY	Interim Estimate - Source Year	Audit Year
2021	2017	2024
2022	2018	2025
2023	2019	2026
2024	2020	2027
2025	2021	2028
2026	2022	2029

State Fiscal Year 2023
Year of Change

Why hospitals may experience DSH liability for the first time



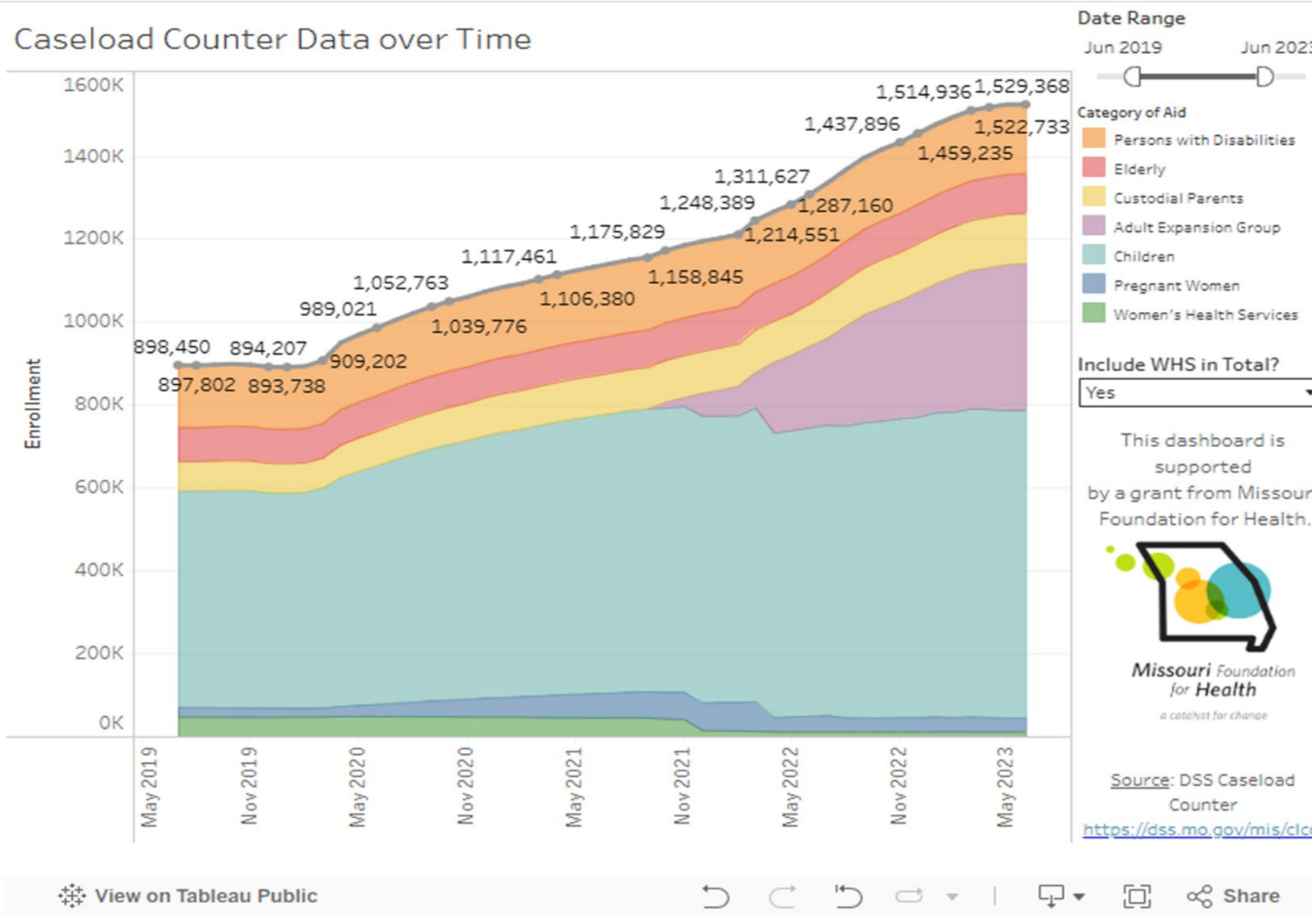
Missouri – Enrollment began October 1, 2021

October 1, 2021 – Federal rule stating no TPL patients included in MCD DSH

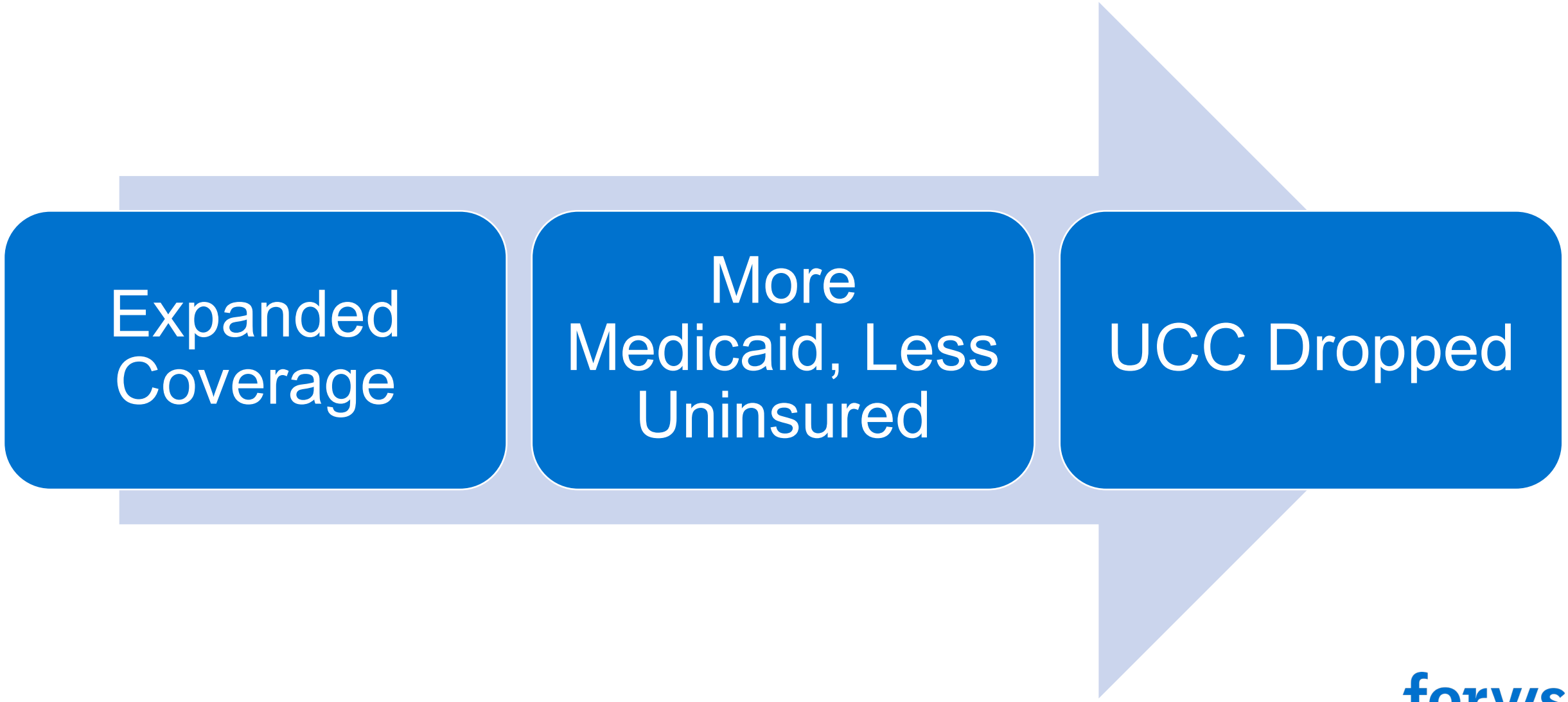
Changes to both IP and OP Payment methodologies

Medicaid Expansion

1. Missouri Enrollment began October 1, 2021 (purple section)
2. Enrollment Counts from 900,000 enrollees in June 2019 to 1,500,000 in June 2023
3. [Caseload Counter Data over Time | Tableau Public]



Medicaid Expansion Impact



Consolidated Appropriations Act *Effective October 1, 2021*

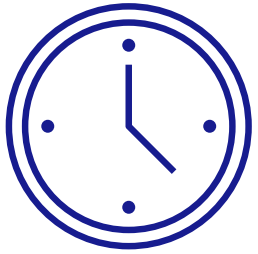
1. Patients with Third-Party Liability (Medicare or Commercial coverage) are excluded from Medicaid DSH
   - Effective for Missouri State Fiscal 2023
   - Removes Crossover and OME populations from DSH Limit
2. Supplemental Payment Provisions
   - States were “encouraged” to consider moving from supplemental payment, or add-on payment methodologies to incorporate into rate
   - For this reason, and others, Missouri rebased IP rates effective State Fiscal 2023

Medicaid Rate Changes

Do you know the impact?

Inpatient – Per diem rates are updated, starting July 1, 2022 to be cost-based, previously on fixed per diem rate

Outpatient - Simplified Fee Schedule started July 20, 021, previously paid on a percent of charge



Inpatient – Moved to DRG effective July 1, 2025

Hospital UCC
Uncompensated Care – SFY2023 Changes

"What was the **LOSS** that the hospital incurred in treating these patients?" (below are typical results)

Medicaid FFS	Medicaid HMO	Crossovers	Other Medicaid Eligible	Uninsured
• Higher Payment Rates • Increased Enrollment	• Higher Payment Rates • Increased Enrollment	• EXCLUDED for first time	• EXCLUDED for first time	• Potential decrease because of Medicaid expansion
Result	**Result**	**Result**	**Result**	**Result**
• Less of a LOSS	• Less of a LOSS	• Depends on Medicare Profitability	• Depends on Commercial Profitability	• Less of a LOSS

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Looking Forward

Federal DSH Funding Cuts

FY2026 +

- **Scheduled Allotment Cuts:** Current law requires $8B cut each year for FFY2026-2028 – more than a 50% reduction in total federal DSH funding nationwide
- **Uncertainty:** Congress has postponed these cuts multiple times. Hospitals and associations (AHA, MHA, etc) are advocating continued delays
- **Implication:** If the $8B/year cuts happen, Missouri hospitals will see far less Medicaid coverage losses. This heightens the importance of maximizing every available dollar and engaging in advocacy.

OBBBA - Overview

July 4, 2025

- **2025 Federal Law** – sweeping Medicaid changes to reduce federal spending by $1 trillion over 10 years
- **Goals** – curb Medicaid costs by tightening eligibility and capping payments. Key provisions include new enrolee requirements, accelerated renewals, and limits on how states finance Medicaid
- **Big Picture** – Fewer people on Medicaid, more uninsured, and cuts to Medicaid funding streams that support supplemental payments.

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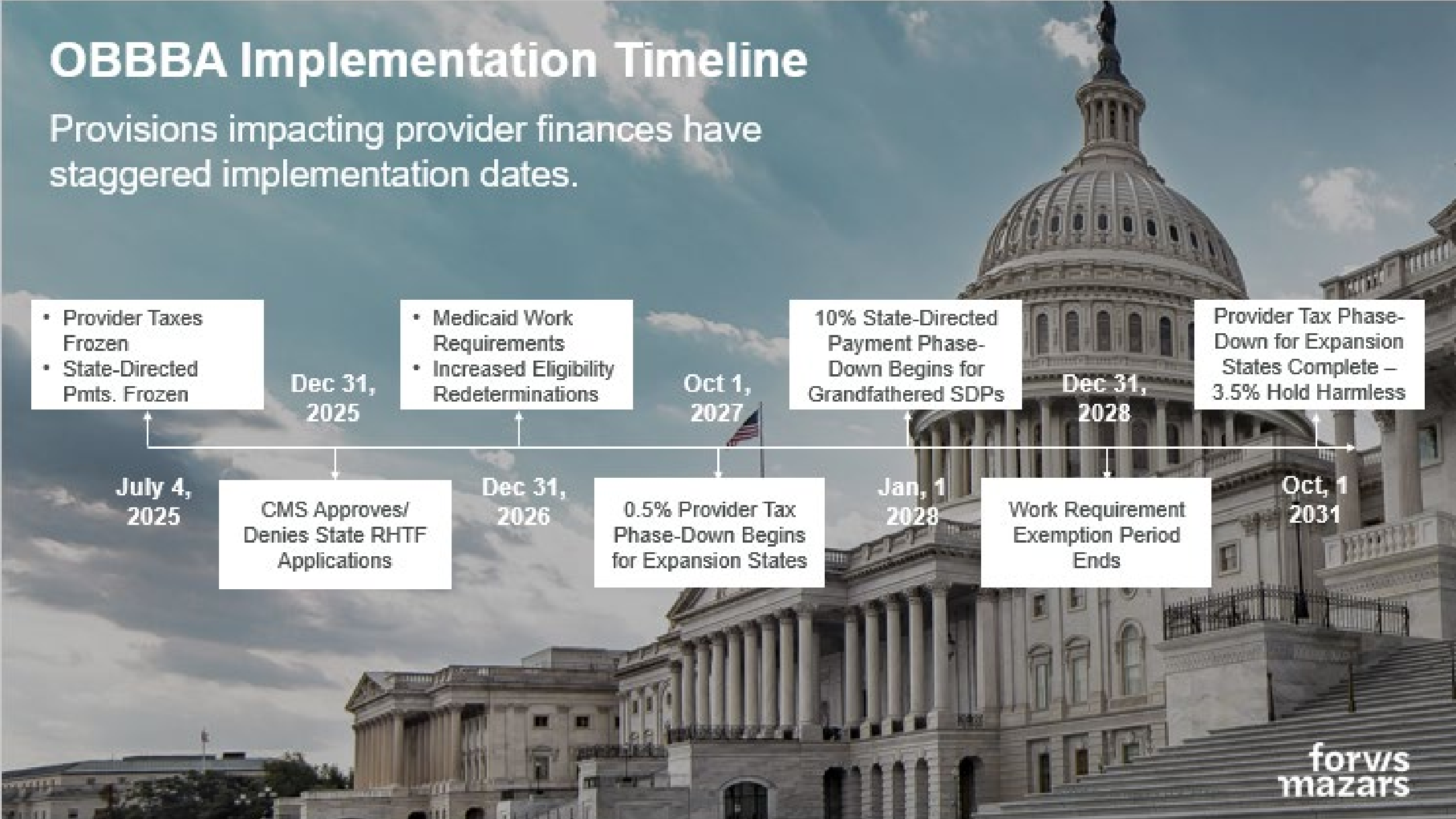
OBBBA - Overview

July 4, 2025

Provision	Who?	What?	When?	Potential Impact
Medicaid Work Requirements	Ages 19-64	Unless exception, must work	January 1, 2027	Loss of Medicaid coverage
Eligibility Redeterminations	Expansion enrollees	Eligibility redetermination every 6 months	January 1, 2027	Loss of Medicaid coverage
Rural Transformation Grants	The state of MO	If approved, MO could get $100-$200M per year to distribute to Hospitals	FY2026-2030	Funds to rural hospitals to cover qualified costs to improve rural health care delivery
Provider Tax Changes	MO Hospitals	Provider tax caps decrease from 5.5%-3.5% over time	2028-2032	Reduction in Federal participation in MO Medicaid funding
Supplemental Payment Changes	The state of MO	Medicaid HMO limited to Medicare Rates	2028-2032	Reduction in Federal participation in MO Medicaid funding

OBBBA Implementation Timeline

Provisions impacting provider finances have staggered implementation dates.



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OBBBA: Hospital Margin Impact

Changes will increase uninsured, reduce Medicaid payments, and reduce eligibility for safety net programs.

Legislative Changes

Eligibility Requirements

Financing Restrictions

Direct Margin Impact

- Increased Uninsured
- Reduced State Medicaid Pmts.
- Increased Rev. Cycle Issues

Secondary Margin Impact

- Medicare DSH Eligibility
- 340B Eligibility
- Decreased Medicare DSH Payments

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OBBBA: Rural Health Transformation Program

OBBBA creates a $50B rural health transformation program, available for five years, that states can apply for with funding starting in 2026.

Allocation

- Provides $10B per year for five years
- $5B distributed evenly to each state
- $5B distributed to states based on CMS allocation method

Application

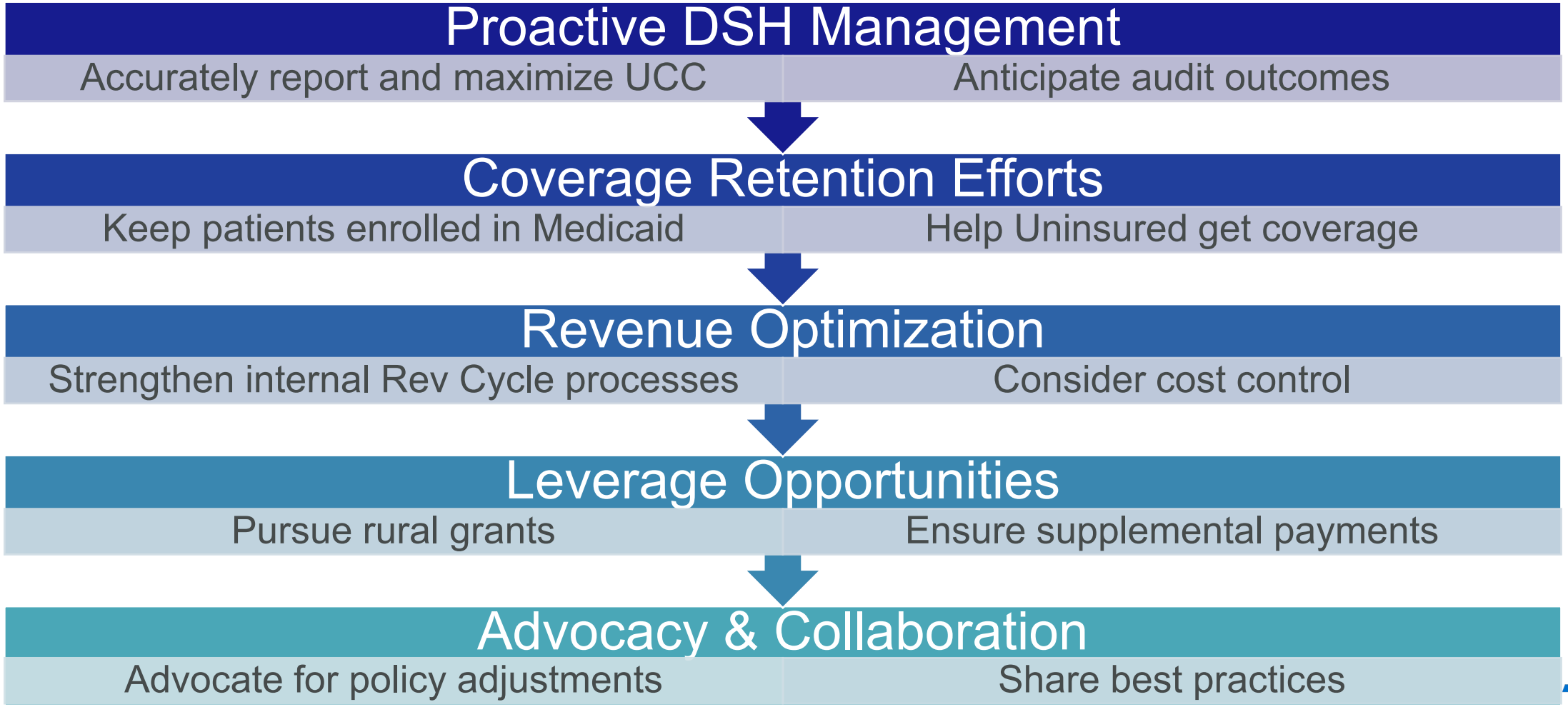
- States must apply via a one-time application
- Required to submit a detailed rural health transformation plan
- Funds are not eligible for FMAP
- Not more than 10% can be used for administrative costs

Uses

- Prevent/manage chronic disease
- Increase provider payments
- Adopt technologies to improve care delivery
- Recruit clinicians to rural communities
- Right size rural delivery systems
- Support SUD treatment
- Encourage innovative care models

Strategies to…

Preserve DSH and Maximize Medicaid Revenue



Strategy 1: Proactive DSH Management

1. Be aware of your potential liability
   - Do you know your potential liability through September 30, 2026?
   - ***DSH payments have been received***, are they being reserved if needed?

2. Capture as much Uncompensated Care Cost as possible
   - ***Cost Report review –*** is your cost report as accurate as it can be? If a PPS hospital, you may not be thinking like a cost-reimbursed hospital, but DSH relies on cost report.
   - ***Other Medicaid Eligibles –*** are there patients without third party insurance payments who were eligible for Medicaid on date of service?
   - ***Uninsured –*** are there patients with insurance on file where the insurance did not pay? Research for potential inclusion as uninsured

DSH Liability estimate

Estimate the loss each category

- VOLUMES/CHARGES
  - Internal reports
  - Forecasted volumes
- PAYMENTS
  - Paid claims reports
  - Estimate unpaids
- COST
  - Cost report
  - Financial statements
  - Cost-to-Charge
  - Per Diem Cost

Medicaid FFS/HMO

- Actual Paid Claims data
- Consider cost changes

Medicaid Unpaid

- Patients with no TPL coverage
- Medicaid eligibility - infocrossing

Uninsured

- No insurance in file, no insurance paid
- Additional Uninsured

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Strategy 2: Support Medicaid Enrollment & Retention

1. Outreach & Enrollment Assistance
   - Consider dedicating staff or partnering with community orgs to help patients with Medicaid applications and renewals

2. Presumptive Eligibility & Charity Transactions
   - Use **hospital presumptive eligibility (HPE)** aggressively where applicable – keep in mind the work requirements, but could get current visit covered by Medicaid.
   - Guide patients to marketplace insurance or other programs if they do not qualify for Medicaid

3. Monitor Unwinding Disenrollments
   - Track how many patients are presenting without Medicaid that had it in the previous year. Treat Medicaid coverage retention as part of your revenue cycle.

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Strategy 3: Revenue Optimization

1. Optimizing DRG Coding
   - Since Medicaid DRGs are live, ensure coding accurately reflects patient acuity
2. Negotiate MCO Contracts
   - Push for contract language that mirrors any fee-for-service improvements
3. Revenue Cycle KPI's
   - Monitor Medicaid-specific KPI's like denial rates, time to payment, etc. High denial rates might point to documentation improvements that can be made
4. Control Costs & Length of Stay
   - Vendor negotiations, labor cost analysis, consideration of care efficiency
   - Manage LOS through partnerships with SNFs, efficient discharges and daily multidisciplinary rounds
   - Focus on high-Medicaid volume areas like OB and behavioral health

Strategy 4: Leverage Opportunities

1. Rural Health Transformation Program (RHTP) engagement
   - Stay involved with Missouri's RHTP, brainstorming projects that align with grant goals so that you can propose when the funds are available

2. Rural Emergency Hospital (REH) conversion grants
   - Aimed at small rural hospitals to convert to emergency-only models

3. Consider other HRSA rural workforce program grants
   - Nursing education, community health support, Health IT support, case management

Strategy 5: Advocacy and Collaboration

1. Stay involved with HFMA
   - HFMA is a great way to collaborate with other providers and share ideas
2. Explore Options
   - Consider collaborations or affiliations to better survive funding changes
3. Advocate on Policy
   - Stay involved with Missouri Hospital Association and national groups, and provide data to policymakers to show impacts of the changes on your hospital

Date

Key Takeaways

- The state is changing – stay alert and involved
- Actions for Hospitals
  - Protect DSH dollars
  - Keep patients enrolled in Medicaid
  - Optimize operations under Medicaid DRGs
  - Engage in advocacy

Questions?

Contact

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