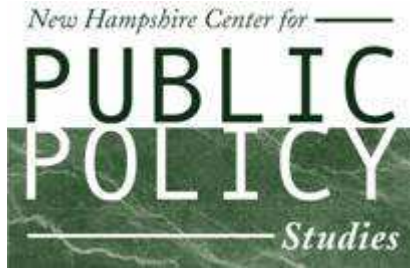
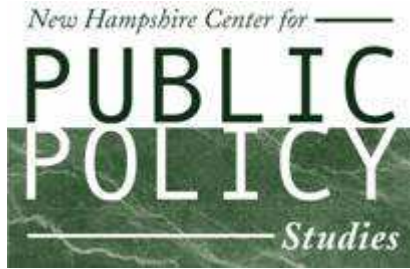


Understanding the Impacts of Changes in New Hampshire's Disproportionate Share (DSH) Program



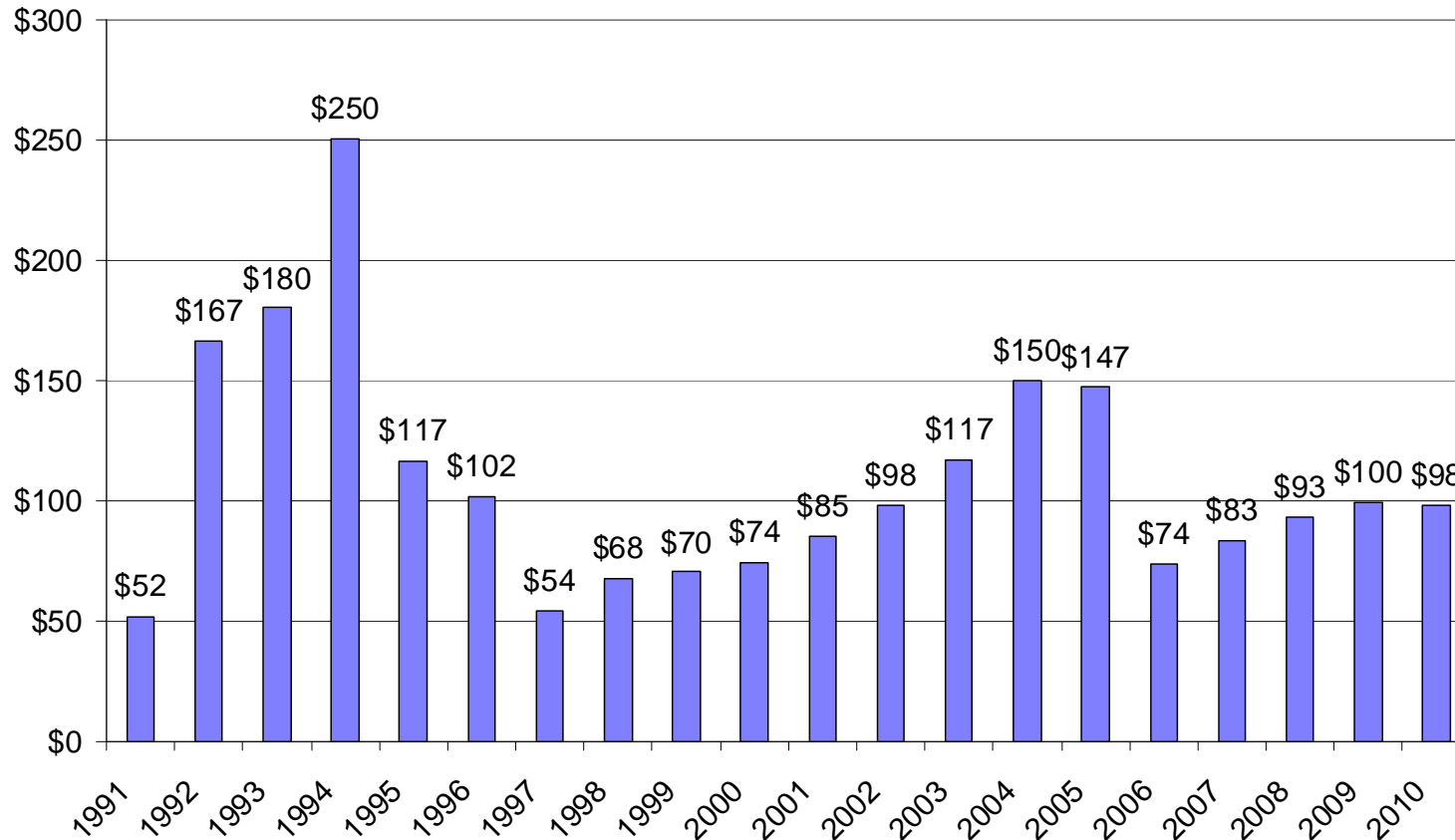
New Hampshire's DSH Program: The Medicaid Enhancement Tax

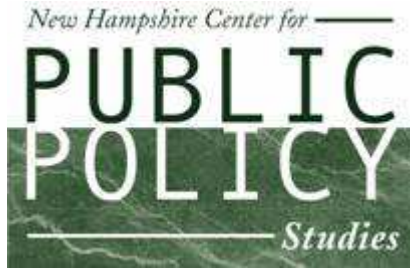
- Beginning in 1991, used to expand revenues for state, indirectly (or directly, depending on your perspective) providing support for Medicaid provider payments.
 - Method: Tax hospitals → make payments to hospitals → draw down matching federal dollars.
 - Has brought in over \$2b in revenues to the state since its inception.
- Has experienced significant change over the past two years
 - Legislature significantly changed the program in the last legislative session.
 - State faces a potential \$35m audit finding
 - The Affordable Care Act includes provisions phasing out the DSH program, and the state has not yet made plans for the federal phase out of the program.



The NH Disproportionate Share Program has brought in significant resources to the state.

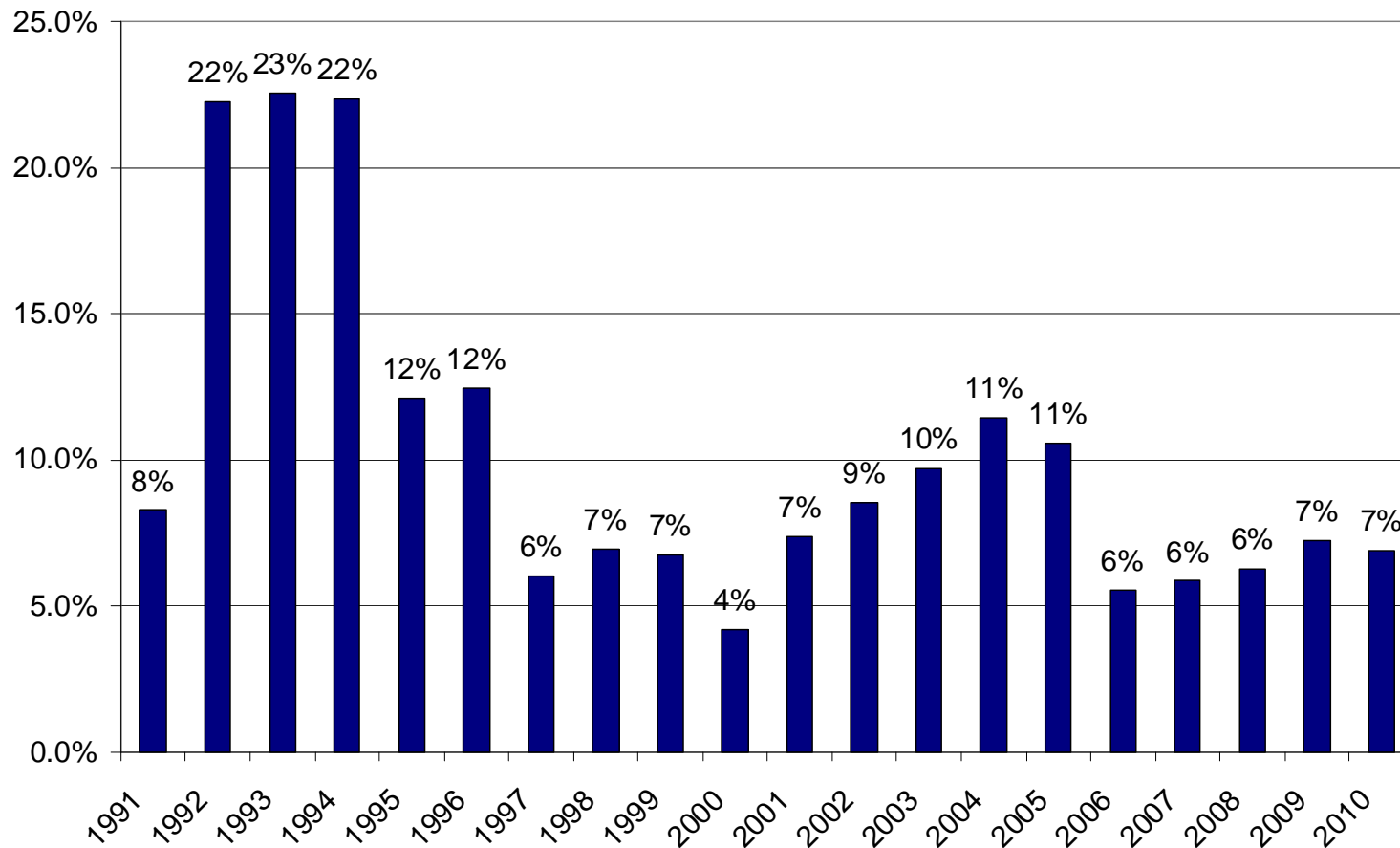
Medicaid Enhancement Revenues to the General Fund
(In Millions \$)

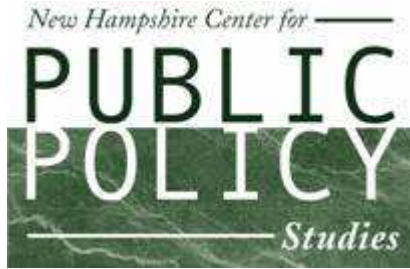




And it represents a significant share of NH's general fund revenues

Medicaid Enhancement Revenues as a share of General Fund Revenues

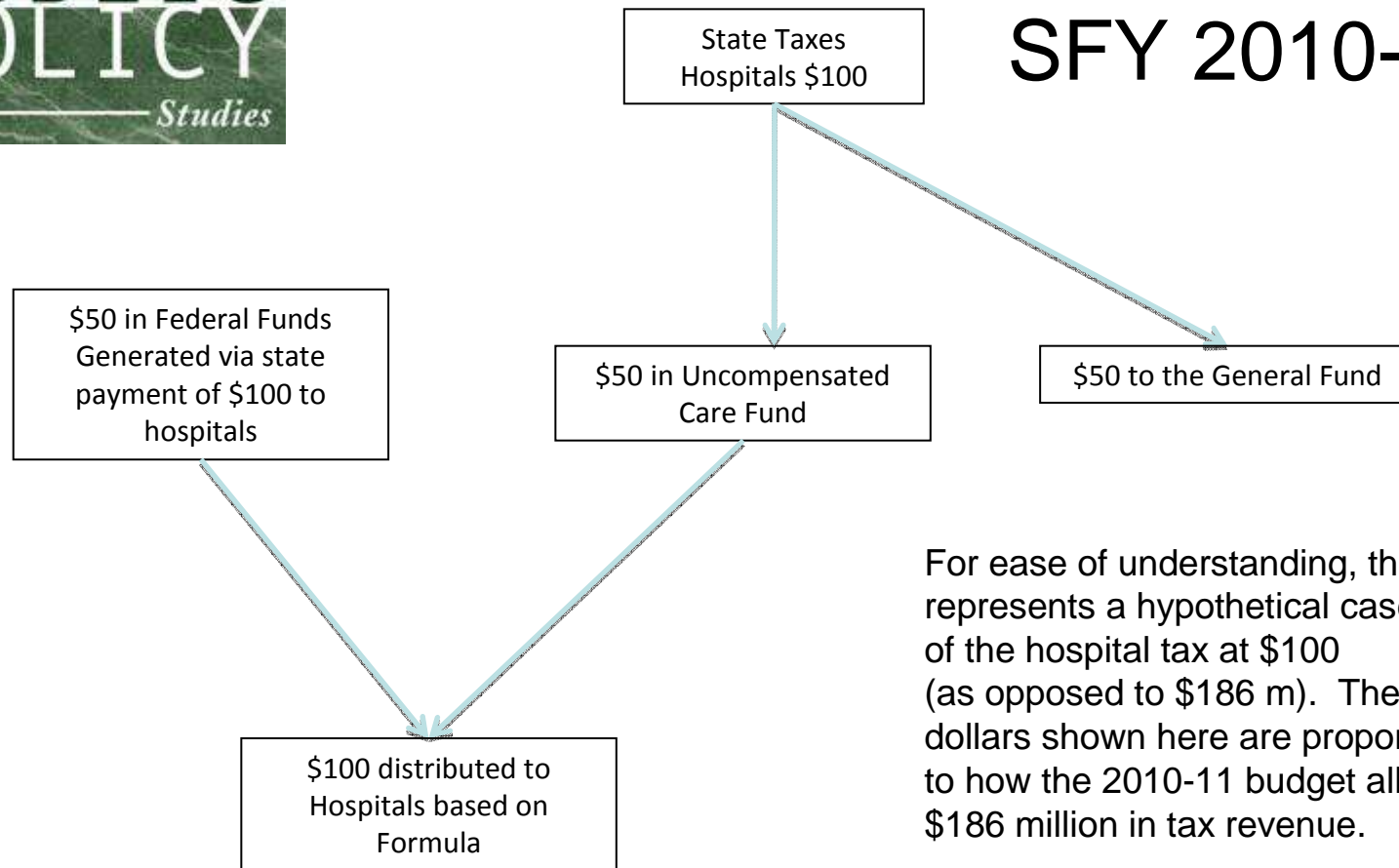




The DSH Program in FY2010-11

- Beginning in 2010, the program redistributed the pool of state resources created by the hospital tax to hospitals based on their provision of uncompensated care, among other things.
- This arrangement created “winners” and “losers,” whereas previously the program essentially ensured that hospitals received in return exactly what they provided in taxes.
- The previous program is diagrammed in the next slide, and the payments and net position relative to the prior program characteristics are shown in the slide after that.

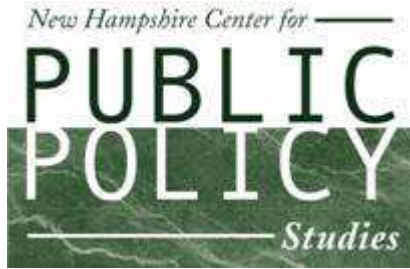
DSH Program in SFY 2010-11



For ease of understanding, this represents a hypothetical case of the hospital tax at \$100 (as opposed to \$186 m). The dollars shown here are proportionate to how the 2010-11 budget allocated the full \$186 million in tax revenue.

Note that in this case \$100 or 100% of the original tax amount is returned to the hospital industry, with some hospitals receiving more, and some less, than the tax they paid

Note: This diagram shows the flow, and source of funds, not the transactions that occur which deposit into state funds, expenditures made, and federal match generated.

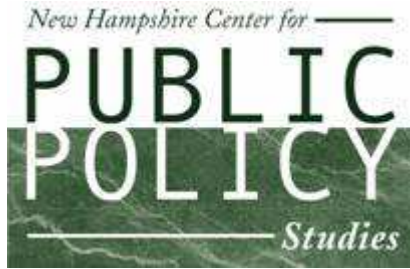


Payments and Net Position in previous system

Hospital Name	Critical Access Designation	Total DSH Payment	DSH Payment - Tax Payment
Alice Peck Day Memorial Hospital	Critical Access Hospital (CAH)	\$1,976,308	\$195,492
Androscoggin Valley Hospital	Critical Access Hospital (CAH)	\$3,718,080	\$1,118,337
Cottage Hospital	Critical Access Hospital (CAH)	\$2,488,420	\$1,124,832
Franklin Regional Hospital	Critical Access Hospital (CAH)	\$4,230,597	\$2,984,395
Huggins Hospital	Critical Access Hospital (CAH)	\$4,301,264	\$2,034,088
Littleton Regional Hospital	Critical Access Hospital (CAH)	\$3,666,805	\$520,171
Monadnock Community Hospital	Critical Access Hospital (CAH)	\$3,566,936	\$152,900
New London Hospital	Critical Access Hospital (CAH)	\$2,580,277	\$103,943
Speare Memorial Hospital	Critical Access Hospital (CAH)	\$4,882,196	\$2,778,333
The Memorial Hospital	Critical Access Hospital (CAH)	\$5,196,832	\$2,389,848
Upper Connecticut Valley Hospital	Critical Access Hospital (CAH)	\$1,500,000	\$708,419
Valley Regional Hospital	Critical Access Hospital (CAH)	\$5,128,601	\$3,124,218
Weeks Medical Center	Critical Access Hospital (CAH)	\$2,738,033	\$802,425
Catholic Medical Center	Non-CAH	\$12,027,952	-\$493,478
Concord Hospital	Non-CAH	\$20,536,667	\$2,895,618
Elliot Hospital	Non-CAH	\$16,761,495	\$2,149,949
Exeter Hospital	Non-CAH	\$9,889,671	-\$379,890
Frisbie Memorial Hospital	Non-CAH	\$8,181,669	\$3,415,785
Lakes Region General Hospital	Non-CAH	\$7,064,268	\$1,308,145
Mary Hitchcock Memorial Hospital	Non-CAH	\$41,692,736	\$4,730,333
Parkland Medical Center	Non-CAH	\$4,513,298	-\$903,592
Portsmouth Regional Hospital	Non-CAH	\$4,710,965	-\$5,949,089
Southern New Hampshire Medical Ctr	Non-CAH	\$11,896,946	\$2,509,150
St. Joseph Hospital	Non-CAH	\$5,632,091	-\$3,061,720
The Cheshire Medical Center	Non-CAH	\$6,454,494	-\$1,198,342
Wentworth-Douglass Hospital	Non-CAH	\$10,520,601	-\$737,153

Source: Office of Medicaid Business and Policy

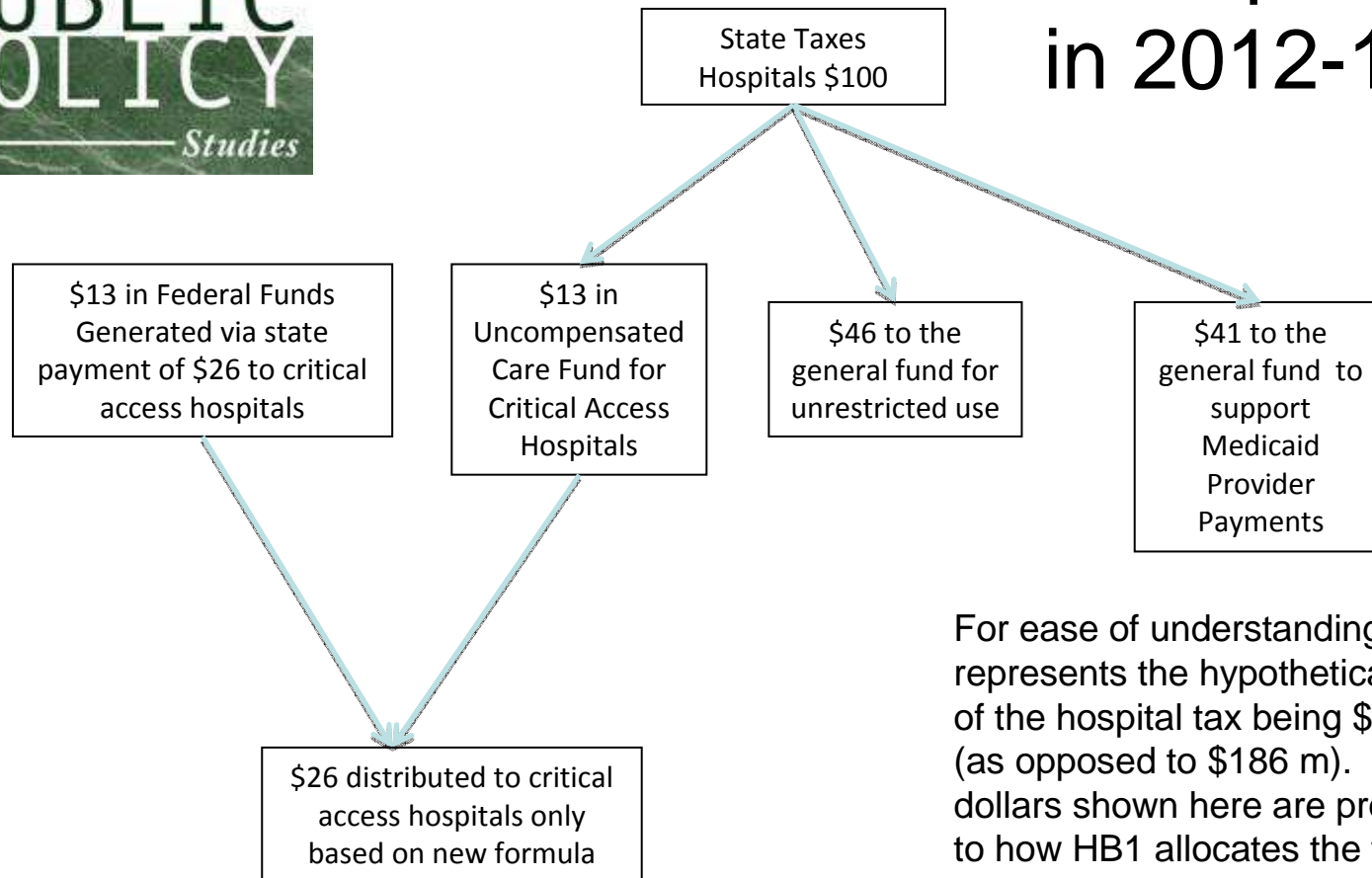
Note: Excludes Rehab Hospitals From Analysis



DSH changes adopted in 2012-2013

- The newly adopted DSH program uses the existing tax on hospitals to
 - Provide approximately the same level of funds to the general fund.
 - Offset existing general fund expenditures within the Medicaid provider payment line items.
 - Create an uncompensated care program for critical access hospitals which potentially holds them harmless.
- The diagram on the next page shows how the new program works.

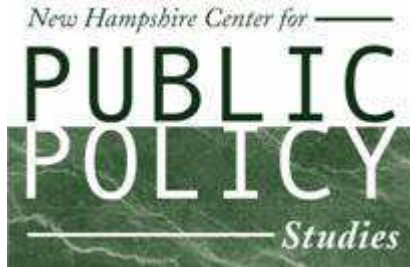
DSH program in 2012-13



For ease of understanding this represents the hypothetical case of the hospital tax being \$100 (as opposed to \$186 m). The dollars shown here are proportionate to how HB1 allocates the full \$186 million in tax revenue.

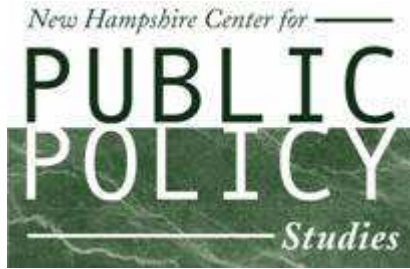
Note that in this case, only \$26 (or 26%) of the original tax is distributed back to hospitals compared to 100% in the current case.

Note: This diagram shows the flow, and source of funds, not the transactions that occur which deposit into state funds, expenditures made, and federal match generated.



How to Assess the Magnitude of the Changes

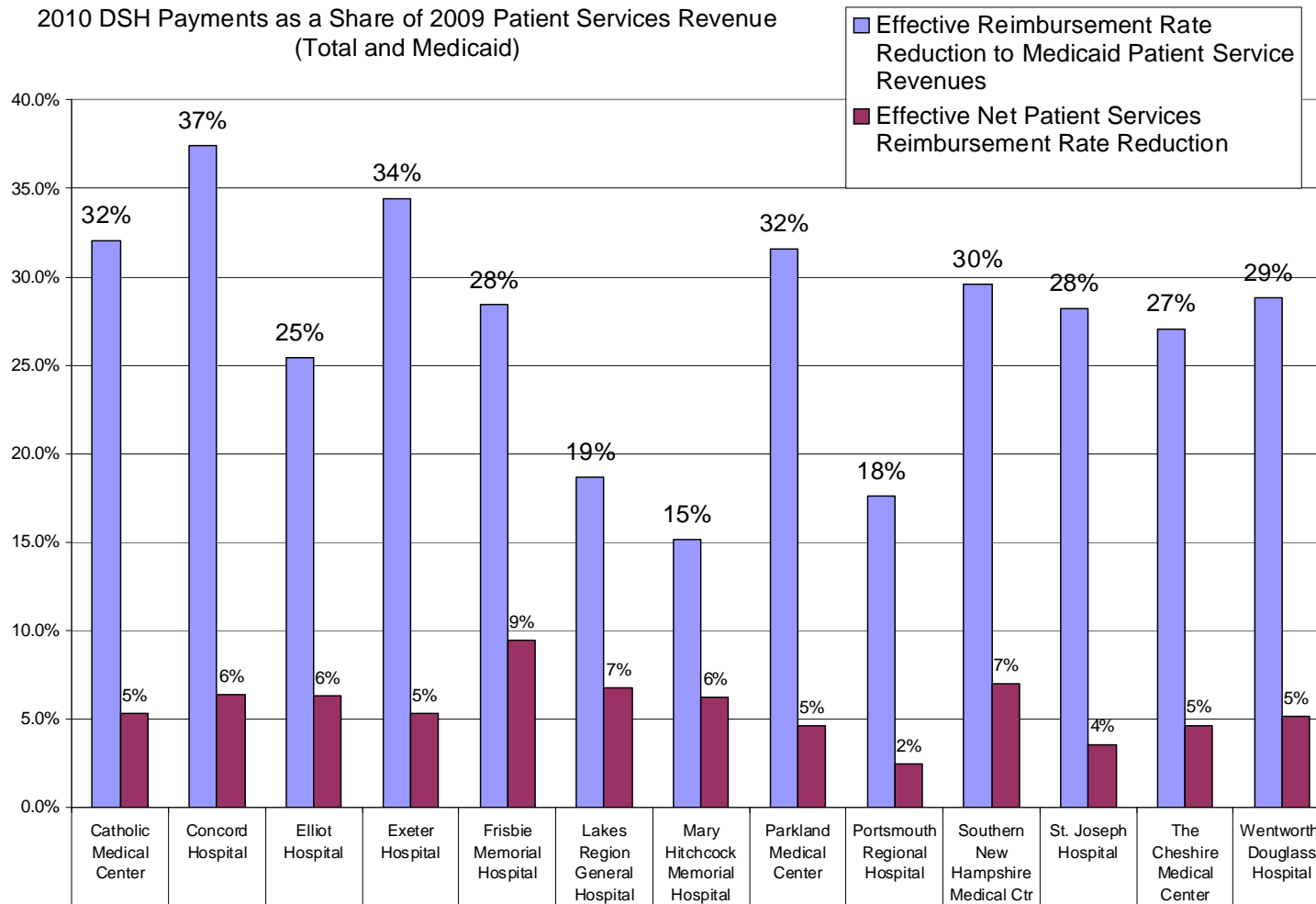
- What share of total Medicaid patient services revenue is accounted for by the Medicaid DSH payment reductions?
- What share of Total patient services revenue is accounted for by the Medicaid DSH payment reductions?

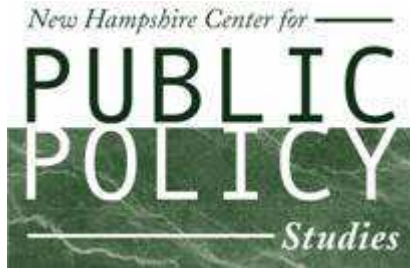


How Big an Impact? Industry wide

- Relative to total revenues, the reduction for non-critical access hospitals resulting from the DSH changes is approximately 5.6%, though some hospitals experience more (Frisbee) and some less (Portsmouth).
- Relative to Medicaid revenues, the percentage reduction for non-critical access hospitals is much larger (27%) with some hospitals seeing bigger (Parkland) and smaller (Dartmouth) reductions.

The Impact of The Changes on Non-Critical Access Hospitals



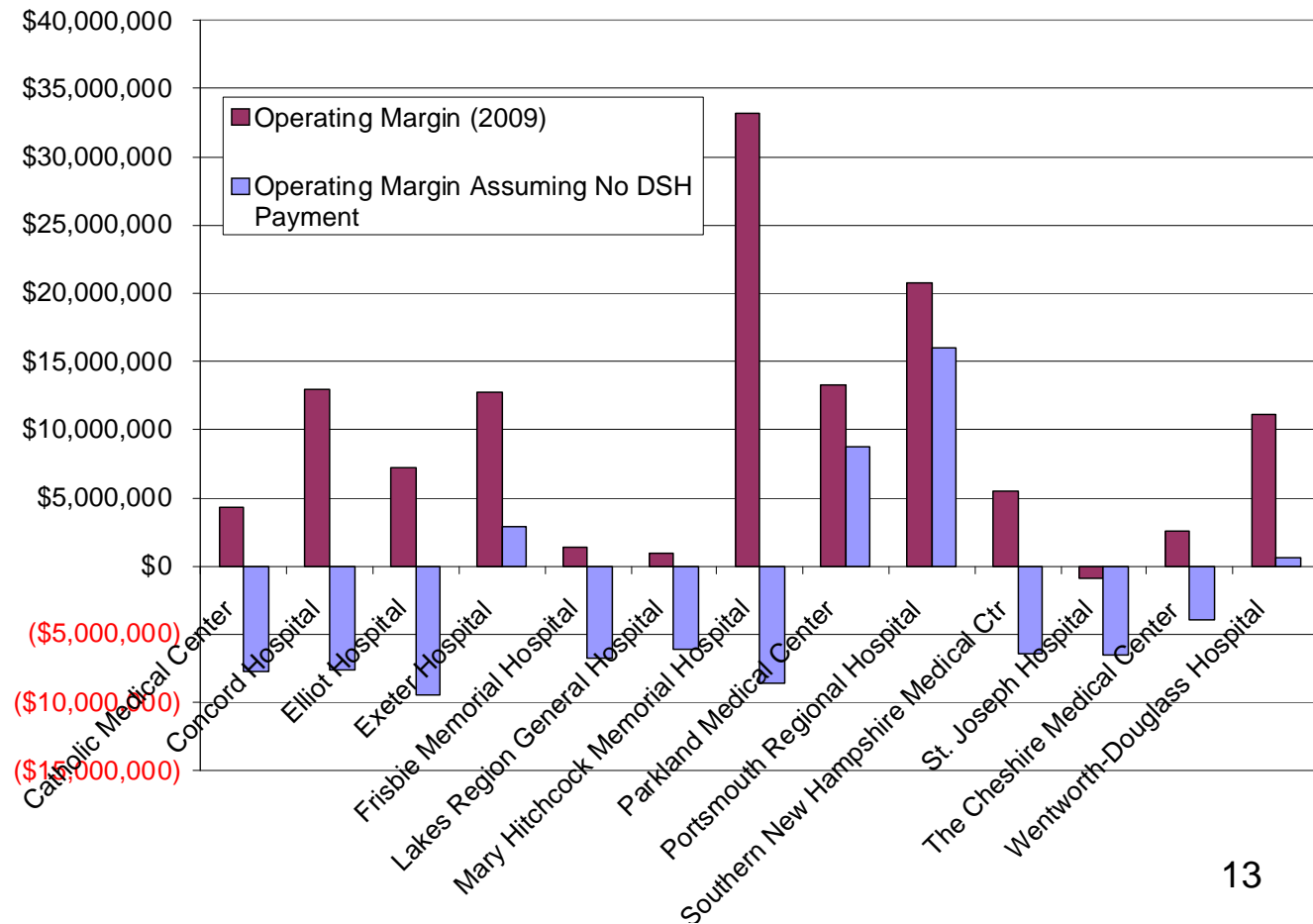


The proposed changes could also effectively reduce the equity in the state's hospital industry

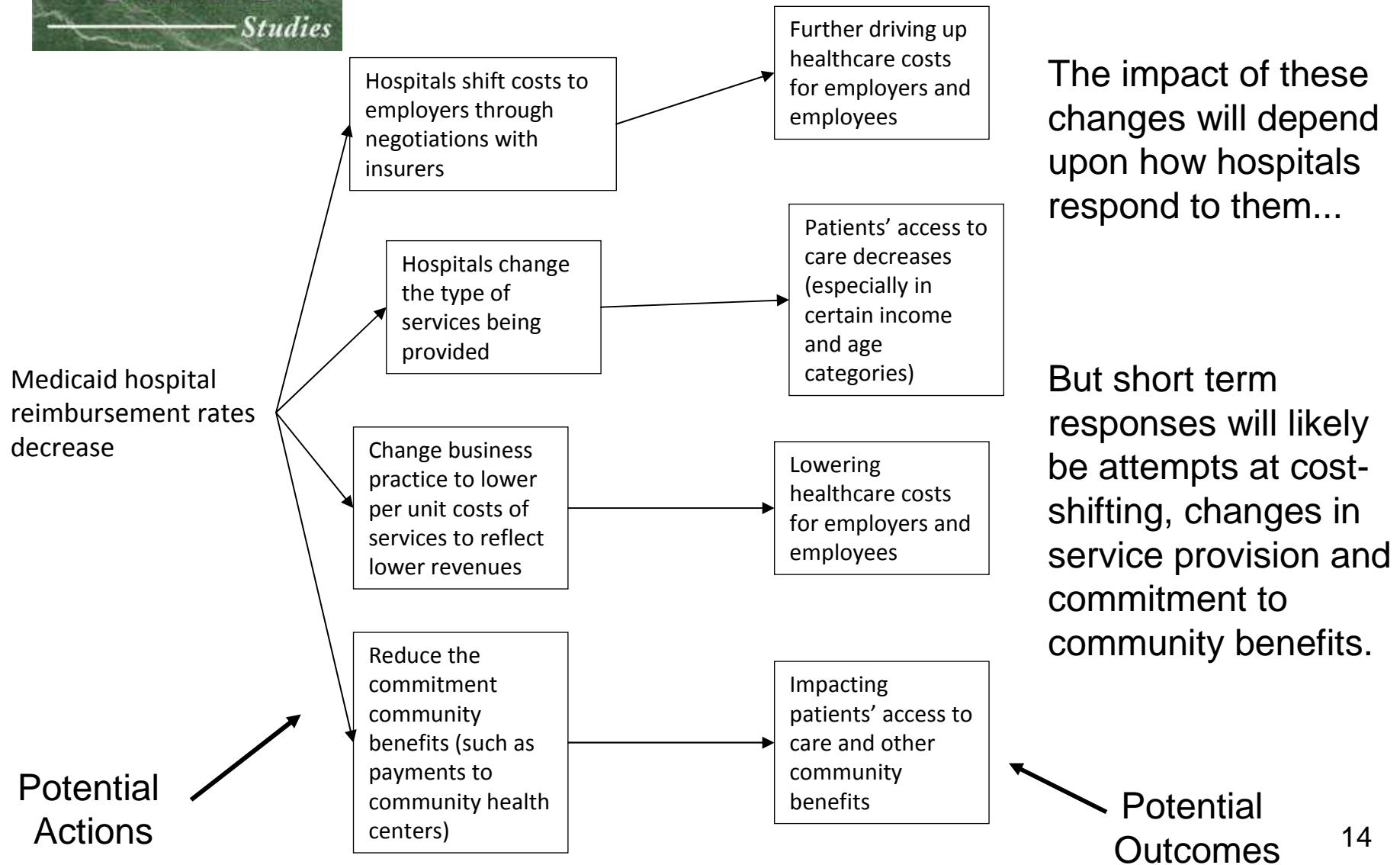
This graph shows what happens if you subtract 2010 DSH payments from 2009 operating margins.

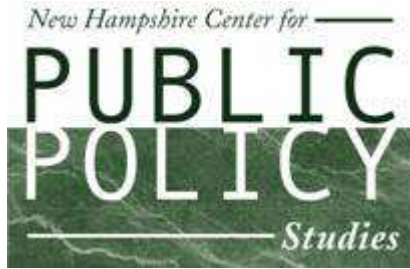
Non-critical access hospitals would see a \$127m net operating gain turn into a \$35m loss in equity, assuming no hospital response (an unlikely scenario!)

Potential Short Term Impact on Hospital Operating Margins



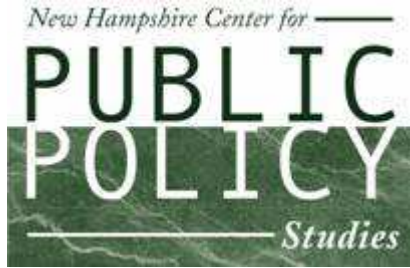
A Health Impact Assessment: How might hospitals respond?





Cost-Shifting

- In 2008, the NH Center for Public Policy Studies estimated that approximately 25% of the private insurance premium dollar could be related to uncompensated care and below expenditure reimbursements for Medicare and Medicaid.
- Is it possible for the hospitals to negotiate higher rates with insurance companies at a level sufficient to offset? Do they have sufficient market power?
- If all the reimbursement rate reductions (totaling ~\$163m) were shifted to premiums, this would represent ~6% increase in premium dollars.
- For an explanation of the cost-shifting phenomenon see: http://www.nhpolicy.org/reports/hospitals_and_costshifting_2008.pdf

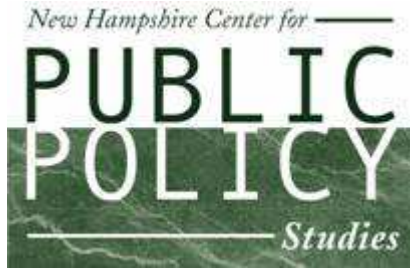


Community Benefits

- Understanding the impact of community benefits will be difficult.
- Health systems and certain providers are required to report on community benefit activities to the Attorney General's Office.
- Understanding the impact will be a function of review and comparison of current to future community benefit reports
- Current community benefit reports can be found here: <http://doj.nh.gov/charitable-trusts/community-benefits/reports-2011.htm>

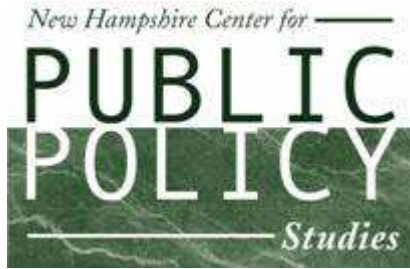
Service Changes

- Demographic changes, including the aging of NH's population, have resulted in changing service provisions, including the elimination of obstetric services for a few hospitals.
- These changes will likely accelerate decision-making around changes to health systems and their structure.
- The impact is impossible to predict but can be monitored by assessing the changing provision of services, changes in emergency department visits, and other measurements.



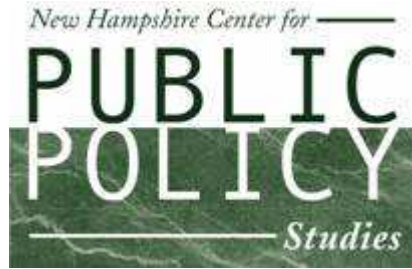
Lowering The Cost of Hospital Care

- The effective reimbursement rate reductions could spur the health systems to increase their efficiency by
 - Increasing the use of best practices
 - Lower costs of inputs (including reductions in employees.)
- Obviously, short term changes will touch only marginal costs (e.g. labor), not fixed costs or those costs that are a function of practice patterns.



Potential risk points in the process going

- Changes in DSH program require approval by the federal government which takes time and is far from certain.
- Changes in effective reimbursement level may trigger review via the Affordable Care Act, which requires a review of the budgetary changes on access to care for Medicaid patients.
 - Hospitals have filed suit under this provision.
- No guarantee that the levels of patient services activity (upon which the 2012-2013 budgets are based) will be met, therefore raising questions about the existing budget.
- Future of the DSH program at the federal level is in question.



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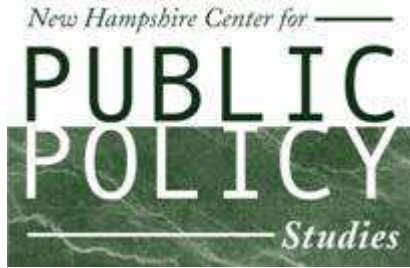
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