OBBBA Tuesdays

# Mitigating Regulatory Impacts: State-Directed Payments

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# Agenda

1. A Challenging Environment
2. OBBBA Overview
3. How to Respond
   - Medicare Area Wage Index (AWI)
   - Medicare Indirect Medical Education (IME) Funding
   - Medicaid Disproportionate Share Hospital (DSH) Funding
   - Revenue Recognition

# 01

## A Challenging Environment

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# Providers Under Pressure

## 50% of provider executives rank margin improvement as one of their top priorities over the next three to five years.

**40%** of hospitals had negative margins in 2024

**16** hospitals closed in 2025
**25** hospitals closed in 2024

**338** rural hospitals at risk of closure

Medicare margin for “efficient hospitals” is **-2%**

**78%** of physicians employed in 2024

**774** nursing homes have closed since 2020


Sources:
1) Mindsets Healthcare Executive Leadership Report,” Forvis Mazars, 2024.
2) https://www.markey.senate.gov/imo/media/doc/letter_on_rural_hospitals.pdf
3) https://www.fitchratings.com/research/us-public-finance/fitch-revises-sector-outlook-for-us-nfp-hospitals-to-neutral-09-12-2024
4) www.medpac.gov/wp-content/uploads/2024/08/Tab-D-Hospital-payment-adequacy-January-2025-SEC.pdf
5) https://www.beckershospitalreview.com/finance/4-hospital-closures-in-2-weeks/?
6) https://www.beckershospitalreview.com/finance/5-hospital-closures-in-2024.html#:~:text=Becker's%20has%20reported%20on%2025,This%20article%20was%20updated%20Dec.
7) https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services-5.html
8) https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023
9) https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Report-Access-to-Nursing-Home-Care-is-Worsening-.aspx






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# 02

## OBBBA Overview

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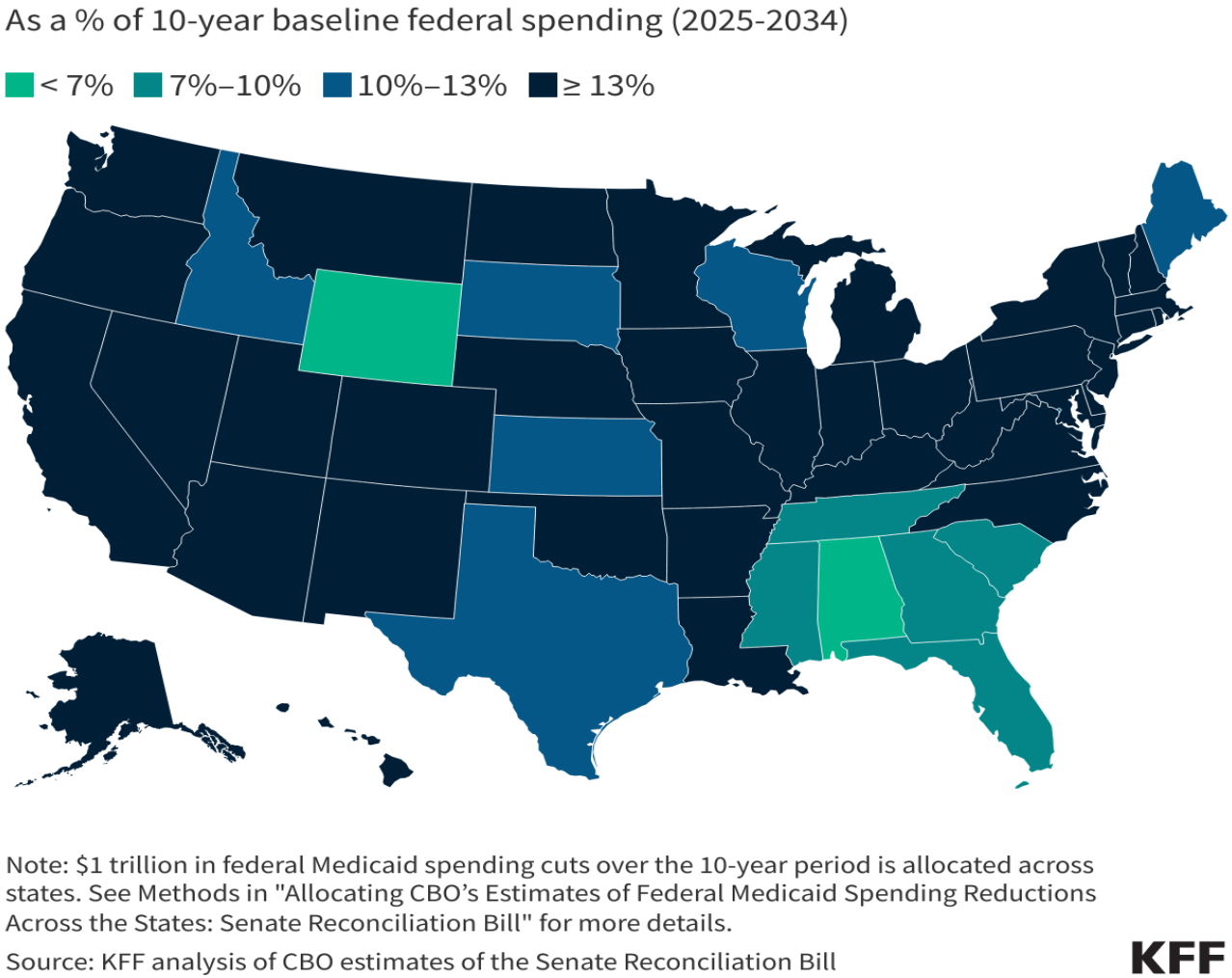
# OBBBA: Medicaid Financing

## Federal cuts to states of $1T over 10 years represent 15% of federal spending on Medicaid.




## Key Financing Changes

- Provider tax freeze & reduction to 3.5% for expansion states ($191B)
- State-directed payment freeze & reduction ($149B)
- Uniform provider tax requirements ($35B)
- Emergency Medicaid FMAP reduction for expansion population ($28B)
- Repeal FMAP enhancement for states that haven't expanded ($14B)


Source: "Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire? | KFF



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# SDP Questions

While there are many questions about the OBBBA, those related to the SDPs could have the greatest impact on providers.

## Grandfathered?

- Definitions:
  Depends on how CMS defines “**good faith effort**” or “**completed preprint**.”

## Medicare Rate?

- Definitions:
  How will CMS define, “**the specified total published Medicare payment rate**?”

# 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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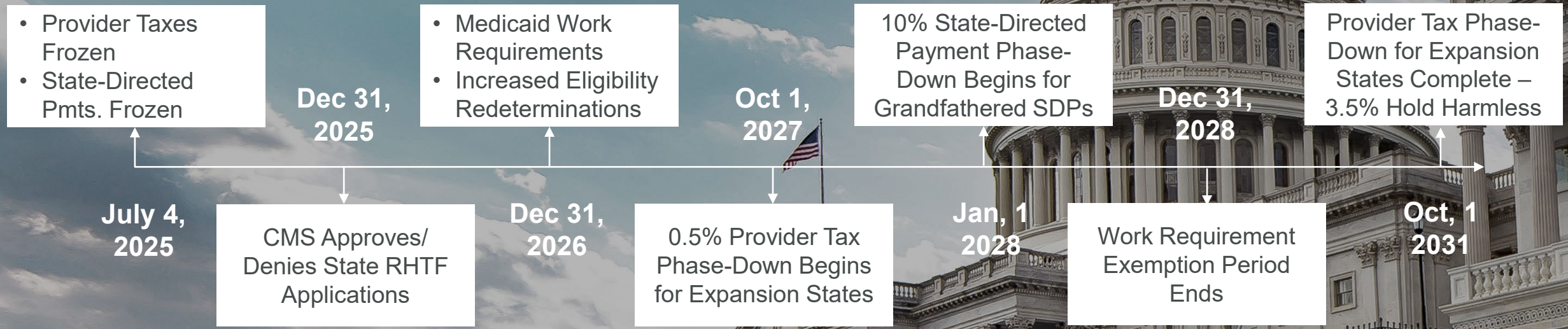
# OBBBA Implementation Timeline

Provisions impacting provider finances have staggered implementation dates.

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# 03

## How to Respond

# OBBBA: State Directed Payments (SDPs)

OBBBA will impose strict caps on SDPs, limiting them to 100% of Medicare rates in Medicaid expansion states and 110% in no expansion states.

| OBBBA Medicare Rate Cap | Estimated Reduction in Funding | Focus Areas |
| --- | --- | --- |
| 100% Medicare rate cap in expansion states<br><br>110% Medicare rate cap in non-expansion states | Reduced State Directed Payments | • Optimize Medicare Wage Index<br>• Increase Indirect Medical Education (IME) Funding<br>• DSH Survey |

# How CMS Pricer Calculates the IPPS Payment

**CMS IPPS Pricer – Key Payment Components**

| Component | Definition | Impact on Payment |
|---|---|---|
| MS-DRG Relative Weight | Reflects case complexity and resource needs. | Multiplies the base rate. Higher weight = higher payment. |
| Standardized Base Rate | National average payment per discharge, split into labor and non-labor shares. | Starting point. Labor portion is wage-adjusted. |
| Area Wage Index | Adjusts for local labor costs. | Multiplies labor portion of base rate. Higher index = higher payment. |
| DSH Adjustment | For hospitals serving many low-income patients. | Percentage add-on to DRG payment. |
| IME Adjustment | For teaching hospitals with residency programs. | Percentage add-on based on resident-to-bed ratio. |
| New Technology Add-On (NTAP) | Temporary payment for approved new tech or drugs. | Adds up to 65% of tech cost to DRG payment. |
| Outlier Payment | For extremely high-cost cases. | Adds ~80% of costs above fixed threshold to payment. |





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# Optimizing Wage Index

Even small wage index changes can have material financial impacts for hospitals since the wage index is applied to labor-related portions of the DRG payments and other rates.

## Why focus on wage index under OBBBA?

- Due to the caps at Medicare levels, hospitals must get as close to Medicare maximum as possible. The Area Wage Index is one lever that can be influenced by the hospital.
- Even in non-expansion states, the 10% cushion above Medicare will not make up the difference of a lower wage index. Many non-expansion states often start with lower Medicare rates.





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# Optimizing Wage Index

## Strategies to Optimize Wage Index: Accurate & Complete Wage Data Reporting

Check that Contract Labor is properly included

Payroll Hours; remove hours that should not be included

Collaborate with other hospitals on bringing up area wage index

Occupational Mix Survey

Geographic Reclassifications

Maximize reportable wage-related costs

# Increase Medicare IME Funding

IME payments offset the added costs of training residents and complex care. Accurate IME reporting strengthens the hospital's Medicare payment base, which now sets the benchmark for SDP caps under OBBBA.

## Why focus on IME under OBBBA?

- Due to the caps at Medicare levels, hospitals must get as close to Medicare maximum as possible. IME payments are applied as add-ons to both the operating and capital components of the Medicare IPPS per-discharge payment.
- Teaching programs themselves can help to address the growing physician shortages.





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# Increase IME

## Strategies to IME Funding

Accurately count all eligible residents

Optimize the Intern-to-Bed (IRB) Ratio
*Managing both the numerator and denominator*

Explore Affiliation Agreements to look at resident cap sharing

Compliance at time of filing to keep more funding during audit

Exhaust the possibilities

Leverage Section 401 (urban-to-rural) for cap increases

# Optimizing Medicaid DSH

## Strategies to Help Increase Uncompensated Care

- Background
- Common Issues/Pitfalls
- Optimizing Accuracy
- Other Considerations

# What's a DSH Survey?

## What It Measures and How It Is Used?

- Complex annual data collection tool
- Documents Medicaid and Uninsured patient volumes
- Calculates hospital uncompensated care cost
- Establishes the hospital-specific DSH limit, *i.e.,* max DSH payment)
- Often used to distribute DSH funds
- Always used to document states' compliance with Medicaid DSH rules (and substantiate ability to retain DSH funding)

# Common Issues/Pitfalls

## Data Integrity

- Multiple data sources
  - Patient Accounting
  - Cost Reporting
  - State Paid Claims
- Validity Checks
  - Patient days
  - Charges

## Patient Population

- Medicaid and Uninsured
- Proper Payor Identification
- Undescriptive Plan Names

## Mechanics

- Proper Matching of Cost and Charges
- Accumulation of Patient Days

# Data Integrity Example

## Medicaid Day Reconciliation

| | |
|---|---|
| Medicaid Fee-for-Service | 4,800 |
| Medicaid Managed Care | 2,800 |
| Other Medicaid Eligible | 1,500 |
| Total Medicaid Days - Survey | 9,100 |
| | |
| Total Medicaid Days - Cost Report | 11,700 |
| | |
| Variance | (2,600) |

# Patient Population

## Identifying the Uninsured

### Commonly Missed Patients

- Non-covered services
- Exhausted coverage
- Sub-provider patients
- Undocumented aliens
- Lab or therapy only patients
- Service paid by religious organizations

### Important Considerations

- Medical necessity - elective services, *e.g.,* plastics, are excluded
- Coverage must be exhausted before obtaining service
- High-deductible plans are considered coverage even if the patient must satisfy their deductible
- Inmates or otherwise involuntarily in custody for criminal charges are considered to have coverage

### Uninsured Definition

42 CFR 447.295

*No source of third-party coverage for a specific inpatient hospital or outpatient hospital service* means that the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and for which there is no other legally liable third party.

# Mechanics Example

## Proper Matching of Cost & Charges

| Cost Center | CCR | Proper Matching: Program Charges | Proper Matching: Calculated Cost | Improper Matching: Program Charges | Improper Matching: Calculated Cost |
|---|---|---|---|---|---|
| 71 MEDICAL SUPPLIES CHARGED TO PATIENT | 0.16 | 50,000,000 | 8,000,000 | 70,000,000 | 11,200,000 |
| 72 IMPL. DEV. CHARGED TO PATIENTS | 0.25 | 20,000,000 | 5,000,000 | - | - |
| | | 70,000,000 | 13,000,000 | 70,000,000 | 11,200,000 |

| | |
|---|---|
| Impact on Cost | (1,800,000) |

# ASC 606: 5 Steps for Revenue Recognition in Healthcare

1. Identify the contract – Example: Patient admission agreement

2. Identify performance obligations – Example: Inpatient care, diagnostic tests

3. Determine transaction price – Example: Insurance reimbursement, copayments

4. Allocate transaction price – Example: Split between surgery and post-op care

5. Recognize revenue – Example: Over-time for ongoing treatment

# Summary of Key Issues

## Variable Consideration Challenges

- Healthcare providers face uncertainty estimating Medicaid reimbursements under OBBBA's funding cuts and risks.

## Reassessment of Performance Obligations

- Changes in payment structures require reevaluating if services count as distinct performance obligations.

## Timing of Revenue Recognition

- Providers must decide if revenue recognition is over-time or at service completion under new models.

## Importance of Subsequent Disclosures

- Consistent disclosures are essential for transparency on legislative impacts and payor mix changes.

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# Questions?

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