Policy Terms for Pediatrics

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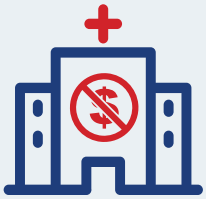
Given the dynamic landscape of health and health care policy, child advocates may feel challenged in understanding and responding to the major issues that impact children. We created Policy Terms for Pediatrics (PTP) to empower individuals invested in improving child health through policy and advocacy.

UNCOMPENSATED CARE

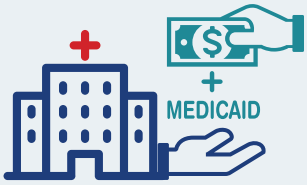
WHAT DOES IT MEAN

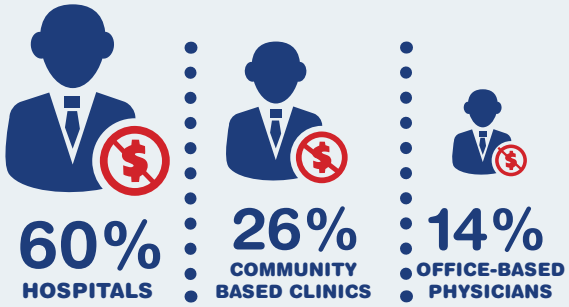
Uncompensated care (UC): any medical service not paid for by an insurer or patient. It includes losses stemming from both bad debt and financial assistance. Bad debt includes payments the provider expected to receive but never collected, while financial assistance includes payments the provider did not receive and never expected to receive based on the patient's inability to pay.



Disproportionate Share Hospital (DSH) payments: lump-sum payments made to safety-net hospitals that serve a high proportion of Medicaid or uninsured patients.

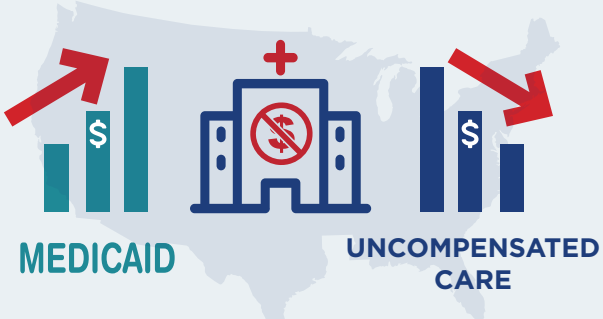
Upper Payment Limit (UPL) payments: payments that make up the difference between Medicaid payments for services and maximum payment allowed for that service. UPL offsets "Medicaid shortfall" by bringing Medicaid payments up to parity with what Medicare pays for a given service.





Across providers, hospitals provide the most UC (60%), followed by community based clinics (26%), and office-based physicians (14%). In 2015, hospitals provided an estimated $35.7 billion in UC nationwide to uninsured or underinsured patients. To ensure that vulnerable patients receive care and health care systems serving them remain viable, the burden of UC is defrayed by a complex array of federal and state government funds. Medicaid, the single largest provider of UC funding, which provided 25% of funding in 2013, comes in two major payment forms: UPL and DSH. Since federal and state funding do not negate UC costs completely, hospitals must manage some financial loss.

WHY DO WE CARE



States that expanded Medicaid, UC costs fell from 3.9% to 2.3%

UC disproportionately affects hospitals and clinics that serve low-income or uninsured patients. Because these safety-net providers give more UC, they heavily rely on Medicaid for insurance payments and supplemental funding. In states that expanded Medicaid, UC costs fell from 3.9% to 2.3% of hospital operating costs between 2013 and 2015, saving an estimated $6.2 billion. If the remaining non-expansion states had expanded Medicaid, UC costs would have fallen by another $6.2 billion.

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Future legislation that phases out Medicaid expansion will likely undo these savings. This will leave safety-net providers vulnerable to large cost increases. Under the recently proposed Better Care Reconciliation Act (BCRA), a potential replacement of the ACA, Medicaid spending would be expected to fall by $772 billion over the next decade. Federal spending cuts would both reduce the number of people covered by Medicaid and the amount of supplemental funding for providers. These cuts would likely affect the viability of safety-net hospitals and clinics caring for low-income and uninsured patients.

36 million children, who depend on CHIP or Medicaid would be vulnerable to significant limitations in necessary care due to per capita caps on federal financing under BCRA. This is especially concerning for the 5.7 million children with special health care needs who rely on Medicaid for extensive care, but do not meet the stringent disability guidelines for per capita cap exemption. On average, annual Medicaid spending for care of children with special needs is 12 times more than children without special care needs. Children's hospitals and providers may be vulnerable to dramatic increases in UC as BCRA would fundamentally reshape future healthcare delivery.

WHAT DO WE DO

With so much flux in current health policy, pediatricians have a responsibility to help develop models that benefit patients, clinical practice, and the broader society. Child care advocates invested in the well-being of children, can maximize their impact by:

1. Becoming more educated on how uncompensated care is addressed at health care practices or institutions in their community.
2. If working in a health care system, learning how much UC is given and how it affects finances.
3. Researching the policy positions of state and federal representatives and senators regarding UC.
4. If associated with an academic institution, collaborating with the institution's Government Relations office to learn more about UC.

Costs associated with uncompensated care will likely increase under current health policy proposals. Despite great complexity and fluctuation in current policy, pediatricians must understand how these policy changes will affect patients and providers in order to best advocate for the health and wellbeing of all children.

START BY READING MORE ...

http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medicaid-expansion-hospital-uncompensated-care
http://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/
http://www.aha.org/content/16/uncompensatedcarefactsheet.pdf
https://www.cbo.gov/publication/52849
https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
http://files.kff.org/attachment/Issue-Brief-Medicaid-Restructuring-and-Children-with-Special-Health-Care-Needs

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