FACTSHEET

Medicaid and Medicare DSH

THE ISSUE

The Medicaid and Medicare Disproportionate Share Hospital (DSH) programs have, since their inception in the early 1980s, provided vital financial support to hospitals that serve the nation's most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured. Because the *Patient Protection and Affordable Care Act* (ACA) was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress deemed it appropriate to cut both Medicaid and Medicare DSH payments to hospitals. Specifically, the ACA reduces Medicaid DSH payments by an estimated $14.1 billion from fiscal year (FY) 2014 through 2019, and Medicare DSH payments by $22.1 billion from FY 2014 through FY 2019. The ACA also calls for targeting DSH funds to hospitals treating large numbers of uninsured. However, with the uncertainty of state governments' decision on Medicaid expansion, the promise of health care coverage improvements may not be realized for some years to come.

AHA POSITION

Support H.R. 1920 that would delay DSH cuts for two years to allow for coverage expansions to be more fully realized and better data to become available.

WHY?

- **The Supreme Court decision on the ACA's Medicaid expansion will result in fewer covered individuals.** The Court's 2012 decision ruled that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. As of May 2013, 18 states are expanding their Medicaid programs. As a result, according to recent Congressional Budget Office (CBO) projections, the ACA will expand coverage to only 25 million – rather than 32 million – individuals.

- **It is unclear whether the insurance exchange marketplaces will be ready to enroll individuals beginning Oct. 1.** Much depends on the interoperability of information systems to determine eligibility for subsidies, verification of income through the federal information hub, and determination of Medicaid eligibility as well as successful outreach enrollment programs. More than half of the states' new insurance marketplaces will be operated as federal exchanges. Very little is known, at this point, about how these exchanges will operate and how they will interface with the state insurance markets and state Medicaid programs. In addition, a number of related rules still have yet to be finalized, and one of the biggest open questions is exactly how the federally facilitated exchanges will operate.

- **DSH redistributions will be based on questionable data.** For Medicaid DSH, the Centers for Medicare & Medicaid Services (CMS) is planning to use the Medicaid DSH audit data to determine distribution of the funds. However, many are concerned that the audit data do not accurately reflect the number of uninsured a hospital serves or the amount of its Medicaid shortfall.

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KEY FACTS

Even under the current levels of DSH funding, hospital costs for providing care to Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured are not fully met. Medicaid, on average, covers only 95 cents of every dollar spent treating Medicaid patients, while Medicare on average covers only 91 cents of every dollar treating Medicare patients. And in 2011 hospitals provided $41.1 billion of uncompensated care.

Medicaid ACA DSH Facts

For Medicaid, the ACA instructed the Department of Health and Human Services (HHS) secretary to consider how the reductions should be allocated across the states. The secretary must give consideration to states based on three existing categories: low-DSH states; non-low-DSH states; and 1115 waiver expansion states. The ACA instructed the secretary to impose a "smaller percentage reduction" on low-DSH states. In addition, the secretary must take into consideration two factors when establishing the methodology for distributing DSH payment reductions: a state's percentage of remaining uninsured; and whether a state targets DSH payments to hospitals serving a high volume of Medicaid inpatients and hospitals that have high levels of uncompensated care (excluding bad debt).

CMS issued its proposed rule implementing the Medicaid DSH reductions on May 13. The agency chose not to factor states' decisions whether to expand their Medicaid programs into its proposal for implementing the ACA's DSH reductions. CMS reports that it does not have sufficient information on the impact of state decisions to implement expanded coverage. As a result, CMS would apply its proposed methodology, known as the DSH Health Reform Methodology (DHRM), to reduce the DSH allotments only during the first two years of the scheduled reductions — FYs 2014 and 2015. CMS notes that the two-year reduction methodology allows for further data refinement and methodology improvements before the ACA's larger DSH reductions are slated to begin. The agency plans to issue future rulemaking to implement the DSH reductions due to the issues of coverage expansion in FY 2014 and beyond as well uncertainty around the data sources that will be used to generate the Medicaid DSH allotment reductions.

For example, the ACA introduces the concept of targeting the DSH funds to hospitals with high levels of Medicaid inpatient utilization and high levels of uncompensated care. In the proposed rule's DHRM, CMS intends to rely on data drawn from each states' Medicaid DSH auditing report. The proposed rule notes that there are some challenges in calculating total uncompensated care costs for hospitals using the Medicaid DSH audit data because the audit report does not collect total hospital costs. In addition, CMS has a regulation pending since 2012 that makes changes to the Medicaid DSH audit program. That pending regulation would make improvements in the definition of hospital uncompensated care costs such as allowing unreimbursed costs for those individuals with minimal heath care coverage. It also clarifies that all costs incurred in providing hospital services to Medicaid patients should be counted in the determination of the hospital-specific DSH limit. These important regulatory Medicaid DSH policy changes, that predate the ACA Medicaid DSH rule, have not been finalized. The AHA has concerns that CMS will rely on the Medicaid DSH audit data to develop the methodology to reduce DSH payments, even though the audit data is considered incomplete and not reflective of hospital uncompensated care costs.

Medicare DSH Facts

The ACA made changes to Medicare DSH payments beginning in FY 2014. Specifically, it requires that hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the current formula, with the remaining 75 percent flowing into a separate funding pool for Medicare DSH hospitals. This pool will be reduced as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

CMS issued its FY 2014 inpatient PPS rule on April 26, which contained its proposals for implementing the new Medicare DSH policy.

Empirically justified DSH payments. CMS proposes to distribute the 25 percent of Medicare DSH funds in the exact manner in which Medicare DSH payments are currently distributed: through a hospital-specific percentage add-on applied to the base diagnosis-related group (DRG) payment rates. Consequently, a hospital's DSH payments are tied to its volume and mix of PPS cases. The add-on is determined by a formula that is calculated as the sum of two ratios: (1) Medicaid patient days as a share of total patient days; and (2) Medicare Supplemental Security Income (SSI) days as a percentage of total Medicare days.

Uncompensated care DSH payments. CMS proposes to use CBO data to reduce the 75 percent pool by about $1 billion in FY 2014. In addition, it proposes to redistribute the funds using inpatient days of Medicaid beneficiaries plus inpatient days of Medicare SSI beneficiaries as a proxy for measuring the amount of uncompensated care hospitals provide. CMS would distribute these payments on a periodic interim, rather than per-discharge, basis.

CMS considered using charity care, bad debt and other data from the hospital cost report worksheet S-10 to measure uncompensated care. However, due to concerns that the revised S-10 is relatively new and has not historically been used for payment purposes, the agency decided that its use was not appropriate at this time.