AMERICA'S ESSENTIAL HOSPITALS

Modernizing Medicaid DSH: Policy Options To Ensure Vital Support for Essential Hospitals

Medicaid disproportionate share hospital (DSH) payments support hospitals that provide care to Medicaid and low-income patients. Since 1981, hospitals have relied on this funding to help cover the costs of providing such care. DSH payment policy has been shaped by several legislative and regulatory actions since its inception. However, the state of the health care delivery system, implications of the Affordable Care Act's (ACA's) DSH reductions, and current legislative activity related to health care reform have highlighted an opportunity to further modernize Medicaid DSH policy.

America's Essential Hospitals recommends removing unnecessary regulatory barriers that prevent states from using DSH payments to support timely, state-based initiatives—such as promoting integrated, coordinated care. The following policy proposals are offered to modernize the Medicaid DSH program to reflect the current state of the health care delivery system and the challenges faced by hospitals that care for the nation's vulnerable populations. The association urges Congress and the administration to adopt these changes to protect this crucial funding stream.

As outlined in more detail below, the impending ACA-mandated reductions to state Medicaid DSH allotments pose a dire threat to the vitality of essential hospitals and the ability of patients to access needed care. Congress first must delay the allotment reductions and then work to modernize Medicaid DSH policy.

What is Medicaid DSH?

Medicaid DSH payments are statutorily required payments that states make to hospitals that serve a high proportion of Medicaid and other low-income patient populations. These payments have been in existence since 1981, when Congress amended the Social Security Act to delink Medicaid hospital reimbursement from Medicare payment policy.

Starting with Medicaid's inception in 1965, states were required to pay hospitals for care to Medicaid beneficiaries per Medicare cost principles. Concerned that this state flexibility could harm certain hospitals and their patients, Congress in 1981 required state hospital payment methodologies to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[1]

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Initially, states were slow to adopt explicit DSH payment adjustments and the Health Care Financing Administration (HCFA)—now the Centers for Medicare & Medicaid Services (CMS)—erected regulatory barriers and limits that further impeded implementation. Congress responded by clarifying in the Omnibus Budget Reconciliation Act of 1986 that Medicaid hospital upper payment limitations did not apply to DSH payments. The next year, Congress adopted a requirement that states make DSH payments to "deemed DSH hospitals"—hospitals that serve the highest share of low-income patients. At the same time, Congress imposed certain minimal standards for any hospital receiving DSH funds: the hospital must have a Medicaid utilization rate of at least 1 percent and, with certain exceptions, at least two obstetricians with staff privileges who treat Medicaid enrollees.[2]

DSH spending began to increase, in part due to the lack of limits on DSH payments and a 1985 federal regulation that allowed states to use both public and private donations as sources of nonfederal Medicaid financing. This prompted concern from federal policymakers who acted to rein in spending.

In 1991, national and state-specific caps were set on the amount of federal funds available to make DSH payments. The state-specific caps are known as allotments and are published annually in the Federal Register. Allotments first were established for fiscal year (FY) 1993 and based on state DSH spending in 1991. Additional congressional action has made incremental adjustments to these allotments over the years—including allowing the allotments of low-DSH states (states with significantly lower DSH allotments than others) to grow more quickly in the early 2000s. Allotments now increase from year to year using a calculation that increases a state's previous fiscal year allotment by the percentage change in the Consumer Price Index for all Urban Consumers for the previous fiscal year.

In 1993, Congress created hospital-specific DSH payment limits that prohibit states from making DSH payments higher than the cost of uncompensated care for hospital services provided to Medicaid and uninsured patients. Uncompensated care costs are defined as the sum of Medicaid shortfall (the difference between Medicaid payments and the cost of providing services to Medicaid patients) and the unpaid costs of care for the uninsured. Costs incurred by hospitals for physicians, hospital-based federally qualified health centers, and underinsured patients (e.g. patients who cannot afford to cover their high deductibles) are not counted toward a hospital's DSH limit.[3] The calculation for the hospital-specific limit has been defined and implemented through rulemaking.

To ensure transparency and accountability in the Medicaid DSH payment program, Congress in 2003 added statutory requirements for states to submit an independent certified audit of their DSH payments and an accompanying annual report to the Secretary of Health and Human Services (HHS). CMS in 2008 finalized rulemaking for the implementation of the annual DSH audit and report requirements. Reports must identify all hospitals receiving DSH payments and provide data demonstrating compliance with the hospital-specific DSH limit. The agency subsequently developed and posted to its website additional guidance for states to meet all audit and reporting requirements. Once verified by CMS, the DSH audit reports are made available to the public. However, there is a significant data lag for the release of the audits, with a current lag of nearly five years.

Essential Hospitals Rely on Medicaid DSH Payments

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Filling a vital role in their communities, our more than 300 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Our members provide this care while operating on margins substantially lower than the rest of the hospital field—a zero percent aggregate operating margin compared with 8.3 percent for all hospitals nationwide. If our members were to stop receiving Medicaid DSH payments, their aggregate operating margin would drop to negative 6.21 percent.[4]

Our members serve as cornerstones of care for everyone in their communities, providing specialized inpatient, outpatient, and emergency services—such as trauma, burn, and inpatient psychiatric care—that often are unavailable elsewhere. In the 10 largest U.S. cities, our members operate 45 percent of all level I trauma centers, 79 percent of all burn-care beds, and 35 percent of psychiatric beds.[5] In addition, the average member of America's Essential Hospitals operates a network of 20 or more ambulatory care sites and delivers ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates. In addition, more than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide.

Essential hospitals are pillars in the Medicaid delivery system and have a demonstrated ability to make a real and lasting effect on the well-being of disadvantaged patients. Our members' background of caring for low-income, vulnerable populations has given them the expertise, passion, and commitment to apply and adapt proven models of care and to pioneer new models to meet their patients' specialized needs. Members of America's Essential Hospitals consistently find innovative and efficient strategies for providing high-quality, complex care—all while facing high costs, complex patient needs, and limited resources. But the reality is that with their patient mix and margins, essential hospitals are utterly dependent on Medicaid funding to carry out their missions and remain viable. In short, our members are at the very heart of the Medicaid delivery system, providing access where none exists, innovating with populations others ignore, and depending on Medicaid support to stay afloat.

Members of America's Essential Hospitals rely on multiple vital funding streams—but especially Medicaid DSH—to provide needed care to their communities and serve vulnerable populations that rely on them. In addition, they work closely with their state Medicaid offices to advance their states' policy priorities and meet population health needs.

Effect of the ACA on Medicaid DSH Payments

The ACA expanded health care coverage for low-income people, in part by increasing Medicaid eligibility to those with an income less than 138 percent of the federal poverty level. As originally passed, all states would have been required to expand Medicaid eligibility; Based on that expectation, Congress included substantial cuts to Medicaid DSH state allotments. As enacted in

the ACA, DSH allotment reductions would have begun in FY 2014 and ended after FY 2020, with allotments then reverting back to pre-ACA levels. The planned reductions ranged from $500 million in FY 2014 to $5.6 billion in FY 2019. In total, allotments would have been reduced by $17.1 billion over 10 years.

LEGISLATIVE ACTION

In 2012, the Supreme Court dramatically altered the scope of the ACA's anticipated coverage expansions by ruling that states could not be required to expand Medicaid eligibility. As a result, the Medicaid expansion became optional, but the DSH cuts did not account for the possibility of non-expansion states.

Since passage of the ACA, Congress has altered the DSH allotment reductions multiple times—in some cases to delay the implementation of the cuts, in others to extend the cuts to additional out-years, and sometimes doing both. By extending the DSH cuts beyond the original period included in the ACA, Congress often has used DSH as a source of scored budgetary savings that can pay for other legislation. This mechanism has come to be known as "DSH rebasing." For example, Congress twice extended the DSH cuts without any accompanying postponement of scheduled allotment reductions. The Middle Class Tax Relief and Job Creation Act of 2012, P.L. 112-96, Sec. 3203 (2012); The American Taxpayer Relief Act of 2012, P.L. 112-240, Sec. 641 (2013).

Congress repeatedly has recognized the devastating effect that Medicaid DSH allotment reductions would have on hospitals and has passed legislation for three consecutive years to delay the cuts:

- The Bipartisan Budget Act of 2013 delayed the DSH reductions to FY 2016, eliminated the FY 2014 reduction, added the amount of the FY 2015 reduction to the FY 2016 reduction, and extended the reduction schedule through FY 2023;
- The Protecting Access to Medicare Act of 2014 delayed the onset of the reductions to FY 2017, adjusted the total reductions in future years, and extended them to FY 2024; and
- The Medicare Access and CHIP Reauthorization Act of 2015 delayed the onset of the reductions to FY 2018, adjusted the amount of the reductions, and extended them to FY 2025.

Without further congressional action, Medicaid DSH allotment reductions will begin on October 1, 2017, under this schedule of annual reduction amounts:

- $2 billion in FY 2018;
- $3 billion in FY 2019;
- $4 billion in FY 2020;
- $5 billion in FY 2021;
- $6 billion in FY 2022;
- $7 billion in FY 2023;
- $8 billion in FY 2024; and
- $8 billion in FY 2025.

The current reduction schedule would cut the Medicaid DSH program by $43 billion over 10 years. This is significantly more than the $17.1 billion total reduction initially set in the ACA and poses a great threat to the program and the hospitals that rely on this crucial funding stream.

REGULATORY ACTION

The methodology for implementing the reductions was left to the discretion of the Secretary of HHS, with these requirements:

- The largest reductions are imposed on states that either have the lowest percentages of uninsured individuals or do not target DSH payments on hospitals with large volumes of Medicaid inpatients or uncompensated care;
- A smaller percentage of the total reductions are imposed on low-DSH states; and
- The methodology accounts for DSH funds used in Section 1115 waiver demonstrations that expand Medicaid coverage.

In 2013, through notice and comment rulemaking, CMS proposed and finalized its methodology for the DSH allotment reductions. The agency's methodology addressed only the first two years of the ACA's scheduled reductions—FYs 2014 and 2015. And it did not account for state expansion decisions because no timely data would have been available to do so. After accounting for low-DSH states, CMS calculated DSH allotment reductions for each state that weighed states' uninsured percentages, Medicaid inpatient volume, and uncompensated care levels. The timeframe and process by which the agency would recoup the reduced allotment amounts was not included in the methodology rulemaking. Before CMS issued additional guidance, the reductions were delayed by the passage of the Bipartisan Budget Act of 2013—rendering additional guidance or rulemaking unnecessary at the time. It is important to note that if DSH allotment reductions go into effect as scheduled, the agency must issue new rulemaking to implement the reductions in FY 2018 and beyond, because the previous methodology only addressed the allotment reductions for FYs 2014 and 2015.

Looming DSH Cuts

Barring further congressional action, the FY 2018 DSH allotment reductions will begin on October 1, 2017. CMS has yet to issue new rulemaking on implementing the reductions, leading to uncertainty for states and providers that rely on this funding. There is further uncertainty as states and providers monitor movement in Congress. Under the new administration, Congress and the president have vowed to repeal and replace the ACA.

Additionally, in states that did not expand Medicaid, about 4.7 million people who would have qualified for the expanded coverage are left uninsured. Essential hospitals continue to provide needed care to their communities, but at a price. America's Essential Hospitals projects that by 2026, member hospitals will see $81.5 billion more in uncompensated care than expected when Congress passed the ACA in 2010. Coupled with high levels of uncompensated care costs, reductions in Medicaid DSH payments to essential hospitals are unsustainable. As noted earlier, without Medicaid DSH payments, essential hospitals face catastrophic economic outlooks, including negative operating margins.

Because Medicaid coverage levels remain substantially below projections when the ACA was passed and states and providers continue to face uncertainty, the impending Medicaid DSH allotment reductions pose a threat to the vitality of essential hospitals nationwide. To ensure patients and communities continue to access needed care, Congress must act immediately to ensure that the Medicaid DSH cuts do not go into effect.

Modernizing Medicaid DSH Payments

First and foremost, it is imperative that Congress acts to ensure the impending Medicaid DSH allotment reductions are eliminated entirely. The cuts, as currently structured, are unsustainable and we cannot understate the threat they pose to hospitals. Hospitals must be able to rely on stable, adequate funding to provide needed care for patients in their communities. In addition to ensuring adequate funding, there are several structural issues with the DSH program that Congress and the administration can improve and modernize.

America's Essential Hospitals believes that the calculation, allocation, and administration of Medicaid DSH payments can and should be improved. Our policy proposals are suggestions for modernizing the Medicaid DSH program by removing unnecessary regulatory barriers that prevent states from using DSH to support timely state-based initiatives. These proposals would not require any new federal spending because the DSH allotments would limit overall DSH payments. We encourage Congress and the administration to consider these proposals and we are ready to work together to implement the needed improvements. However, these policy options do not work in a world where DSH payments are drastically reduced as currently prescribed—these options would not overcome the challenges hospitals would face if uncompensated care was drastically underfunded.

IMPROVE TARGETING OF DSH PAYMENTS TO ESSENTIAL PROVIDERS

Current law allows states to make DSH payments to virtually any hospital in their state, as long as it has at least a 1 percent Medicaid utilization rate—which almost all hospitals do. This extremely low floor has led to great variation in how states distribute DSH dollars. In some circumstances, states have chosen to broadly disseminate their DSH allotment among all hospitals, leaving less funds available for hospitals that are serving the highest share of Medicaid and low-income patients in their state. **Medicaid DSH payments should be better targeted to prevent the dilution of funds to essential providers that are relied on by vulnerable populations and communities.**

In the 2013 reduction methodology, CMS provided incentives for states to better target their DSH payments to hospitals providing care to a disproportionate share of Medicaid and uninsured patients. While we disagree with the statutorily-mandated reductions, we applaud Congress for directing the Secretary of HHS to implement a methodology to distribute the cuts using a targeting approach and the agency's recognition of the need for better targeting through its rulemaking. Further, Congress also has required the Medicaid and CHIP Payment and Access Commission (MACPAC) to issue annual reports on Medicaid DSH that provide critical data regarding coverage levels and uncompensated care throughout the country. In its 2016 report, MACPAC concluded that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and that have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH

payments. The commission expanded on its conclusion in a March 2017 report that analyzed the effects on hospitals and states of raising the minimum federal eligibility criteria for DSH payments.[6] MACPAC's analysis can serve as an important resource to identify better ways to ensure DSH dollars are distributed to hospital providers that truly serve a disproportionate number of vulnerable patients.

UPDATE DSH STATUTE TO ACCOUNT FOR ALL HOSPITAL COSTS

Not all costs that hospitals incur for providing care to Medicaid and uninsured patients are included in the Medicaid hospital-specific DSH limit calculation. Under current rules, only those costs associated with a narrow definition of inpatient and outpatient hospital services can be included in the uncompensated care definition. **America's Essential Hospitals recommends that CMS update DSH policy to account for all hospital costs associated with providing care to patients. This includes, but is not limited to, the costs incurred by hospitals for services provided by physicians that are directly employed or affiliated with a hospital; costs for nonhospital community-based services; costs for hospital services when a patient's benefits are exhausted during a hospital stay; and uncompensated costs of unpaid medical bills for patients in high-deductible or catastrophic-only health plans.**

Costs for Services by Hospital-Employed or Affiliated Physicians

Many physicians are directly employed by the hospital or are affiliated with the hospital. Yet, because physician costs are not captured in the DSH limit, hospitals often must subsidize the cost of care provided to indigent patients by these physicians. Allowing for inclusion of these costs is logical, as many hospitals must compensate physicians for providing indigent care hospital services. Without these payments—particularly for hospitals that serve a disproportionate share of low-income patients—hospital services would not be available to this patient population.

Nonhospital Community-Based Services

Hospitals often incur costs of care that takes place outside their walls, coordinating nonhospital community-based services, such as post-acute care services, that are critical to ensure the best outcomes for patients. These nonhospital services are crucial in the health care delivery system—they often are key to keeping patients healthy and out of the hospital. Excluding these costs from the DSH limit calculation hinders the ability of hospitals to provide needed services.

Unreimbursed Costs for Treating Vulnerable Patients

DSH policy only allows states to compensate hospitals for unreimbursed costs associated with Medicaid patients and uninsured patients. CMS rightly includes in the definition of uninsured patients those who have no coverage for the hospital services provided, even if they are otherwise nominally insured (e.g., if they have reached a limit on covered hospital days before admission). But this policy disregards the true extent of unreimbursed costs incurred by hospitals treating vulnerable patients. Costs for inpatient hospital services provided when insurance benefits are exhausted during a hospital stay should be properly included in the DSH limit calculation as costs of services for which an individual has no source of third-party coverage. Under CMS policy, the DSH limit would include the costs of a multiday hospital stay for an

individual who had reached a day limit before admission, but not for an individual who had even one day of coverage left upon admission. In both cases, the hospital has provided uncompensated services.

Increasingly, hospitals also are burdened with the costs of patients who are nominally insured but whose coverage leaves them with large medical bills they cannot afford. The low-income populations treated by DSH hospitals are less likely to have other resources available to cover the costs of their care. DSH costs should include the uncompensated costs of unpaid medical bills for patients in high-deductible or catastrophic-only health plans, which are more likely to impose large cost-sharing burdens on patients. The exclusion of costs for the underinsured leads to a significant understatement of the burden of uncompensated care shouldered by essential hospitals.

Updating Medicaid DSH policy to allow for all hospital costs associated with providing care is crucial to ensure providers filling a safety-net role receive the support they need to care for their communities. DSH policy must accurately reflect the burden shouldered by DSH hospitals.

STREAMLINE MEDICAID DSH AUDITS AND REPORTING REQUIREMENTS

Under the Medicare Modernization Act of 2003, Congress required states to obtain independent certified audits of DSH payments to hospitals and report audit results to CMS to ensure payments do not exceed the hospital-specific DSH limit. CMS in 2008 finalized the rules implementing this requirement, and audits have been ongoing since.[7] The resulting process has become cumbersome, expensive, and inefficient. **As such, America's Essential Hospitals recommends moving toward a prospective DSH audit methodology.**

While issuing the rules governing the audits, CMS announced several previously unannounced policies on calculating unreimbursed costs that have proved challenging for providers and states. For example, among these new rules is a requirement to retrospectively reconcile DSH payments with actual unreimbursed costs incurred in the same audited payment year based on final Medicare cost reports, rather than using projected unreimbursed costs based on prior-year data. This requirement introduced a substantive change in policy that has placed a massive, costly administrative burden on states and hospitals for a relatively minimal gain in oversight, transparency, and accountability. Moreover, this has created a significant data lag—nearly five years—in the public reporting of provider-specific Medicaid DSH payments and DSH limits. CMS must objectively weight this burden against the minimal additional accuracy gained by retroactively calculating the DSH limit based on audited cost data rather than relying on projected cost data.

Moving toward a prospective audit methodology would work to streamline the process and minimize the burden and challenges. To the extent that relying on estimated costs based on prior year data might result in payments that are different than actual costs, as determined through subsequent audits, future DSH computations would account for those variances. Moreover, the financial exposure for the federal government using estimated, rather than reconciled, data would not be significant, as total DSH expenditures are limited by the statewide DSH allotment. Therefore, the disadvantages of the retrospective reconciliation mandate far exceed its benefits. In addition, states still would be required annually to report to CMS their DSH payments and

their calculations of the DSH limits on a hospital-specific basis, and CMS annually would be required to post such reports on its website for public use. Our proposal, however, would significantly improve the usefulness of this data by making it available to researchers, policymakers, and the public years earlier.

INCREASE STATE DSH ALLOTMENTS TO REFLECT ACTUAL LEVELS OF UNCOMPENSATED CARE COSTS

Congress in 1991 instituted the national and state-specific caps on the amount of federal funds that could be used to make DSH payments. These caps initially were established for FY 1993 and were based on a state's DSH spending in 1991. As a result, states today still live with the effect of spending decisions made a quarter of a century ago, with some states forever saddled with inadequate DSH allotments that are not tied to need. The allotments, set at a point in time, do not reflect a state's current uncompensated care burden. **America's Essential Hospitals recommends rebasing low-DSH state allotments to better reflect the actual level of uncompensated care costs in such states.**

Recognizing that some states still had low allotments, Congress was prompted to include allotment increases for low-DSH states that continued through FY 2008.[8] Other than providing temporary increases in response to economic pressures, such as the 2009 recession, allotments since then have been adjusted solely for inflation. Despite efforts to fix the imbalance in allotments, low-DSH states still have DSH allotments that do not reflect the reality of their uncompensated care. Allowing for a rebasing would improve that inequity.

Conclusion

The need for Congress to protect current levels of Medicaid DSH funding by eliminating the ACA-mandated allotment reductions cannot be overstated. At the same time, the Medicaid DSH program must be modernized. The policy options outlined above allow for that modernization and for DSH policy to better reflect the evolution of the health care delivery system. However, these policy options will not work if the Medicaid DSH allotment reductions go into effect beginning in FY 2018.

Congress must act now to prevent the Medicaid DSH allotment reductions from going into effect on October 1, 2017. Congress must eliminate the DSH allotment reductions or—at the very minimum—delay the onset of the reductions by two years. Once the reductions are eliminated, Congress and the administration should focus on modernizing the Medicaid DSH program to ensure that essential hospitals can continue to rely on this crucial funding stream. America's Essential Hospitals and its members stand ready to work on how best to implement these needed improvements to DSH policy.

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[1] Social Security Act § 1902(a)(13)(A)(iv)

[2] MACPAC. Chapter 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments. March 2016. https://www.macpac.gov/wp-content/uploads/2016/03/Overview-of-Medicaid-Policy-on-Disproportionate-Share-Hospital-Payments.pdf. Accessed April 2017.

[3] MACPAC. Chapter 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments. March 2016. https://www.macpac.gov/wp-content/uploads/2016/03/Overview-of-Medicaid-Policy-on-Disproportionate-Share-Hospital-Payments.pdf. Accessed April 2017.

[4] Landry C, Ramiah K, Rangarao S, Roberson B. *2014 Essential Data, Our Hospitals, Our Patients; Results of America's Essential Hospitals 2014 Annual Member Characteristics Survey.* America's Essential Hospitals. June 2016. https://2c4xez132caw2w3cpr1il98fssf-wpengine.netdna-ssl.com/wp-content/uploads/2016/06/2014-Essential-Data-Our-Hospitals-Our-Patients.pdf. Accessed April 2017.

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[6] MACPAC. Report to Congress on Medicaid and CHIP. March 2017. https://www.macpac.gov/wp-content/uploads/2017/03/March-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf. Accessed April 2017.

[7] 73 Fed. Reg. 77904. December 19, 2008.

[8] P.L. 106-554. December 21, 2000.