The House-passed Build Back Better Act includes a provision that would cut Medicaid disproportionate share hospital (DSH) and uncompensated care pool payments to states that did not expand Medicaid as envisioned by the Affordable Care Act (ACA).

The bill would cut DSH payments to these states by 12.5 percent beginning in fiscal year (FY) 2023. If a state expands Medicaid after FY 2023, its full DSH allotment would be restored for the year it expands. Conversely, if an expansion state rolls back its expansion, it would receive a 12.5 percent cut for that fiscal year, prorated by the days for which expanded coverage is available. These states’ share of ACA DSH cuts scheduled to start in FY 2024 would come on top of the 12.5 percent cut.

This document dispels common misconceptions about these proposed DSH cuts.

**MYTH: PROVIDING HEALTH CARE COVERAGE TO MORE PEOPLE LESSENS THE NEED FOR DSH PAYMENTS.**
America’s Essential Hospitals supports congressional efforts to expand access to health care coverage in the Build Back Better Act. Covered lives are healthy lives. But history has shown the need for critical safety net supports, such as (DSH) payments, does not disappear with coverage expansion. Even in states that expanded Medicaid, essential hospitals still face uncompensated care costs, such as treating underinsured patients and Medicaid payments that fall short of costs. No matter how comprehensively designed, closing the coverage gap likely will not reach every uninsured individual or adequately cover every needed service; many will continue to fall through the cracks.

**MYTH: ALL HOSPITALS WILL BENEFIT FROM EXPANDED ACA MARKETPLACE ACCESS BECAUSE PRIVATE PLANS REIMBURSE MORE FOR CARE THAN MEDICAID.**
Expansion of private insurance coverage through the federal marketplace might not translate to increased revenue or services for high-Medicaid and safety net providers. Essential hospitals often are carved out of commercial health plan networks—the very networks these new expansion patients would enter. Experience has shown us that after the ACA expanded coverage through its marketplace plans, private insurers resisted attempts by essential hospitals to join their networks. This means essential hospitals likely would not see a shift in their payer mix toward more privately insured patients under the Build Back Better Act coverage provisions.

The act’s proposed DSH cuts would amount to a $4.7 billion loss to hospitals during the 10-year budgetary window. Essential hospitals operate with strained finances due to the complexity of the services they provide and the needs of the patients they treat, as well as the disparity in provider reimbursements between public and private payers. A cut of this magnitude would exacerbate the financial challenges these hospitals face and could impede their ability to care for patients with substantial medical and socioeconomic needs.

A recent study by the Urban Institute and Robert Wood Johnson Foundation confirmed some hospitals—especially those that fill a safety net role—will be harmed by the proposed DSH cuts. Restricting critical funds to hospitals that care for marginalized populations in low-income communities would harm the very people the Build Back Better Act intends to help.

**MYTH: IN NON-EXPANSION STATES, DSH PAYMENTS WOULD DUPLICATE ADDITIONAL REVENUE HOSPITALS RECEIVE BY TREATING PEOPLE WHO GAIN MARKETPLACE COVERAGE UNDER THE BUILD BACK BETTER ACT.**
Once previously uncovered patients become eligible for ACA marketplace coverage, any of their uncompensated costs, including unpaid deductibles and cost sharing, will not be eligible for DSH payments. DSH payments cover uncompensated care costs only for uninsured patients and to make up Medicaid shortfalls. Any unpaid copayments or
bad debt from patients covered by marketplace plans cannot count toward DSH payments.

**MYTH: POLICIES THAT PUNISH STATES THAT HAVEN’T EXPANDED MEDICAID WILL, IN THE LONG RUN, HELP COMMUNITIES IN NEED.**

America’s Essential Hospitals believes all people deserve and should have access to health care coverage and supports legislative efforts to expand access to coverage. But these efforts should not be tied to DSH payments for providers that see high numbers of Medicaid and low-income patients.

These are the same providers that anchor their communities and invest their limited resources to provide high-quality, comprehensive care to patients with complex medical and socioeconomic needs. They rely on DSH and other safety net supports to eliminate health disparities and promote health equity.

Further, the decision to expand Medicaid is made at the state level, not by safety net providers. Federal law sets broad requirements for Medicaid and mandates coverage of some populations and benefits while leaving others optional. The choice to expand Medicaid eligibility to those earning up to 138 percent of the federal poverty level is among those optional benefits. State flexibility and innovation are at the very core of the Medicaid program. Federal action to punish states for not engaging in optional plan design sets an alarming and harmful precedent and is a slippery slope.

Cutting the DSH program—especially with hospitals still on the front lines of COVID-19—is misguided. We urge Congress to remove the cuts to Medicaid DSH payments proposed in the Build Back Better Act.