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How Do Medicaid Disproportionate Share Hospital (DSH) Payments Change Under the ACA?

SUMMARY

DSH, or "disproportionate share" hospitals are hospitals that serve a large number of Medicaid and low-income uninsured patients. Under federal law, stateMedicaid programs must "take into account the situation of" these hospitals in setting payment rates for inpatient services. States generally achieve this requirement by making supplemental paymnets to hosptials. While states have considerable discretion in determining the amount of DSH payments to each DSH hospital, their discretion is bounded by two caps – one at the state level, and the other at the facility level. Federal DSH payments are estimated to total $17.4 billion in FY 2011. Based on the assumption of increased coverage and therefore reduced uncompensated care costs under the Affordable Care Act (ACA), the law calls for a reduction in federal Medicaid Disproportionate Share Hospital (DSH) allotments. The statute requires annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020.

To implement these annual reductions, the statute requires that the Secretary reduce annual state DSH allotments, and payments to states. The ACA requires the Secretary of HHS to develop a methodology to allocate the reductions that must take into account 5 factors: impose a smaller percentage reduction on low DSH states; impose larger percentage reductions on states that have the lowest percentages of uninsured individuals; impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients or with high levels of uncompensated care, and the methodology must take into account whether the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009. The Centers for Medicare and Medicaid Services (CMS) released a final rule to allocate the reduction in the DSH allotments for FY 2014 and FY 2015 in September 2013.

This brief provides some background in DSH payments, how DSH payments are affected by the ACA, the methodology for the DSH reductions across states for FY 2014 and FY 2015 and a look at the implications of the DSH reductions.

WHAT ARE DSH PAYMENTS?

DSH, or "disproportionate share" hospitals are hospitals that serve a large number of Medicaid and low-income uninsured patients. Under federal law, stateMedicaid programs must "take into account the situation of" these hospitals in setting payment rates for inpatient services.[1] This requirement has come to mean making a payment supplemental to the reimbursement a hospital would normally receive under the Medicaid program for inpatient services. The hospitals qualifying for these additional payments are generally determined by each state (subject to federal minimum standards), and the amount of additional payments made to each facility is set by each state (subject to federal maximum limits).[2] In many states, these DSH payments have been crucial to the financial stability of "safety net" hospitals. Federal DSH payments are estimated to total $17.4 billion in FY 2011.[3]

While states have considerable discretion in determining the amount of DSH payments to each DSH hospital, their discretion is bounded by two caps – one at the state level, and the other at the facility level. At the state level, the total amount of federal funds that each state can spend on DSH is specified in an annual DSH allotment for each state. While there have been some special adjustments, the DSH allotments are generally calculated based on the previous year's allotment increased by inflation but then subject to a cap of 12 percent of the total amount of Medicaid expenditures under the state plan during the FY. When the DSH caps were originally set, they locked in variation across states in DSH spending. Based on data reported to CMS in August 2003, state with DSH payments less then three percent of total Medicaid spending were determined to be "low-DSH" states and were permitted to receive higher annual increases in DSH allotments than non-low DSH states. At the facility level, Medicaid DSH payments that a state can make to an individual hospital is limited to 100 percent of the costs incurred by a hospital for serving Medicaid and uninsured patients for which it has not been compensated by Medicaid.

HOW DOES THE ACA CHANGE DSH PAYMENTS?

Based on the assumption of increased coverage and therefore reduced uncompensated care costs under the ACA, the law calls for a reduction in federal DSH allotments. The statute requires annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. The aggregate annual reduction amounts are as follows:

Annual Aggregate Reductions in Federal DSH Funding	
Year	Reductions
2014	$500 million
2015	$600 million
2016	$600 million
2017	$1.8 billion
2018	$5 billion
2019	$5.6 billion
2020	$3 billion

The American Taxpayer Relief Act extends the DSH cuts for FY 2021 and FY 2022 by an inflation adjustment (CPI-U). To implement these annual reductions, the statute requires that the Secretary reduce annual state DSH allotments, and payments to states. The ACA requires the Secretary of HHS to develop a methodology to allocate the reductions that must take into account 5 factors:

- Impose a smaller percentage reduction on low DSH states.
- Impose larger percentage reductions on states that have the lowest percentages of uninsured individuals during the most recent year for which such data are available
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients.
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

WHAT IS THE METHODOLOGY TO ALLOCATE THE DSH CUTS ACROSS STATES?

On September 13, CMS a final regulation about the DSH cuts in the ACA[4]. Similar to the proposed rule, the final rule applies to DSH reductions in federal fiscal year 2014 and 2015 and does not account for a state's decision to expand Medicaid or not in the methodology to implement the DSH cuts. CMS states it will revisit the methodology for how to allocate cuts for fiscal 2016 and later years in a separate rule. The final rule specifies a DSH Health Reform Methodology (DHRM) that accounts for the five factors specified in the statute.

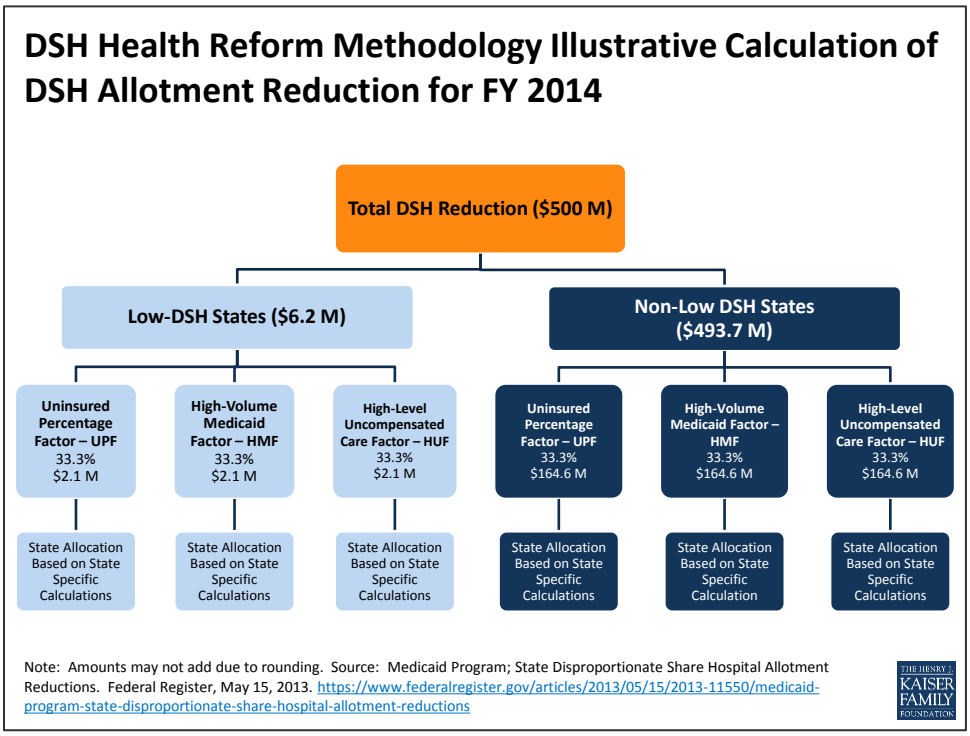
Under the rule, CMS would start with the the allotment reduction specified in the law for a given year and then follow a number of steps to allocate the reduction across states:

1. **Is the state a Low-DSH State or a Non-Low DSH State?** For each FY, CMS will separate low-DSH States and non-low DSH states into distinct State groups. CMS will allocate a portion of the aggregate DSH allotment reductions to each State group based on a calculation that accounts for the share of total allotments for low-DSH states multiplied by the Low DSH Adjustment Factor (LDF). The LDF is the mean DSH payments per total Medicaid spending in the low-DSH and the non-low DSH groups converted to a percentage. The reduction for the low DSH State group is calculated by multiplying the LDF by the aggregate DSH allotment reduction for the low DSH State group. The non-low DSH reduction is the full allotment reduction minus the low-DSH reduction.
2. **How will the reductions be allocated for the Low-DSH and Non-Low DSH States?** For each group (low-DHS and non-low DSH states) CMS will create three equal pools to allocate the group reduction. The three pools look at a states' uninsured percentage factor and then how well the states target DSH payments based on Medicaid volume and uncompensated care.
3. **How will the pool amounts be allocated across states?** Once the pools are created, the rule uses state specific data to allocate the reductions across states. States are evaluated based on how they compare (in terms of uninsured and targeting payments) relative to other states in the group. For example, a state's High-Volume Medicaid Factor

(HMF) reduction is based on its DSH payments to hospitals with Medicaid Inpatient Utilization Rates (MIURs) less than 1 standard deviation above the mean compared to the group total of these payments.

4. **What is a states total reduction?** Once the pool amounts are allocated across states, the total reduction is the sum of the state specific reduction for the three factors.
5. **What other factors are considered?** To address the statutory requirement that the methodology take into account the extent to which the DSH allotment for a state was used for a coverage expansion approved under Section 1115 Waiver prior to July 31, 2009 the rule proposes to exclude the DSH funds used for expansions in the HMF and HUF pools.

The proposed rule issued in May 2013 included illustrative calculations for the FY 2014 DSH reductions.[5] The proposed rule also showed these illustrative calculations for each state (see Table 1). The final rule requires states to submit additional data that will be used in the final DSH reduction calculations.



In addition to the methodology to implement the statutory DSH reductions, the rule also includes additional DSH reporting requirements for use in implementing the DSH health reform methodology. States are required to submit the mean MIUR for all hospitals receiving Medicaid payments in the State and the value of one standard deviation above such mean. States must provide the data for State Plan Rate Year (SPRY) 2008, SPRY 2009, SPRY 2010, and SPRY 2011 by June 30, 2014. States must provide this data for each subsequent SPRY to CMS by June 30 of each year. To determine which SPRY's data the state must submit, subtract 3 years from the calendar year in which the data is due. For example, SPRY 2012 data must be submitted to CMS by June 30, 2015. In addition, CMS noted they they intend to publish a DHRM technical guide that provides information regaridn the DHRM calculation and data sources.

WHAT ARE THE IMPLICATIONS OF THE DSH CHANGES?

As specified in the law, the methodology to allocate the DSH reductions takes into account how well states target DSH payments to hospitals that serve a high percentage of Medicaid patients or uncompensated care. Given the formula, states may examine how well DSH payments are targeted within their states. Overall, the DSH reductions for FY 2014 and FY 2015 are relatively small compared to later years when more significant reductions in coverage were anticipated and the rule affecting these two years does not account for a state's decision to implement the Medicaid expansion. If the current methodology were maintained for years beyond FY 2105, states that implement the Medicaid expansion could see fewer uninsured and therefore see larger percentage reductions in DSH compared to state that do not implement the expansion. However, states that implement the Medicaid expansion are expected to see new patient revenues associated with new Medicaid coverage that could potentially offset the DSH reductions while states that do not move forward will not see new revenues from new Medicaid coverage but

continue to see high uncompensated care costs. CMS has indicated that there is no timeline for states to decide to implement the expansion. As the DSH reductions increase, states may weigh the fiscal gains of new coverage against the reduction in DSH for hospitals. This decision may also be affected by how CMS treats the decision to not implement the Medicaid expansion in future regulations to allocate the DSH reductions beyond FY 2015.

ENDNOTES

[1] Section 1902(a)(13)(A)(iv) of the Social Security Act, 42 USC 1396a(a)(13)(A)(iv).

[2] To qualify as a DSH hospital a hospital must meet two minimum qualifying criteria. The first criterion is that the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid pateints (except when the hospital predominantly service children under 18 years ot the hospital does not offer obstetric services to the general public). The second criterion is that the hospital has a Medicaid inpatient utilization rate (MIUR) of at least 1 percent. A hospital is deemed as a DSH if the hospital's MIUR is at least one standard deviation above the mean MIUR in the state, or if the hospital's low-income utilization rate exceeds 25 percent.

[3] Kaiser Family Foundation, State Health Facts. Distribution of Medicaid Spending by Service, FY 2011. http://kff.org/medicaid/state-indicator/spending-by-service/#table

[4] Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, Federal Register: Vol. 78, No. 181 , Wednesday, September 18, 2013 http://www.gpo.gov/fdsys/pkg/FR-2013-09-18/pdf/2013-22686.pdf

[5] Medicaid Program; State Disproportionate Share Hospital Allotment Reductions. Federal Register, May 15, 2013. https://www.federalregister.gov/articles/2013/05/15/2013-11550/medicaid-program-state-disproportionate-share-hospital-allotment-reductions

TABLE 1:
FY 2014 DSH HEALTH REFORM METHODOLOGY - ILLUSTRATIVE CALCULATIONS IN NPRM

State	Unreduced FY 2014 DSH Allotment (Estimate)	Reduction Based on UPF (Uninsured Factor)	Reduction Based on HMF (High Volume Factor)	Reduction Based on On HUF (High Level Uncomp'd Care Factor)	Total Reduction	Reduction As % of Unreduced DSH Allotment	FY 2014 Reduced Allotment
US Total	$11,685,025	$166,667	$166,667	$166,667	($500,000)	-4.3%	$11,185,025
Regular DSH ($1,000s)							
Alabama	$327,307	$4,451	$6,451	$5,966	($16,867)	5.15%	$310,439
Arkansas	$107,772	$1,226	$2,321	$4,144	($7,690)	7.14%	$100,081
California	$1,166,862	$12,496	$19,339	$788	($32,623)	2.80%	$1,134,239
Colorado	$98,458	$1,228	$953	$3,262	($5,443)	5.53%	$93,015
Connecticut	$212,882	$4,647	$4,209	$4,475	($13,331)	6.26%	$199,552
DC	$65,195	$1,703	$463	$844	($3,010)	4.62%	$62,185
Florida	$212,882	$1,988	$2,888	$5,216	($10,091)	4.74%	$202,791
Georgia	$286,061	$2,883	$3,131	$5,061	($11,074)	3.87%	$274,986
Illinois	$228,849	$3,299	$3,645	$3,900	($10,843)	4.74%	$218,005
Indiana	$227,518	$3,046	$3,283	$1,280	($7,609)	3.34%	$219,909
Kansas	$43,907	$628	$922	$683	($2,233)	5.09%	$41,674
Kentucky	$154,340	$2,009	$2,430	$2,069	($6,507)	4.22%	$147,832
Louisiana	$731,960	$8,157	$12,282	$4,906	($25,345)	3.46%	$706,615
Maine	$111,763	$2,189	$1,324	$2,413	($5,927)	5.30%	$105,836
Maryland	$81,161	$1,430	$1,639	$1,727	($4,796)	5.91%	$76,365
Massachusetts	$324,646	$14,613	$1,032	$1,077	($16,721)	5.15%	$307,924
Michigan	$282,069	$4,528	$3,256	$5,661	($13,445)	4.77%	$268,624
Mississippi	$162,323	$1,771	$1,929	$716	($4,416)	2.72%	$157,907
Missouri	$504,265	$7,606	$7,180	$11,118	($25,903)	5.14%	$478,362
Nevada	$49,229	$432	$226	$258	($916)	1.86%	$48,313
New Hampshire	$170,411	$3,039	$2,714	$2,904	($8,657)	5.08%	$161,754
New Jersey	$685,215	$10,273	$9,990	$9,086	($29,349)	4.28%	$655,866
New York	$1,709,712	$28,518	$17,331	$19,683	($65,532)	3.83%	$1,644,180
North Carolina	$314,002	$3,717	$6,628	$3,952	($14,297)	4.55%	$299,704
Ohio	$432,417	$6,970	$6,497	$9,943	($23,409)	5.41%	$409,008
Pennsylvania	$597,401	$11,668	$9,875	$12,324	($33,867)	5.67%	$563,535
Rhode Island	$69,187	$1,129	$1,332	$1,002	($3,463)	5.01%	$65,724
South Carolina	$348,595	$3,948	$5,769	$3,995	($13,712)	3.93%	$334,883
Tennessee	$54,007	$747	$860	$920	($2,527)	4.68%	$51,480
Texas	$1,017,844	$8,522	$18,256	$29,359	($56,137)	5.52%	$961,707
Vermont	$23,949	$591	$435	$276	($1,302)	5.44%	$22,647
Virginia	$93,251	$1,417	$1,718	$1,230	($4,366)	4.68%	$88,885
Washington	$196,916	$2,744	$3,136	$3,355	($9,236)	4.69%	$187,680
West Virginia	$71,848	$977	$1,144	$995	($3,117)	4.34%	$68,731
Total Regular DSH	$11,164,204	$164,589	$164,589	$164,589	($493,767)	4.42%	$10,670,437
Low DSH ($1,000s)							
Alaska	$21,682	$52	$174	$87	($313)	1.45%	$21,368
Arizona	$45,916	$129	$129	$42	($301)	0.66%	$45,616
Delaware	$9,636	$47	$0	$0	($47)	0.49%	$9,589
Hawaii	$10,394	$63	$71	$104	($238)	2.29%	$10,156
Idaho	$17,496	$47	$112	$50	($209)	1.19%	$17,287
Iowa	$41,918	$214	$76	$116	($406)	0.97%	$41,512
Minnesota	$79,500	$417	$257	$623	($1,297)	1.63%	$78,202
Montana	$12,082	$33	$69	$90	($191)	1.58%	$11,890
Nebraska	$30,121	$124	$239	$249	($612)	2.03%	$29,509
New Mexico	$21,682	$53	$169	$53	($274)	1.26%	$21,408
North Dakota	$10,167	$49	$60	$13	($123)	1.21%	$10,044
Oklahoma	$38,545	$97	$110	$392	($599)	1.56%	$37,946
Oregon	$48,182	$134	$381	$9	($524)	1.09%	$47,658
South Dakota	$11,756	$45	$70	$37	($152)	1.29%	$11,604
Utah	$20,882	$65	$159	$212	($436)	2.09%	$20,446
Wisconsin	$100,622	$508	$0	$0	($508)	0.50%	$100,114
Wyoming	$241	$1	$1	$0	($2)	0.97%	$239
Total Low DSH	$520,821	$2,078	$2,078	$2,078	($6,233)	1.20%	$514,588

NOTES: *All of the values on this chart are only for the purposes of illustrating DSH Health Reform Methodology (DHRM). Data are shown in $1,000. Potential DSH Diversion state are DC, ME, MA, WI.

SOURCE: Federal Register, May 15, 2013 (Vol. 78, No. 94), pp 28551 -28569, at https://www.federalregister.gov/articles/2013/05/15/2013-11550/medicaid-program-state-disproportionate-share-hospital-allotment-reductions#t-1.