National Association of Public Hospitals and Health Systems

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Equitable, Sustainable, Reliable Safety Net Financing: Medicaid DSH

Medicaid disproportionate share hospital (DSH) payments help hospitals cover a portion of their Medicaid and uninsured losses and support essential communitywide health services and physician training at teaching hospitals. The National Association of Public Hospitals and Health Systems (NAPH) represents the nation's major providers of Medicaid and uninsured care. This policy brief outlines NAPH's recommendations for implementing the reductions to Medicaid DSH funding specified in the Affordable Care Act (ACA).

The ACA promises to expand coverage for low-income Americans, in part by expanding Medicaid eligibility criteria to cover an additional 16 million uninsured Americans. However, even after coverage expansion is fully implemented, at least 23 million Americans are estimated to remain uninsured. At the same time, the ACA prescribes reductions in funding sources—such as DSH—that are used to support hospitals that care for a disproportionate share of Medicaid and uninsured patients.

The Medicaid coverage expansion is set to begin in calendar year (CY) 2014, though the rate at which coverage actually expands remains to be seen. The prescribed Medicaid DSH reductions are slated to begin in fiscal year (FY) 2014, regardless of how quickly coverage expansion occurs. These reductions would come at a time when Medicaid providers around the country should be preparing to bolster their capacity to treat millions of new Medicaid patients. Reductions in this crucial lifeline for safety net hospitals will not only jeopardize the delivery system's readiness for the CY 2014 expansion, but also threaten to erode existing capacity to meet the needs of Medicaid and uninsured patients.

For these reasons, it is critically important that the secretary of the U.S. Department of Health and Human

NAPH members include the largest metropolitan safety net health systems in the country. These health systems fill an ever-increasing gap in access to care by providing a significant level of uncompensated care to low-income, uninsured, and vulnerable populations. In fact, NAPH members represent just 2 percent of acute care hospitals nationwide, yet they provide 20 percent of all hospital-based uncompensated care. In addition to providing essential community services like top-level trauma care, burn care, and neonatal intensive care, these health systems help newly uninsured patients and those newly eligible for public coverage programs navigate the health system to get the care they need.

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Services develop a methodology for achieving cuts to the DSH program that supports the hospitals that Medicaid and uninsured patients rely on most heavily. **Any methodology developed by the secretary to reduce DSH allotments should ensure that the remaining funds are used for the hospitals with the greatest need, consistent with Congress' original intent in enacting the DSH program.** With this goal in mind, NAPH has developed a methodology designed to incentivize states to target reduced DSH funds to hospitals assuming the greatest share of low-income care, without mandating any particular allocation of DSH payments.

Background on Medicaid DSH

As is true for much of the Medicaid program, states have considerable discretion in designing their DSH program, within federal limitations. In practice, states have directed DSH payments to hospitals for a range of important safety net needs, including (1) covering financial losses from caring for Medicaid and uninsured patients, (2) ensuring safety net facilities are able to deliver essential communitywide health care services, and (3) supporting physician training. These uses support the original purpose of the DSH program, which in part is to help sustain safety net hospitals and their activities.

Proposed Methodology

Federal Medicaid DSH policy has always balanced state flexibility with the federal interest in ensuring that hospitals with the highest shares of low-income care receive DSH payments. To this end, the ACA directs the secretary to develop a DSH health reform methodology that would impose the largest percentage reductions in DSH allotments on states that (1) have the lowest percentages of uninsured individuals **or** (2) do not target their DSH payments to hospitals with high levels of uncompensated care and high volumes of Medicaid inpatients. (The ACA also states that low DSH states and states that have used DSH for coverage waivers must also be taken into account.)

With this framework in mind, NAPH used an analytical model to develop a methodology that would (1) incentivize states to target their DSH dollars to hospitals with high levels of uncompensated care and Medicaid inpatients, i.e., high-need hospitals, and (2) adopt a phased approach to incorporating DSH cuts that would reevaluate the methodology when data reflecting the impact of health reform are available.

Using the ACA's option of a "targeting" concept, NAPH recommends that the secretary determine the size of DSH reductions for each state based on the amount of DSH dollars the state spends on low-need DSH hospitals, i.e., those that do not have high levels of uncompensated care and Medicaid inpatients.

This recommended approach would be used solely to determine the amount of the reduction to each state's allotment. States would retain the flexibility to determine how to direct their DSH dollars, but at the same time be incentivized to ensure their DSH programs are as targeted as possible on the highest-need hospitals to minimize the cuts they will be required to absorb in future years.

Specific Recommendations

NAPH's approach includes the following specifications for how the secretary should implement the DSH reductions.

Because data reflecting the effects of coverage expansions on the number of uninsured individuals will not be available for several years, the secretary should not use the percentage of uninsured individuals as a metric for allocating the DSH cuts in the early years of the program. Instead, the secretary should focus on the "targeting" prong of the ACA framework.

Given the ACA's emphasis on the number and needs of the residual uninsured in its description of DSH reform methodology, the secretary should use uninsured uncompensated care cost (UCC)—i.e., without accounting for Medicaid shortfall—as the metric for determining hospitals' uncompensated care burden. However, shortfalls from treating Medicaid patients remains a significant issue for safety net providers. The secretary should use the Medicaid inpatient utilization rate (MIUR) to help capture the burden on hospitals that care for a large proportion of Medicaid patients.

In order to appropriately determine the degree to which states target their DSH payments to high-need DSH hospitals, the secretary should take into account the differences among the states' Medicaid programs and use state-specific thresholds when identifying targeted payments.

The methodology should be implemented on a state-specific basis. In other words, in order to determine high- and low-need DSH hospitals, hospitals in each state would be compared to the state-level uninsured UCC burden and MIUR benchmarks developed with data from hospitals in that state only.

Using the state-based thresholds, the secretary should protect the portion of a state's DSH payments that are paid to hospitals with high

uninsured UCC burden or MIUR, i.e., targeted dollars, and recoup the amount of payments made to hospitals with low uninsured UCC burden and MIUR, i.e., untargeted dollars, to meet the mandated levels of DSH cuts.

The secretary should set a high threshold using the MIUR and allow the uninsured UCC burden thresholds to vary from year to year to achieve the level of cuts required by the ACA. In most years, as the level of cuts increases, the uninsured UCC burden and/or the MIUR thresholds would need to be raised.

The secretary should take the time between 2014 and 2017 to conduct research on the accuracy of various available data, determine valid and reliable data sources, and determine whether the methodology needs to be updated for 2018 and beyond, when post-coverage expansion data are available. Specifically, during the 2014 to 2017 time period, the secretary should explore the availability of any data that would take into account the delivery of both inpatient and outpatient care to Medicaid beneficiaries, which would reflect the current practice of medicine through which hospitals deliver more care in the ambulatory setting.

The secretary should also ensure that all data used are the most up-to-date data available and have been reconciled and fully settled.

Conclusions

As safety net providers around the country prepare to bolster their capacity to treat millions of new Medicaid and uninsured patients, the secretary should take steps to minimize the impact of mandated DSH cuts on the safety net delivery system. Specifically, the secretary should establish safety net financing policy, through the DSH health reform methodology, that would support and ensure funding for core safety net missions such as providing uncompensated care to un- and underinsured patients, training tomorrow's health care workforce, and providing essential community services such as trauma and burn care. ■

If you have questions about this issue, or would like more information, contact Xiaoyi Huang (xhuang@naph.org) at NAPH.