



Reforming the Medicaid Disproportionate Share Hospital Program

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As the Senate and House work to merge their respective health reform bills, reductions in future federal funding for the Medicaid Disproportionate Share Hospital (DSH) program are being considered as one means of financing coverage expansions. The Medicaid DSH program provides funding allotments to states to subsidize certain hospitals for the unreimbursed costs they incur treating uninsured and Medicaid patients. Under current law, the federal government is expected to spend more than \$100 billion on the Medicaid DSH program over the next 10 years.

Proposed funding reductions in Medicaid DSH payments are based on the expectation that expansions in insurance coverage will lead to reductions in uncompensated care. However, even in a reformed health care environment, DSH payments will still be necessary to support care for those who will remain uninsured — estimated to be 18-23 million — as well as to subsidize the relatively low Medicaid reimbursement rates for 15 million new Medicaid patients. Bills in the House and Senate use different policy approaches to reduce Medicaid DSH spending by different aggregate levels. In this issue brief, we examine these approaches to consider the potential impact on safety-net care and the degree to which they can help improve some of the historical shortcomings of the Medicaid DSH program.

Building on the recent paper published in *Health Affairs*, we outline a specific financing approach that would initially link future state Medicaid DSH allotments to measures of Medicaid enrollment and the number of uninsured persons at the state level.¹ In future years, state allotments would be linked to more

direct measures of uncompensated care volume as they become available. This approach would produce more gradual spending reductions over time relative to current legislation and would explicitly avoid funding “cliffs” that could subject providers of safety-net care to additional financing pressures. Further, it would recognize the critical role that Medicaid will continue to play in expanding insurance coverage through health care reform and the ongoing reliance by many institutions on relatively low Medicaid reimbursements.

Additionally, we include new ideas that could help ensure federal spending on Medicaid DSH is more directly connected to the delivery of care for vulnerable populations than it is now. This includes promoting greater innovative delivery system reform approaches to better coordinate care for vulnerable populations, as well as new options to support DSH institutions when they take steps to promote greater accountability for results.

CURRENT LEGISLATIVE PROPOSALS

House and Senate health reform legislation propose different approaches for redirecting Medicaid DSH spending to help offset the costs of the larger legislative package.

Under the House bill, current Medicaid DSH allotments would prevail through 2016. Subsequently, aggregate spending reductions would take effect — totaling \$1.5 billion in 2017, \$2.5 billion in 2018, and \$6 billion by 2019. The Secretary of Health and Human Services (HHS) would distribute these aggregate reductions across states, making smaller

relative allotment adjustments for states with higher percentages of uninsured individuals and for those that adequately target payments to hospitals with the largest uncompensated care volumes. The Congressional Budget Office (CBO) estimates that this approach would produce \$10 billion in savings over a 10-year period (2010–2019).²

The Senate bill would maintain Medicaid DSH allotments at current levels until individual states achieve reductions in the rate of uninsured by at least 45 percent, relative to 2009 levels. Once a state's uninsured rate drops by this amount, its Medicaid DSH allotment would automatically be cut in half. The Senate bill allows smaller funding reductions for low-DSH states (25 percent instead of 50 percent) as well as for states that spent 99.9 percent of their allotment on average during the years 2004 through 2008 (17.5 percent for low-DSH states and 35 percent for other states). For all states, additional reductions would occur in subsequent years as individual states reduce the number of persons without health insurance. The bill also establishes a floor to ensure that state allotments cannot be lower than 50 percent of their 2012 allotments. CBO estimates that adjustments would not begin until 2015 and that this policy would produce much larger savings than the House bill, specifically \$18.5 billion in cuts to the federal share of Medicaid DSH over a 10-year period.³

To varying degrees, both of these bills offer at least a modest transition to the practice of linking spending to the uninsured rate at the state level relative to current law. The House bill would accomplish this by allowing the HHS Secretary to consider state uninsured rates as she implements aggregate DSH cuts; the Senate bill would accomplish this more directly by reducing payments when states actually achieve significant reductions in uninsured rates. However, these legislative approaches may raise several potential challenges related to future financing of safety-net care for vulnerable populations.

First, the actual magnitude of aggregate funding reductions in the House bill has no explicit linkage to indicators of uncompensated care. As noted, while the HHS Secretary can consider such indicators when adjusting specific state allotments, aggregate cuts that are unrelated to actual reductions in uncompensated care could place additional pressures on safety-net institutions should reductions in uncompensated care not materialize as quickly as predicted.

Second, legislation in both the House and Senate would result in a significant funding “cliff” for Medicaid DSH allotments and hence for individual hospitals. The House bill's funding cliff would begin for all states in 2017 and would gradually increase in subsequent years. The Senate bill would create a significant funding cliff in different years for different states based on when their respective uninsured rates drop by at least 45 percent. Depending on how these reductions are passed on to hospitals, substantial and rapid funding reductions could adversely affect safety-net institutions that still have high uncompensated care volumes when the cliffs take effect.

Third, neither the House nor Senate bill would address the important and likely increasing role that Medicaid payments will play in total revenue for many institutions as health reform is implemented.

ALTERNATIVE APPROACHES FOR REFORMING THE MEDICAID DSH PROGRAM

As Congress considers a unified reform package that could pass both the House and Senate, opportunities exist to build upon and improve proposed legislation regarding Medicaid DSH policies while still achieving significant savings that can help offset the broader costs of reform.

Proposed Financing Approach

The following alternative approach to reforming Medicaid DSH combines aspects of both the House and Senate bills, while also adding elements that would further improve the program:

Starting in 2013, set each state's annual Medicaid DSH allotment based on objective indicators of uncompensated care at the individual state level.

- Unlike the House bill, our approach would ensure that any reductions in the federal share of Medicaid DSH spending would only occur if real — not predicted — changes in indicators of uncompensated care actually materialize.

Initially, we suggest using the number of persons without health insurance and the number of persons enrolled in Medicaid as state-level measures on which state allotments are based, until more direct measures of uncompensated care are available.

- Unlike both the House and Senate bills, our approach would hold state allotments harmless when the number of uninsured persons is reduced by expanding Medicaid enrollment.⁴
- Given concerns about the relative inadequacy of Medicaid reimbursements in covering the costs of care — particularly for institutions with high volumes of Medicaid patients — this policy would help provide more financial stability for those institutions that will continue to rely on Medicaid payments for a significant share of their revenue after reform is enacted.
- Our short-term implementation strategy includes initially relying on proxies for uncompensated care to determine allocations (e.g., measures of uninsurance and Medicaid enrollment). However, once consistent, timely, and audited measures of hospital-level data on charity care and bad debt become more available nationally, our proposal would transition to more direct measures of uncompensated care volume at the hospital level.

Implement funding adjustments on a gradual, lagged basis.

- To calculate 2013 state allotments, the Centers for Medicare & Medicaid Services (CMS) would divide total 2012 federal DSH allotments by the average of the total number of uninsured persons and Medicaid enrollments (at a national level) from the previous two years. This would produce a national, incremental DSH cost amount per uninsured and Medicaid enrollee, and this figure would be updated for inflation each year based on the Consumer Price Index (CPI-U).
- To calculate individual state allotments annually, CMS would multiply this figure by the applicable number of uninsured persons and Medicaid enrollees in each individual state.
- As the two-year rolling average number of Medicaid enrollees and uninsured persons changes over time in response to coverage reform at the individual state level, federal funding for Medicaid DSH in each state would automatically change on a lagged basis. This would produce gradual federal savings that could help support further reductions in uncompensated care through coverage expansions.
- If the number of uninsured people declines relatively slowly in some states, reductions in the corresponding federal Medicaid DSH funding would be gradual as well. This would prevent eventual funding “cliffs” that could jeopardize the stability of the safety-net system.

In making specific allotment decisions, permit the HHS Secretary to consider a range of adjustments to the basic approach we have outlined.

- Adjustments to the proposed approach could include variations in the cost to treat certain populations, differential Medicaid provider rates per state, the extent to which states target funding to hospitals with high volumes of uncompensated care, and historical state-to-state imbalances in DSH allotments.

Budget Impact

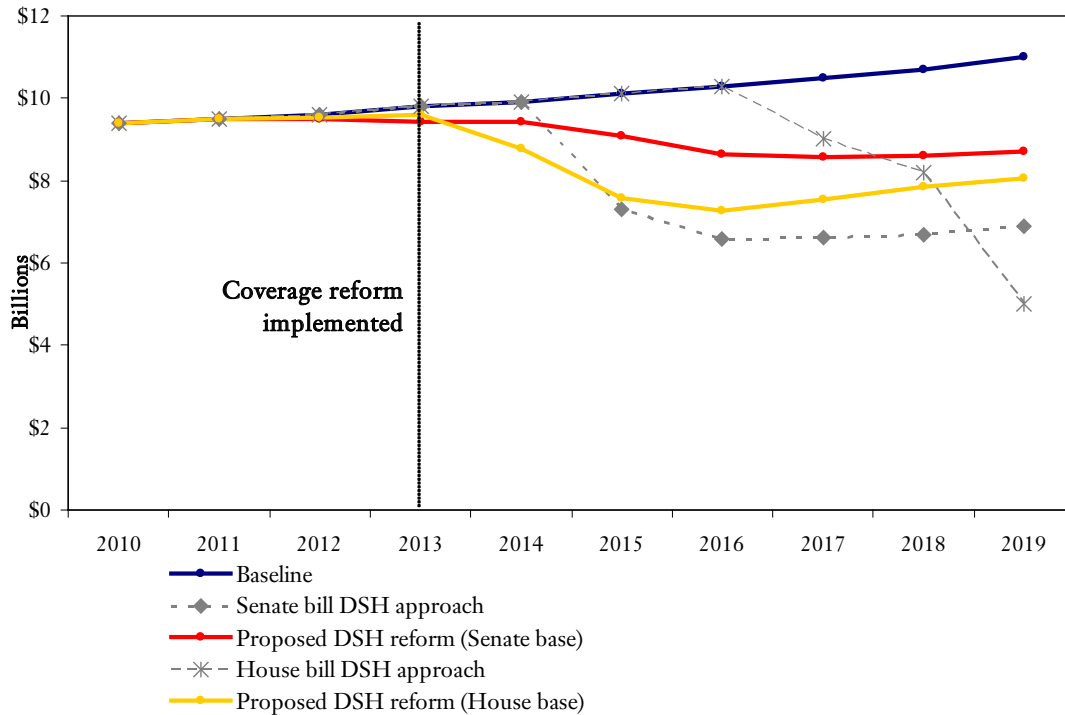
We modeled the financial impact of our proposed DSH reform on the coverage reform aspects of both the Senate bill and the House bill. For both bills, we used CBO estimates of Medicaid enrollments and number of uninsured persons over a 10-year budget window.

The DSH reform approach we propose would save a significant amount of money for the federal government, funds which could be used to partially offset the costs of the broader health care reform package. The range of savings presented here is comparable to the savings estimates in the House and Senate bills. Specifically, if our approach were incorporated in the House bill (in lieu of the Medicaid DSH policy currently contained in the bill, which would save \$10 billion), it would generate total federal savings of \$15.7 billion over a 10-year budget window. If our proposal were to be adopted based on the coverage reforms included in the current Senate bill (and in place of the Senate’s current Medicaid DSH proposal), it would generate savings of \$9.9 billion compared to the Senate’s current projected Medicaid DSH cuts of \$18.5 billion over the 10-year budget window. Differences between the CBO projections for the House and the Senate bills simply reflect the underlying differences in the coverage-related provisions in the two bills.

OTHER REFORMS TO MODERNIZE THE MEDICAID DSH PROGRAM

In addition to the proposed financing reforms, Congress could also consider implementing additional Medicaid DSH reforms to help modernize the program and ensure that it supports high-value, coordinated care for those it was designed to support. Such reforms would include the following:

Exhibit 1. Projected 10-Year Federal Spending on DSH Under Proposal and Current Legislation



Improve reporting requirements.

- States should be required to provide detailed hospital-level information regarding provider taxes and other intergovernmental transfer policies used to supplement their share of Medicaid DSH funding, in addition to the current state reporting requirement on methods used to distribute DSH funds to hospitals.
- State reporting requirements should also be coordinated with hospital-level reporting, which will increasingly include more timely, transparent, and detailed information on the uncompensated care provided by hospitals that receive supplemental funds, as well as other measures assessing the quality of care delivered by safety-net institutions.

incentives to certain institutions to facilitate the use of electronic systems for timely reporting of quality and cost measures to improve care coordination and patient outcomes. The intent is to build on and reinforce health information technology (IT) incentives available through the American Recovery and Reinvestment Act of 2009.

- Consistent with other aspects of health reform legislation, the authority would be designed to support states and hospitals when they take steps to improve care and lower costs. Over time, these efforts should ensure that a greater proportion of federal supplemental hospital and other payments are linked to documented improvements in care for vulnerable populations.

Provide states with additional flexibility to use DSH allotments to test and evaluate innovative initiatives that improve care for vulnerable populations.

- For example, states should be permitted under Section 1115 or a related authority to provide hospitals with grants, outside of per-institution caps, to develop new collaborations with federally-qualified health centers or other outpatient clinics that encourage the delivery of coordinated care in appropriate clinical settings.
- This authority could also allow states to use a portion of their DSH allotments to provide

Connect Medicaid DSH policy changes more explicitly to the broader goals of health reform legislation, specifically to reforms aimed at promoting greater overall coordination of care and accountability for cost and quality throughout the health care system.

- Provide opportunities for states to “earn back” Medicaid DSH funding reductions by implementing accountability-based payment systems.
- On behalf of DSH hospitals that commit to participating in a range of reforms designed to promote accountability for results — such as

shared savings programs tied to actual measures of cost and quality results, advanced medical homes linked to actual cost and quality results — states should be permitted to apply for temporary exemptions that would temporarily reduce the rate at which a portion of their Medicaid DSH allotments are reduced for eligible hospitals.

- Eligible institutions should be able to demonstrate that they are complying with new reporting requirements that can help document the impact on patient care and the volume of uncompensated care delivered. Such funds should be used by eligible hospitals to help them actively participate in larger payment and delivery system reforms that, in turn, foster greater accountability for cost and quality for the populations they serve.

CONCLUSION

The proposed Medicaid DSH financing approach we outline would ensure that spending reductions occur on a gradual and lagged basis in response to the somewhat unpredictable effects of health care reform. This would help “smooth out” funding reductions over time, rather than implementing more drastic cuts over a shorter time period as the House proposes, or abruptly cutting payments in individual states once a certain coverage threshold has been reached as proposed in the Senate.

The proposed reform would also hold hospitals harmless on their federal Medicaid DSH allotments for reductions in the rate of uninsurance achieved

through expanded Medicaid enrollments. This should help certain types of hospitals that rely heavily on Medicaid reimbursements remain financially stable. In addition, our approach would allow the HHS Secretary to consider and account for other drivers of uncompensated care, including variation in Medicaid provider reimbursement rates, costs to treat certain populations in different communities and states, and historical state-to-state Medicaid DSH funding imbalances.

The proposal introduces both a short- and long-term strategy for better targeting Medicaid DSH funding to states and hospitals that provide a disproportionate share of uncompensated health care. We believe that linking spending to actual indicators of the uncompensated care that DSH funding is intended to subsidize is a more appropriate long-term solution than is provided in current law or the House and Senate proposals.

Finally, the current reform environment creates an important opportunity to consider other ways to improve the Medicaid DSH program aside from simply reducing aggregate spending levels. Specifically, we propose complementary reforms designed to better target federal Medicaid DSH spending and better support hospitals and other health care facilities that take innovative, coordinated approaches to providing high-value health care to vulnerable populations.

1. McKethan A, Nguyen N, Sasse BE, and Kocot SL, “Reforming The Medicaid Disproportionate-Share Hospital Program,” *Health Affairs* 28, no. 5 (2009): w926–936.

2. For more details regarding CBO cost estimates for H.R. 3962, Affordable Health Care for America Act, see the November 20, 2009 letter from the CBO to the Honorable John D. Dingell. See: <http://www.cbo.gov/ftpdocs/107xx/doc10741/hr3962Revised.pdf>

3. For more details regarding CBO cost estimates for The Patient Protection and Affordable Care Act, see the December 19, 2009 letter from the CBO to the Honorable Harry Reid. See: <http://www.cbo.gov/doc.cfm?index=10868>

4. In practice, HHS/CMS could apply evidence-informed weights to measures of uninsured populations and Medicaid enrollments when calculating state allotments to account for relative drivers of uncompensated care. The modeling results above weighted them equally, but alternatives weighting approaches are certainly possible.