MACPAC

Medicaid Disproportionate Share Hospital Payment: Major Policy Questions

Medicaid and CHIP Payment and Access Commission
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Overview

- Status of MACPAC report on disproportionate share hospital (DSH) payments
- Policy questions raised by analysis:
  - What data improvements could improve the analysis of DSH payment policy?
  - What types of hospitals should DSH payments support?
  - What types of uncompensated care should DSH payments be based on?
- Discussion of potential policy approaches

Status of MACPAC DSH report

- Beginning in February 2016, MACPAC must submit an annual report to Congress on the relationship of DSH allotments to:
  - changes in the number of uninsured individuals
  - the amount and sources of hospitals' uncompensated care costs
  - hospitals with high levels of uncompensated care that also provide essential community services
- Staff are preparing a draft of the first report

Issues for discussion

- Data improvements:
  - Collecting Medicaid payment data for all hospitals
  - Collecting non-federal share information
  - Better link DSH data to other federal data sources
- Policy approaches:
  - Focusing DSH payments on high-need hospitals
  - Changing the definition of uncompensated care for Medicaid DSH
  - Rebasing state DSH allotments or adjusting the formula for DSH allotment reductions

Data limitations

- Medicaid DSH audit data
  - Only include DSH hospitals
  - Significant data lag
  - Do not include information on intergovernmental transfer (IGT) payments, which reduce net payments
- Medicare cost reports
  - Do not include sufficient detail on Medicaid payments to calculate Medicaid shortfall reliably
- The Commission may want to comment or make recommendations on data improvements

What types of hospitals should DSH payments support?

Characteristics of DSH hospitals

- Virtually all US hospitals meet the minimum requirements to be eligible for DSH payments
- About half of all US hospitals received DSH payments in 2010
  - Some states provide DSH payments to all hospitals, while others make DSH payments to only one or two hospitals
- One quarter of DSH hospitals must receive DSH payments because they have high Medicaid or low-income utilization rates
  - These deemed DSH hospitals are particularly reliant on DSH payments

Other federal support for hospitals

- Medicaid
  - Non-DSH supplemental payments
- Medicare
  - Medicare DSH payments
  - Indirect medical education (IME) payments
- Other support
  - 340b drug discount program
  - Non-profit tax exemption

Effects of the ACA on hospital finances

- Pending DSH reductions are premised on the assumption that coverage expansions will reduce the need for DSH payments
- Early reports suggest that the ACA is improving hospital finances generally
  - Moody's Investors Services upgraded its outlook for non-profit hospitals from negative to stable
- However, we do not know the effects of the ACA on DSH hospitals in particular

What types of uncompensated care should DSH payments be based on?

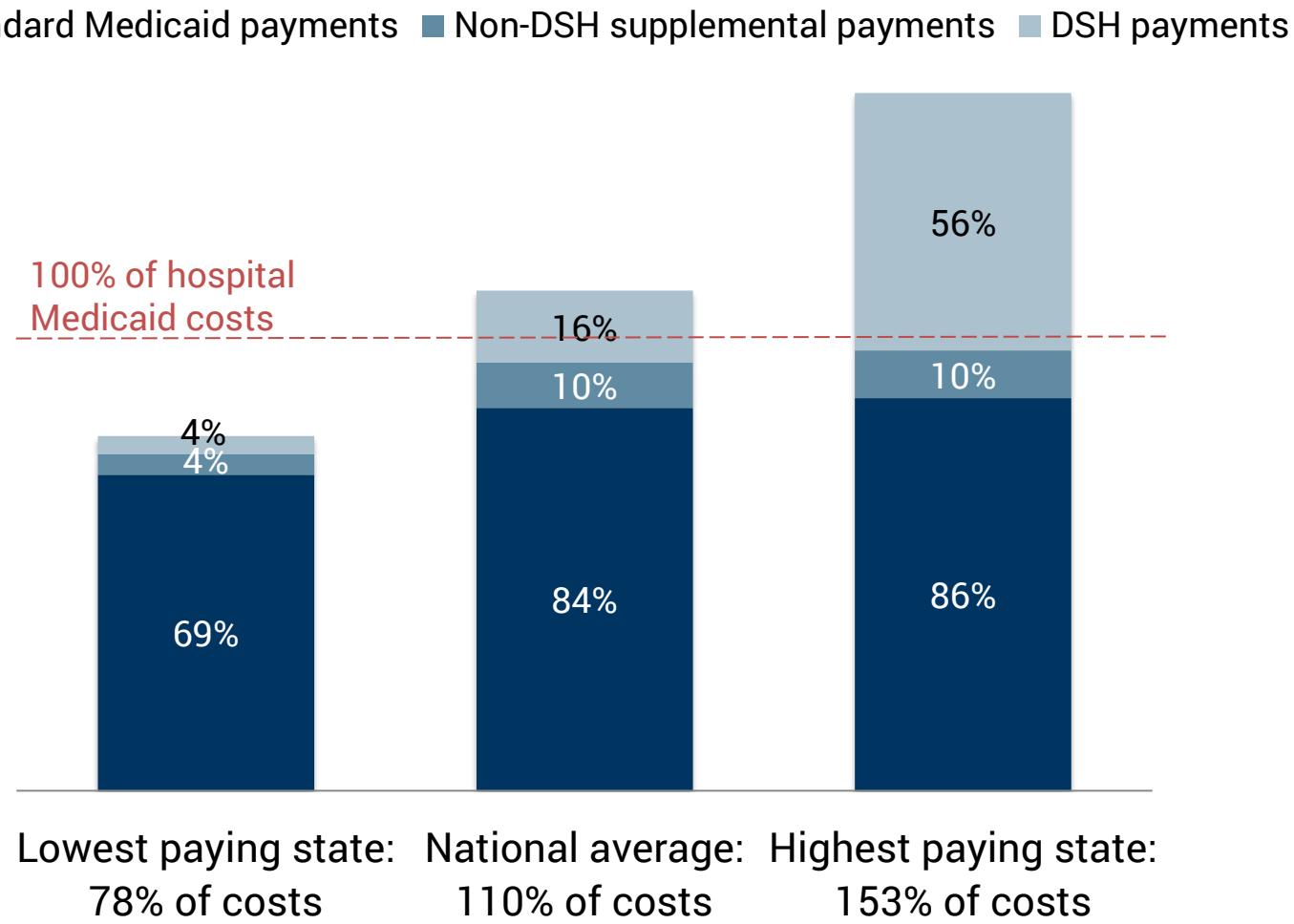
Uncompensated care components

- Medicaid DSH payments cannot exceed a hospital's uncompensated care costs
- For Medicaid DSH purposes, two types of uncompensated care are included:
  - Medicaid shortfall
  - Unpaid costs of care for the uninsured
- Other definitions of uncompensated care also include bad debt

Medicaid shortfall

- In 2010, DSH hospitals reported $6.4 billion in Medicaid shortfall
- The ACA is expected to increase Medicaid shortfall because of increased Medicaid enrollment
- Medicaid shortfall can be addressed through regular Medicaid payment rates as well as DSH

Medicaid payment to DSH hospitals as percent of Medicaid costs, SPRY 2010



Note: DSH is disproportionate share hospital. UPL is upper payment limit. SPRY is state plan rate year.
Source: MACPAC analysis of 2010 DSH audit data, excluding institutions for mental diseases (IMDs)

Unpaid costs for the uninsured

- In 2010, DSH hospitals reported $23.2 billion in unpaid costs of care for the uninsured
- The ACA is reducing unpaid costs of care for the uninsured, particularly in states that have expanded Medicaid
- There will still be uncompensated care for the uninsured after the full implementation of the ACA

Bad debt for individuals with insurance

- In 2011, DSH hospitals reported $11.8 billion in non-Medicare bad debt
  - Our data on bad debt are limited and include bad debt for the uninsured
- Early reports suggest that bad debt is decreasing in states that have expanded Medicaid coverage

Discussion

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- The Commission may want to comment on or make recommendations on data improvements
- In addition, our analysis raises questions about the intent and implementation of DSH payment policy that could be the focus of recommendations

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  - Changing the definition of uncompensated care for Medicaid DSH
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