CHAPTER 3

Improving Data as the First Step to a More Targeted Disproportionate Share Hospital Policy

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Recommendation

- The Secretary of the U.S. Department of Health and Human Services should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

Key Points

- In the Commission's view, Medicaid disproportionate share hospital (DSH) payments should be better targeted to the hospitals that serve a disproportionate share of Medicaid and low-income patients and have higher levels of uncompensated care, consistent with the original statutory intent.
- The scheduled reduction of Medicaid DSH allotments of 16 percent in fiscal year (FY) 2018 and up to 55 percent in FY 2025 makes such targeting particularly important.
- Lack of complete and timely data on Medicaid shortfall creates substantial challenges in considering how to better target payments in the future.
  - DSH audits suggest that some hospitals receive Medicaid payments that exceed their costs, but these audits do not include information about provider contributions to the state's Medicaid share, which could be considered an additional cost, thus reducing net payments.
  - Existing data sources do not include complete provider-level data on non-DSH supplemental payments, which are a substantial source of Medicaid revenue for many hospitals.
- In future reports, the Commission will continue to monitor the effects of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) on hospitals receiving DSH payments.
- The Commission will also more fully explore potential policy approaches to improving the targeting of federal Medicaid DSH funding, including:
  - modifying the criteria for DSH payment eligibility;
  - redefining uncompensated care for Medicaid DSH purposes; and
  - rebasing states' DSH allotments.

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MACPAC's analyses find wide variation in the level and distribution of current state DSH allotments, which have little meaningful relationship to measures meant to identify those safety net institutions most in need. In the Commission's view, Medicaid DSH payments should be better targeted toward the hospitals that serve a disproportionate share of Medicaid and low-income patients and have higher levels of uncompensated care, consistent with the original statutory intent. The scheduled reduction of Medicaid DSH allotments of 16 percent in fiscal year (FY) 2018 and up to 55 percent in FY 2025 makes such targeting particularly important. It also creates an opportunity to do so, as states will need to review their DSH spending in response to the allotment reductions.

The Commission will continue analyzing federal policy approaches to improve the targeting of Medicaid DSH payments in future reports. To this end, we plan to examine several key questions, including:

- Are there better measures to identify states and hospitals that should be targeted for DSH funding?
- To what extent do DSH hospitals receive other supplemental payments from Medicaid, Medicare, and other sources, which may affect their amount of uncompensated care regardless of their low-income utilization?
- To what extent should the source of non-federal share affect the distribution of DSH payments?
- How do DSH payments relate to community benefit expenditures for non-profit hospitals?
- How should DSH payments relate to the adequacy of regular Medicaid payments to hospitals?
- What policy approaches would strike the right balance between providing flexibility to states in designing payment and financing methods and ensuring that limited federal DSH dollars are distributed appropriately?
- What policy approaches would best align with the statutory principles for Medicaid payment policy: efficiency, economy, quality, and access?

Our ability to answer these questions will be affected by the availability of timely and reliable data at the institutional level. Existing data sources have substantial limitations for identifying hospitals with the highest levels of uncompensated care, and particularly their amounts of Medicaid shortfall. Available data are also insufficient for assessing the amount of total Medicaid payments (including all supplemental payments) an institution receives and the extent to which the institution contributes to the state's Medicaid share.

Because of the importance of these data for developing DSH policy and improving payment transparency and accountability, the Commission recommends that the Secretary of the U.S. Department of Health and Human Services should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

We begin this chapter by describing the limitations of current data sources for purposes of analyzing and improving DSH payment policy. We then present the Commission's rationale for recommending improved federal collection of provider-level Medicaid payment data. We conclude by outlining some topics for future analysis and broad approaches to improving the targeting of Medicaid DSH payments; we intend to develop these ideas in future reports.

Data Limitations

Analyses of approaches to improve the targeting of Medicaid DSH payments require complete and timely hospital-level financial data, including costs attributable to different patient populations and sources of revenue (e.g., Medicaid, private pay, and other government subsidies). Currently, there are only two national data sources that provide this information. Although they have helped us begin to understand current Medicaid DSH policy and potential policy options for further exploration, it is important to keep in mind the limitations described below to avoid drawing conclusions that may not be fully supported.

Medicaid DSH audit reports

States are required to submit to the Centers for Medicare & Medicaid Services (CMS) audited financial reports of all hospitals that receive Medicaid DSH payments. These reports include information about Medicaid patient revenue, supplemental payments, and the costs of care for Medicaid and uninsured patients. Primary limitations include the following:

- Timely data are not available. Data are published about five years after payments are made, and thus may not reflect current DSH payment policies and levels of uncompensated care (e.g., there are no current data from the period following Medicaid expansion in 2014).
- Comparable data are not available for about half of U.S. hospitals. Because DSH audits are limited to hospitals that receive DSH payments, these data are not sufficient to determine the full amount of a state's uncompensated care or how well a state targets its DSH payments to high-need hospitals.

Medicare cost reports

All hospitals that receive Medicare payments (that is, virtually all U.S. hospitals with the exception of some children's hospitals) are required to submit annual reports on hospital finances, including data on uncompensated care. Primary limitations include the following:

- These data do not describe Medicaid payments in adequate detail. For example, Medicaid DSH payments are not distinguished from other Medicaid revenue, meaning that Medicaid shortfall cannot be determined reliably.
- The definition of uncompensated care in the Medicare cost reports differs from that used for Medicaid DSH payments. Medicare cost reports provide data on charity care and bad debt only, a scope that differs from the uncompensated care measures on Medicaid DSH audits. Further, there are questions about the current reliability of the Medicare cost report uncompensated care data due to outliers and missing data (CMS 2015).

Additionally, neither the Medicare cost report nor the Medicaid DSH audit fully account for the non-federal share of Medicaid payments that is contributed by hospitals themselves, resulting in a potential overstatement of the net amount of Medicaid payments that hospitals receive. Although hospital provider taxes are included in calculations of Medicaid costs, intergovernmental transfers (IGTs) and certified public expenditures (CPEs) are not. The amount of money represented by this absence is significant: in 2012, about two-thirds of DSH payments were financed by non-state

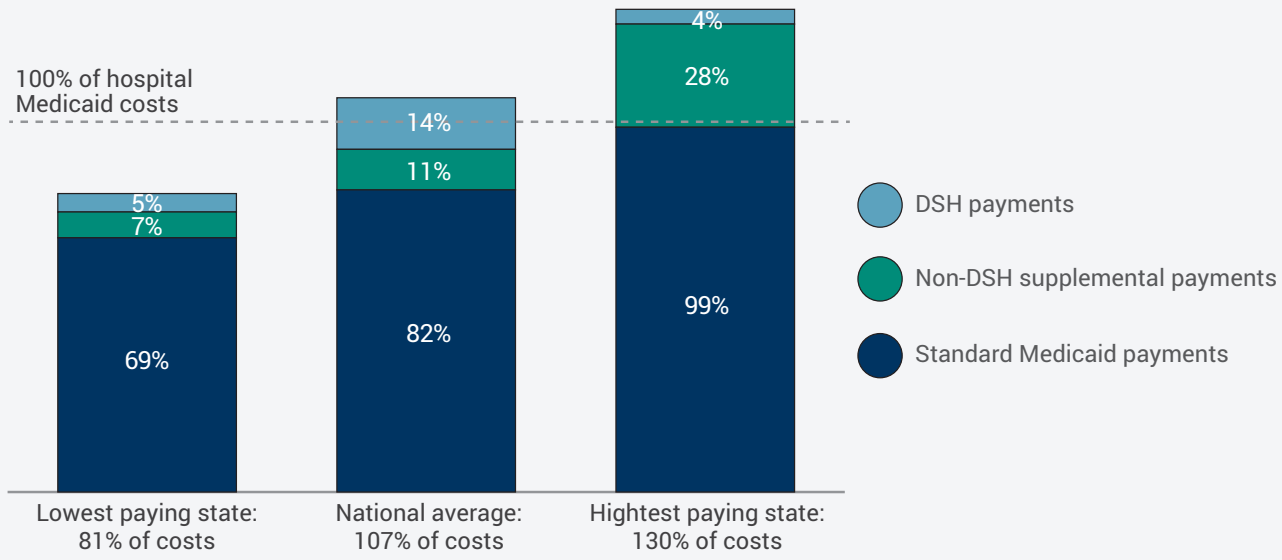
sources of funding and eight states used non-state funds to finance more than 90 percent of their DSH payments (GAO 2014).

Medicaid shortfall

The most substantial limitation to our ability to analyze Medicaid DSH payments is the lack of complete and timely data on Medicaid shortfall. Because Medicaid shortfall is one of the components of uncompensated care for DSH purposes and because Medicaid shortfall is expected to increase under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the lack of complete and reliable data on Medicaid shortfall is particularly problematic.

Medicaid DSH audit reports, despite their limitations, currently provide the most detailed data on Medicaid shortfall for DSH hospitals. Our preliminary analysis of 2011 DSH audits found that before DSH payments, DSH hospitals were paid an average of 93 percent of total Medicaid costs, and that after DSH payments, most DSH hospitals received more in total Medicaid payment than their costs (Figure 3-1). This analysis does not account for provider contributions toward the non-federal share, contributions that may reduce net payments. After DSH payments, the Medicaid payment-to-cost ratio for DSH hospitals ranged from 81 percent to 130 percent (in the aggregate, by state). In comparison, the Medicare Payment Advisory Committee (MedPAC) reports that Medicare's payment-to-cost ratio was 94.6 percent in 2011 after DSH payments (MedPAC 2015). Using a different methodology, the American Hospital Association reports a lower hospital payment-to-cost ratio after DSH payments for both Medicaid (94.7 percent) and Medicare (91.4 percent) in 2011 (AHA 2015).

FIGURE 3-1. Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs, SPRY 2011



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. This analysis excludes institutions for mental diseases. Payment levels shown do not account for provider contributions to the non-federal share, contributions that may reduce net payments. Numbers do not sum due to rounding.

Source: MACPAC 2015 analysis of 2011 as-filed Medicaid DSH audit data.

The Commission has previously noted that costs are an imperfect measure of payment adequacy and that cost-based payments may not promote efficiency. Nevertheless, cost is one of the few benchmarks generally available for certain provider types, including hospitals. It is important, however, that cost data be defined consistently across hospitals and available in a standardized format if they are to be useful for payment analyses and future policymaking.

When we compare DSH audit data with Medicare cost report data from the same hospitals (from among a subset of hospitals with complete data from both sources), we find several discrepancies in both Medicaid costs and Medicaid payments (Table 3-1). Both data sources show in the aggregate that DSH hospitals received total Medicaid payments (including DSH payments) that exceeded their costs, resulting in a surplus instead of a shortfall. However, the total amounts of Medicaid costs and Medicaid payments vary widely between the two data sources. Further, neither data source includes information on provider contributions towards the non-federal share, which are necessary to calculate net Medicaid payments. Below, we examine possible explanations for these discrepancies and describe other known limitations in our data with respect to Medicaid shortfall.

Definition of Medicaid costs. As noted above, the definition of Medicaid costs differs between Medicare cost reports and Medicaid DSH audits. Medicare cost reports only include costs for Medicaid-covered services. DSH audits also include unpaid costs for services provided to Medicaid patients when Medicaid was not the primary payer—for example, costs for Medicare-funded services provided to people dually eligible for both Medicaid and Medicare. The inclusion of these as Medicaid costs on DSH audits may help explain why Medicaid costs are higher on DSH audits than on Medicare cost reports.

Reporting of Medicaid payments. Differences in the reporting of Medicaid supplemental payments likely account for the discrepancies in Medicaid payment amounts between the two data sources. In the sample of hospitals with complete data from both forms, regular Medicaid payments reported on DSH audits are 5 percent higher than those reported on Medicare cost reports, but supplemental payments (including DSH) are more than 100 percent higher on DSH audits than on Medicare cost reports. Hospitals are instructed to report Medicaid DSH payments on Medicare cost reports, but these payments are not separately reported from other Medicaid hospital payments. In addition, we know that some

TABLE 3-1. Total Medicaid Shortfall Reported on Medicaid DSH Audits and Medicare Cost Reports for Selected Hospitals, 2011 (billions)

	Medicaid DSH audit	Medicare cost report data	Percent difference (cost report data compared to DSH audit data)
Total Medicaid costs	$89.5	$61.8	-31%
Total Medicaid payments, including DSH payments	96.7	80.0	-17
Total Medicaid shortfall after DSH payments (surplus)	**($7.2)**	**($18.2)**	**-153%**

Notes: DSH is disproportionate share hospital. Calculations were made based on data from 2,200 hospitals that submitted complete Medicaid DSH audits as well as complete Medicare cost reports, allowing the data for each hospital to be compared across reports (80 percent of DSH hospitals).

Source: MACPAC 2015 analysis of 2011 as-filed Medicaid DSH audits and 2011 Medicare cost reports.

Medicaid supplemental payments are not reported on DSH audits. These unreported payments include incentive payments to hospitals that are not directly related to services provided, such as Delivery System Reform Incentive Payments (DSRIP), which totaled $6.7 billion in FY 2015 (for more background about DSRIP, see the Commission's June 2014 report to Congress).

Recently, the U.S. Government Accountability Office (GAO) reviewed Medicaid hospital payments in three states and concluded that limited data and unclear policy on supplemental payments restricted its ability analyze payments to individual hospitals (GAO 2015). In one state analysis, GAO identified $750 million in supplemental payments to three DSH hospitals that were not reported on DSH audits. In another, GAO found that a multihospital system received large non-DSH supplemental payments at one hospital facility and large DSH payments at other hospital facilities. In both cases, they found that DSH payments to these hospitals would have been lower if all Medicaid supplemental payments had been taken into account when determining uncompensated care.

Accounting for sources of non-federal share. Neither Medicaid DSH audits nor Medicare cost reports account for the cost to some hospitals of supplying the non-federal share of DSH payments through IGTs or CPEs. These provider contributions can be substantial and they may reduce the net amount of Medicaid payments that these hospitals receive. In 2012, IGTs and CPEs accounted for 44.6 percent of the non-federal share of DSH payments nationally (GAO 2014). Costs for health care-related taxes also need to be identified. Taxes paid by providers are often included in calculations of Medicaid costs, but they are not separately identified in a way that enables analysis. In 2012, provider taxes accounted for 18.5 percent of the non-federal share of DSH payments nationally (GAO 2014).

Commission Recommendation

Recommendation 3.1

The Secretary of the U.S. Department of Health and Human Services should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

Rationale

The policy of making special Medicaid payments to hospitals serving a disproportionate share of Medicaid beneficiaries and other low-income patients has been a feature of the Medicaid program since 1981. As the analysis in this report illustrates, DSH allotments are largely based on state spending in 1992, and they have little meaningful relationship with potential measures of need for DSH payments today. Further, apart from the requirement that deemed DSH hospitals receive DSH payments, states are generally not required to target DSH payments in a particular manner. Some states provide DSH payments to virtually all hospitals in their state, while others make DSH payments to just one or two hospitals.

In light of the congressional directive to the Commission to study the relationship of current and future DSH allotments to measures of need, greater transparency in how hospitals are being paid is important to understanding states' use of Medicaid funds and the extent to which state policies are consistent with federal requirements. Specifically, complete and reliable data regarding all Medicaid payments to hospitals and the sources of the non-federal share of such payments are important for analyzing current policy and for developing more targeted strategies in the future. Given the historical variation in state payment policy and the differences in how states distribute payments

today, provider-level data is needed to understand how different policy approaches would affect not only states but also individual institutions.

Complete data on net Medicaid payments for all providers are important for accurate analyses of the extent to which DSH payments are targeted to providers that serve a disproportionate share of Medicaid and low-income patients and have disproportionate levels of uncompensated care. These data are also important to project the potential effects of policies to improve the targeting of DSH payments. In particular, payment data are needed to calculate Medicaid shortfall, one of the components of uncompensated care that Medicaid DSH covers. Our analysis in this report suggests that Medicaid payments do not necessarily result in a shortfall for all institutions in all states, pointing to the need for better data that can be used to design DSH policy in the future.

This recommendation builds on the Commission's March 2014 recommendation that the Secretary collect and report non-DSH supplemental payment data. Although CMS has begun collecting some provider-specific data on these payments, these data are not publicly available in a format that enables analysis. Moreover, states are increasingly making other types of supplemental payments to providers through Section 1115 expenditure authority (such as DSRIP and uncompensated care pools), and data about these payments are not being systematically collected.

The Commission recommends the collection of all types of Medicaid payments to capture all direct payments for Medicaid services, under both fee-for-service and managed care, and all supplemental payments that are not directly related to services, including upper payment limit (UPL) and Section 1115 supplemental payments. Such data are needed to provide a complete picture of Medicaid's current role in supporting safety-net hospitals, a task that is now not possible given substantial variation in state payment policies and methods. Improvements in DSH policy cannot be achieved by considering DSH payments in isolation. Rather, a full accounting of all Medicaid payments individual hospitals receive is needed to ensure that states are paying these institutions consistent with statutory principles of economy, efficiency, quality, and access.

The Commission has also previously noted that a lack of data on the source of non-federal share for Medicaid payments complicates Medicaid payment analyses. In 47 states and the District of Columbia, some of the non-federal share of Medicaid spending was contributed by local governments and providers in 2012. Such contributions, which are specifically permitted by statute, are particularly important for financing DSH payments. About two-thirds of DSH payments were financed by providers and local governments, and eight states used these funds to finance more than 90 percent of their DSH payments (GAO 2014). Understanding the sources of these funds is important to an overall understanding of Medicaid shortfall because in cases where providers contribute non-federal share, their net payment may be lower than payment data alone indicate. Future policy development must also consider the extent to which the distribution of DSH payments is related to the sources of non-federal share.

This recommendation is consistent with the work of others studying Medicaid payments. Specifically, GAO has also recommended that CMS collect provider-level Medicaid payment data (GAO 2012), as well as provider-level data on the sources of funds used to finance the non-federal share of payments (GAO 2014). GAO's recommended strategies for collecting non-federal share data included, in the short-term, adding these data to CMS's current UPL compliance efforts and, in the longer term, collecting them through the Transformed Medicaid Statistical Information System (T-MSIS). In written comments to GAO, CMS agreed with the importance of collecting information on non-DSH supplemental payments, but disagreed with the need to collect facility-level data on non-federal share as well as the recommendation that such data be collected through T-MSIS.

Considerations for data collection

The Commission has not recommended specific methods for data collection, recognizing that the need for data must be balanced with the burden of collecting them. However, it makes sense to build upon existing data collection efforts to the extent possible. Further, the Commission recognizes that some payment data (e.g., managed care payments) might be challenging to obtain. If the Secretary does not have the authority to collect certain data, legislation may be needed.

Claims data alone (including data obtained through T-MSIS) may not provide all of the information that the Commission has recommended collecting, particularly the source of non-federal share. Still, collecting complete payment data though T-MSIS could be considered, along with supplementing these data with a separate collection of data to identify sources of non-federal share.

Another option would be to expand DSH audits to include all hospitals that receive Medicaid payments. However, the burden on states and hospitals of conducting full audits and the resulting data lag could be considerable. Further, because the legislation that requires DSH audits and reporting is specific to DSH hospitals, the Secretary may not have statutory authority to extend auditing to other hospitals, perhaps requiring congressional action. Nevertheless, DSH audit reporting could serve as a model for broader payment data collection.

Besides DSH audit data, CMS also collects some non-DSH supplemental payment data through annual reports submitted by states to demonstrate their compliance with the UPL regulations. These reports also include the names of entities providing IGTs or CPEs and the amounts (CMS 2013a). However, these reports are not required to be submitted in a standardized format and, thus far, are not available for analysis outside of CMS. They also do not include data related to Medicaid managed care enrollees because managed care payments are not subject to the UPL.

In January 2014, CMS issued a solicitation seeking assistance in oversight and analysis of DSH payments and state UPL submissions (CMS 2014). Although the solicitation does not indicate plans for making data publicly available, specific tasks include compiling a database of DSH and non-DSH supplemental payment data, analyzing payments at state and provider-specific levels, and assessing the utility of T-MSIS data. We will monitor the status of this effort and its potential to address the issues that we have raised in this report and others.

The Commission is concerned about the lack of both the timeliness of data and the ability to link data with other sources. Given the rapid evolution of the U.S. health care system and frequent changes in state Medicaid payment policy, analyses of Medicaid payment should reflect current conditions to the greatest extent possible. Although it may be difficult to reduce the time lag in DSH audit data because of the amount of time needed to ensure accurate accounting for all costs and associated revenues, there may be ways to make other types of Medicaid payment data (e.g., UPL demonstrations) available in a more timely fashion, especially data that are submitted quarterly or annually.

The ability to link different sources of data for the same providers is useful, especially for analyses of payments, such as DSH payments, that offset uncompensated care costs for Medicaid and uninsured patients. CMS recently required that Medicaid DSH audit data include Medicare provider identification numbers, which help link these data to Medicare cost reports. We are also interested in the ability to link Medicaid data with other sources, such as the community benefit report provided to the Internal Revenue Service (IRS).

Implications of the Commission's Recommendation

Federal spending. In 2014, the Congressional Budget Office estimated that the collection of

non-DSH supplemental payment data would not affect federal Medicaid spending, and we assume that their cost estimates would be similar for this recommendation. Depending on the method of collection, it could result in increased administrative effort in developing reporting standards, making required changes to information technology systems, and making the data publicly available, but these activities are not expected to result in increased spending.

States. Reporting of provider-specific Medicaid payments and non-federal share contributions would likely require some increased administrative effort by states to the extent that payment information may need to be compiled from different data systems. Although most of these data should be available in state systems due to existing federal requirements, previous GAO reports about efforts to compile state data on hospital payments noted the challenge of matching records at the provider level (GAO 2015). Moreover, while states that already collect DSH audit data for most hospitals in their state are experienced in reporting hospital-level Medicaid payment data, those with smaller DSH programs would likely face more administrative burdens.

Providers and enrollees. State reporting of provider-level payment and non-federal share data would not have a direct effect on Medicaid payments to providers. Over time, however, increased transparency could lead to modifications in state payment methodologies including state DSH payments.[1]

Next Steps

This is the first of the Commission's annual reports on Medicaid DSH policy. (Future reports will be included within our annual March report to Congress.) In future reports, the Commission will not only continue to monitor the distribution of DSH payments across states and hospitals, but will also work to understand how changes brought about by the ACA are affecting safety-net institutions. In addition, notwithstanding the limitations of currently available Medicaid payment data, the Commission will explore additional work that can be done using current data sources to better understand the role of DSH payments and other sources of financial support to hospitals. The Commission will also more fully explore potential policy approaches to improving the targeting of federal Medicaid DSH funding.

Data exploration

The Commission will explore opportunities to link the hospital-specific data from Medicaid DSH audits and Medicare cost reports with other available sources of hospital data. Reconciling Medicaid DSH data with other data sources will help us better understand whether uncompensated care costs are being reported consistently and whether hospitals are receiving other types of payments for uncompensated care that are not being captured on Medicaid DSH audits.

Community benefit reporting. While only about half of DSH hospitals are non-profit hospitals, community benefit spending data can be linked to DSH audit data to better understand uncompensated care for these hospitals. The IRS requires non-profit hospitals to report their community benefit spending to maintain their non-profit status, and these data are publicly available. These reports include information on Medicaid shortfall and hospital charity care policies (IRS 2014). In 2011, Medicaid shortfall was the single largest category of community benefit expenditures that non-profit hospitals reported (IRS 2015).

Other sources of direct and indirect support for uncompensated care. Medicare cost reports provide hospital-specific information about Medicare DSH payments and other additional Medicare payments that hospitals receive, and MACPAC will use these data to better understand the relationship between Medicare and Medicaid DSH payments. As discussed in

Chapter 1, Medicare DSH payments are one of the largest direct federal payments for hospital uncompensated care, totaling approximately $12.1 billion in 2013.

The Commission is still exploring the availability of hospital-specific data on 340b funding, which is a large indirect source of support for hospitals. The 340b drug program is overseen by the Health Resources and Services Administration (HRSA) but the drug rebates are administered by drug manufacturers, so it is difficult to obtain data on drug rebates at the hospital level. However, HRSA does provide information about which hospitals are eligible for 340b funding, which can potentially be combined with claims data on drug spending at these hospitals to estimate the amount of drug rebates that hospitals receive.

Costs and utilization for dually eligible beneficiaries. The Commission also plans to examine available data about individuals dually eligible for Medicaid and Medicare to better understand the effect of these individuals on our estimates of Medicaid utilization and costs. Accurate data on Medicaid inpatient utilization are particularly important because it is one of the qualifying criteria for deemed DSH hospitals. In 2014, CMS began requiring states to report state-level Medicaid inpatient utilization rates according to Medicaid DSH definitions, but with the delay in implementing DSH allotment reductions, few states have begun reporting these data (CMS 2013b).

As discussed earlier in this chapter, Medicare cost reports and Medicaid DSH audits differ in their treatment of costs and utilization for Medicaid enrollees when Medicaid is not the primary payer. This difference affects reporting of costs and revenue related to services provided to dually eligible beneficiaries, who accounted for 15 percent of Medicaid enrollment and 34 percent of Medicaid spending in 2010 (MACPAC and MedPAC 2015). Medicaid DSH audits include all services provided to Medicaid enrollees, including inpatient services for dually eligible beneficiaries that are paid for by Medicare, but Medicare cost reports classify costs and utilization based on the primary payer for the service.

Essential community services. The Commission will continue to explore available data to identify hospitals that provide access to essential community services. As discussed in Chapter 2, there is no statutory definition of essential community services and there are few data sources that provide national data on the specific services that hospitals provide. For example, in preparing this report, we were unable to identify hospitals that provide primary care or public health services because these services were not separately identifiable on Medicare cost reports or the American Hospital Association annual survey. MACPAC is exploring the use of Medicaid claims and encounter data to gain insight into the types of services—particularly primary care and public health services—that enrollees use at DSH hospitals.

Policy design exploration

Existing federal parameters for defining state allotments and making DSH payments provide a starting point for thinking about federal approaches to improve the targeting of DSH payments. Potential changes to federal statute that the Commission intends to consider include modifying the criteria for DSH payment eligibility, redefining uncompensated care for Medicaid DSH payment purposes, and rebasing state DSH allotments. The Commission is also reviewing other past proposals to improve Medicaid DSH policy (Box 3-1).

Modifying provider eligibility standards. By statute, the minimum qualifying criteria for hospitals receiving DSH payments is a Medicaid inpatient utilization rate of 1 percent, a standard that nearly all U.S. hospitals currently meet. This eligibility threshold could be increased to better target DSH payments to hospitals that serve more Medicaid or low-income patients. Examples of other thresholds to consider include basing eligibility on the average Medicaid inpatient utilization of all providers in

BOX 3-1. Prior Federal Reports on Medicaid Disproportionate Share Hospital (DSH) Policy

On at least two occasions, federal policy advisors have published reports on Medicaid disproportionate share hospital (DSH) policy, highlighting many of the same issues that we raise here.

In the early 1990s, when Medicaid DSH allotments were first established, Congress required the Prospective Payment Assessment Commission (ProPAC), one of the precursor commissions to the Medicare Payment Advisory Commission (MedPAC), to review the criteria used in designating Medicaid DSH hospitals (P.L. 102-234). ProPAC's report, issued in 1994, examined state DSH spending and the role of Medicaid DSH payments on hospital financial status, and it raised many of the same issues we raise in this report (ProPAC 1994). The report recommended that DSH payments should not exceed 12 percent of state Medicaid spending (which is now current law) and also made four recommendations that have not been implemented:

- establish a uniform designation of Medicaid DSH hospitals based on the proportion of care that hospitals provide to Medicaid enrollees and other persons unable to pay for their care;
- set minimum and maximum DSH payment adjustments related to a hospital's uncompensated care;
- apply separate criteria for different hospital types (e.g., teaching, psychiatric, or children's hospitals); and
- set aside 10 percent of DSH spending for primary care services that could promote access for Medicaid enrollees and the uninsured.

In 2002, the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation contracted with researchers from RAND and the Urban Institute to analyze the distribution of DSH payments in both Medicaid and Medicare (Wynn et al. 2002). This report did not make any recommendations, but it analyzed several alternative DSH allocation policies, including joint distribution of Medicare and Medicaid DSH payments and distribution policies based on low-income volume or uncompensated care. The report also suggested that a national database with data on each hospital's uncompensated care and shortfalls from Medicaid and local indigent care programs would be needed to understand the potential effects of alternative allocation policies. It also highlighted the need for data on sources of non-federal share.

a state or on one standard deviation above the average (which is the current threshold used to determine deemed DSH hospitals which must receive DSH payments). In addition, low-income utilization rates, which also account for care for the uninsured, could be factored into the determination of provider eligibility for DSH payments.

Raising the provider eligibility threshold would primarily affect hospitals with lower levels of Medicaid or low-income utilization that currently receive DSH payments. In 2011, about 17 percent of DSH payments went to hospitals with Medicaid inpatient utilization rates at or below the 50th percentile, and about 27 percent of DSH payments were made to hospitals with low-income utilization rates at or below the 50th percentile.

Redefining eligible uncompensated care costs. Under current law, DSH payments to hospitals

cannot exceed their uncompensated care costs, which are defined for Medicaid DSH purposes as the sum of Medicaid shortfall and unpaid costs of care for the uninsured. This definition could be narrowed by excluding particular components, such as Medicaid shortfall, or it could be expanded by adding additional components, such as bad debt for insured individuals or physician services that hospitals provide.

Changing the definition of uncompensated care for Medicaid DSH purposes would change the maximum amount of DSH funding that a hospital could receive, and thus would primarily affect hospitals that are already at their hospital-specific DSH limit. In 2011, 6 percent of DSH hospitals received DSH payments that were equal to 90 percent or more of their hospital-specific limit.

Rebasing state DSH allotments. Current DSH allotments, based on historical spending from 1992, vary widely by state and bear little relationship to objective measures of need. To smooth this state-by-state variation, Congress could rebase DSH allotments according to objective criteria, such as the number of uninsured people or the levels of uncompensated care of high-need hospitals in a state.

For an incremental approach, Congress could incorporate rebased DSH allotments into the formula for pending DSH allotment reductions. However, the current schedule of DSH allotment reductions reduces DSH allotments by more than half by FY 2025, so before taking this approach, the size of pending DSH allotment reductions should be considered.

Endnotes

[1] The full text of the Commission's recommendation and vote can be found on page 160.

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APPENDIX 3A: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. Below we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

Primary Data Sources

DSH audit data

We used 2011 DSH audit reports to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types. These data were provided by the Centers for Medicare & Medicaid Services (CMS) on an as-filed basis and may be subject to change as CMS completes its internal review of state DSH audit reports.

Because 2011 DSH audit data were not available for Minnesota, 2010 DSH audit data were used instead. Minnesota's 2010 DSH audit data were adjusted to 2011 values using the Consumer Price Index for All Urban Consumers (CPI-U). DSH audit data were also not available for Massachusetts, which is exempt from DSH requirements under the terms of the state's Section 1115 demonstration waiver.

Overall, 2,743 hospitals receiving DSH payments are represented in our analysis. Some states provided DSH audit data for hospitals that did not receive DSH payments, and some hospitals received DSH payments from multiple states. We removed 59 non-DSH hospitals from our analysis and combined the data for 33 pairs of duplicate hospitals so that each hospital would only appear once in the dataset.

Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded religious non-medical health care institutions and hospitals participating in special Medicare demonstration projects (28 hospitals were excluded under these criteria). These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. We were unable to identify the Medicare cost reports for 90 DSH hospitals, and so we excluded those 90 hospitals from this analysis.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that had an absolute value of greater than 75 percent (976 hospitals were excluded under this criterion). This approach is consistent with other published studies of hospital margins using Medicare cost report data (Wynn et al. 2002). Operating margins are calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by net patient revenue: (NPR–OE)/NPR. Total margins, in contrast, include additional types of hospital revenue, such as state or local subsidies and revenue from other facets of hospital operations (e.g., parking lot receipts).

Working Definition of Essential Community Services

The statute requires that MACPAC's analysis include data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuums of primary through quaternary care, including the provision of trauma care and public health services.

Our working definition to identify such hospitals in our first report is based on a two part test:

- Is the hospital a deemed DSH hospital?
- Does the hospital provide at least one essential service?

Deemed DSH hospital status

Hospitals must meet one of two criteria to qualify as a deemed DSH hospital: (1) a Medicaid inpatient utilization rate greater than one standard deviation above the mean for hospitals in the state or (2) a low-income utilization rate greater than 25 percent (§ 1923(b)(1) of the Social Security Act). Because deemed DSH hospitals are statutorily required to receive DSH payments, we excluded from our analysis hospitals that did not receive DSH payments in 2011.

Calculation of the Medicaid inpatient utilization rate threshold for each state requires data from all hospitals in that state, and we relied on Medicare cost reports to make those calculations and to determine which hospitals exceeded this threshold. A major limitation of this approach is that Medicaid inpatient utilization reported on Medicare cost reports does not include services provided to Medicaid enrollees that were not paid for by Medicaid (e.g., Medicare-funded services for individuals who are dually eligible for Medicare and Medicaid). However, the Medicaid DSH definition of Medicaid inpatient utilization includes services provided to anyone that is eligible for Medicaid, even if Medicaid is not the primary payer. Thus, our identification of deemed DSH hospitals may omit some hospitals with high utilization by dually eligible beneficiaries and overstate the extent to which hospitals with low utilization by dually eligible beneficiaries (e.g., children's hospitals) exceed the threshold.

The low-income utilization rate threshold for deemed DSH hospitals is the same for all states (25 percent), so we were able to use Medicaid DSH audit data to determine whether hospitals met this criterion. However, about one-quarter of DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions limited our ability to identify all deemed DSH hospitals.

Provision of essential community services

Because the term essential community services is not otherwise defined in statute or regulation, MACPAC convened a technical advisory panel in April 2015 to discuss potential data sources and criteria that could be used to identify such services. The panel included representatives of state Medicaid programs, CMS, and hospital associations as well as researchers and state consultants on DSH policy. Feedback from the technical advisory panel was further discussed at the Commission's May 2015 public meeting.

We identified a number of services that could be considered essential community services using available data from 2013 Medicare cost reports and the 2013 American Hospital Association (AHA) annual survey (Table 3A-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the AHA annual survey.

TABLE 3A-1. Essential Community Services by Data Source

Service type	Data source
Burn services	Medicare cost reports
Dental services	American Hospital Association annual survey
Graduate medical education	Medicare cost reports
HIV/AIDS care	American Hospital Association annual survey
Inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital)	Medicare cost reports
Neonatal intensive care units	American Hospital Association annual survey
Obstetrics and gynecology services	American Hospital Association annual survey
Substance use disorder services	American Hospital Association annual survey
Trauma services	American Hospital Association annual survey

For this first report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. We also included certain hospital types if they were the only hospital in their geographic area to provide certain types of services. These included critical access hospitals because they are often the only hospital within a 25-mile radius. In addition, we included children's hospitals that were the only hospital within a 15-mile radius (measured by driving distance).

Projections of DSH Allotments and DSH Spending

Unreduced DSH allotments

Preliminary DSH allotments for fiscal year (FY) 2016 were provided by CMS, and DSH allotments for subsequent years were estimated based on CPI-U projections in the Congressional Budget Office's August economic baseline (CBO 2015). Because the federal share of DSH allotments is limited to 12 percent of state Medicaid benefit spending, we also adjusted the projected DSH allotments for states whose unreduced DSH allotment might exceed this limit. To perform this calculation, we estimated state benefit spending for future years using actual FY 2014 spending and estimates of national growth rates from the CMS Office of the Actuary (CMS 2014).

DSH allotment reductions

MACPAC contracted with Dobson DaVanzo & Associates and KNG Health to develop a model for estimating DSH allotment reductions. The model uses the DSH Health Reform Methodology that CMS initially developed to apply DSH reductions to FY 2014 (CMS 2013). Although CMS may apply a different reduction methodology for future year DSH reductions, the methodology developed for this report reflects the current statutory requirements and is therefore a reasonable starting point for estimating FY 2018 DSH allotment reductions.

We used a variety of data sources to estimate the factors used in CMS's methodology (Table 3A-2). Our current estimates of DSH allotment reductions do not fully represent the effects of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) because current data are not available for every factor. Specifically, we used

TABLE 3A-2. Data Sources for Factors Used in the DSH Allotment Reduction Model

DSH allotment reduction factor	Data source (year)
Low DSH	Specified in statute (N/A)
Uninsured percentage	American Community Survey (2014)
High volume of Medicaid inpatients	Medicare cost reports (2011)
High level of uncompensated care	DSH audits (2011)
Budget neutrality	Financial Management Group, CMS (2014)

Notes: DSH is disproportionate share hospital. N/A is not applicable. CMS is the Centers for Medicare & Medicaid Services.

2011 data for the Medicaid inpatient factor and the uncompensated care factor. We expect these factors to change as a result of ACA coverage expansions, but we do not yet have 2014 data for them.

To estimate DSH allotment reductions under a scenario in which all states would expand Medicaid to the new group of low-income adults under age 65, we used uninsured rates projected by the Urban Institute (Holahan et al. 2013). To ensure consistent comparisons, we used the Urban Institute projections for states that expanded Medicaid in 2014 even though U.S. Census Bureau American Community Survey data were available.

Hospital-level effects

For our projections of unreduced DSH payments to hospitals in FY 2018, we assumed that DSH payments to individual hospitals would increase at the same rate as the state's overall DSH spending. We used CMS-64 net expenditure data for FY 2011 through FY 2015 to calculate the growth rate in state DSH spending and used the growth in projected state DSH allotments from FY 2016 through FY 2018 to estimate the growth rate in state DSH spending. This growth rate was applied to hospital-specific DSH spending reported on 2011 DSH audits in order to estimate FY 2018 DSH spending by hospital.

For our projections of reduced DSH payments under the proportional reduction model, we reduced DSH payments to each hospital by the change in a state's DSH allotment after taking into account the portion of a state's DSH allotment that was projected to be unspent in FY 2018.

Under the strategic reduction model, we assumed that states would prioritize payments to hospitals that met both the high volume of Medicaid inpatients factor and the high level of uncompensated care factor of the CMS's DSH reduction methodology. We also assumed that after states maximized payments to these hospitals, they would give second priority to hospitals that met only the Medicaid inpatients factor and then give third priority to hospitals that met only the uncompensated care factor. We prioritized the Medicaid inpatients factor over the uncompensated care factor in this model because these hospitals are deemed DSH hospitals, but we note that the CMS DSH reduction methodology does not specifically incentivize DSH payments for one factor over another. A limitation of this model is that it relies on projections of hospital uncompensated care, which then determine the maximum amount of DSH funding a hospital could receive. Given the absence of complete data that reflect the effects of the ACA on hospital uncompensated care, our projections were based on FY 2011 data; hospital-specific limits in FY 2011 were increased to projected FY 2018 levels based

on CMS national health expenditure projections for hospitals.

Preliminary Analysis of 2014 Medicare Cost Report Data

To explore the effects of the ACA on hospital uncompensated care, we examined data from 1,371 hospitals that submitted a full year of uncompensated care data beginning January 1, 2014 (comprising about 23 percent of all U.S. hospitals). We excluded from our analysis hospitals that had not submitted complete uncompensated care data for 2011–2013. DSH hospitals from 40 states accounted for about half of the hospitals in this analysis, which is similar to their share of all U.S. hospitals. All hospital types were included, but children's hospitals, long-term care facilities, and psychiatric hospitals were underrepresented (in the aggregate accounting for less than 10 percent of the total) because of a lack of complete uncompensated care data on Medicare cost reports. Categorized by ownership status, our preliminary analysis included approximately 25 percent of all U.S. non-profit hospitals, 23 percent of all U.S. for-profit hospitals, and 17 percent of all U.S. public hospitals.

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