Medicaid DSH Allotments: How Could Funding for Safety-Net Hospitals Change in 2018?

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) reduced federal funding for Medicaid disproportionate share hospital (DSH) payments under the assumption that hospital uncompensated care costs would decline as insurance coverage increased. Although the reductions were delayed several times, federal DSH payments are slated to be reduced by $2 billion in fiscal year (FY) 2018, which begins October 1, 2017. Additional reductions will occur each year through FY 2025. The amount of federal DSH funds available to each state, referred to as allotments, will vary based on historical state DSH allotments and the methodology that the Centers for Medicare & Medicaid Services (CMS) uses to distribute DSH allotment reductions among states.

This issue brief summarizes MACPAC's projections of FY 2018 state DSH allotments under current law, previously described in MACPAC's March 2017 *Report to Congress on Medicaid and CHIP*, and provides new projections of changes in DSH allotments under the American Health Care Act (AHCA, H.R. 1628). As passed by the U.S. House of Representatives, the AHCA would end DSH allotment reductions for all states beginning in FY 2020 and would not reduce DSH allotments in FY 2018 and FY 2019 for states that did not expand Medicaid to low-income adults with incomes at or below 138 percent of the federal poverty level (FPL). The bill would also provide an additional $10 billion over five years to pay for uncompensated care in non-expansion states, which would be available to both hospital and non-hospital providers.

Under current law, we project that reductions currently scheduled for implementation in FY 2018 will have varying effects on individual state DSH allotments, with state DSH allotment reductions ranging from 1.2 percent to 33.5 percent. In 20 states, the projected DSH allotment reductions for FY 2018 are larger than the state's decline in hospital uncompensated care between 2013 and 2014 (MACPAC 2017).

Under the AHCA, FY 2018 DSH allotment reductions would continue for states that expanded Medicaid, but the DSH allotments and safety-net payments available to non-expansion states would increase by $2 billion in FY 2018. The safety-net payments added by the AHCA are not related to states' prior DSH funding and are projected to be larger than DSH allotments in six states.

Background

State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients.[1] These payments help offset hospital costs for uncompensated care to Medicaid patients and patients who are uninsured. The total amount of DSH payments that a state can make are limited by its federal DSH allotment, which varies by state. In FY 2017, a total of $12 billion in federal funds was allotted for DSH payments. Similar to other types of

Medicaid payments, federal DSH funds must be matched by state funds; in total, $21 billion in state and federal DSH funds were allotted in FY 2017.

The ACA included reductions to federal Medicaid DSH allotments beginning in 2014. The current schedule and amount of cuts are as follows:

- $2.0 billion in FY 2018;
- $3.0 billion in FY 2019;
- $4.0 billion in FY 2020;
- $5.0 billion in FY 2021;
- $6.0 billion in FY 2022;
- $7.0 billion in FY 2023;
- $8.0 billion in FY 2024; and
- $8.0 billion in FY 2025.

Statute requires CMS to develop a methodology for distributing DSH allotment reductions between states. In general, the statute requires CMS to apply larger reductions to states that have the lowest percentage of uninsured individuals and states that do not target DSH payments to hospitals that serve a high volume of Medicaid patients or have high levels of uncompensated care. CMS also must apply lower reductions to states with historically low DSH allotments and take into account the extent to which states have used DSH funds to expand coverage through a Section 1115 demonstration. While CMS developed a methodology to implement FY 2014 DSH allotment reductions before they were delayed, the agency has not indicated whether it will use this same methodology to distribute DSH allotment reductions for FY 2018 or develop a new one.

FY 2018 DSH Allotment Projections

Current law

As noted in our previous reports, using the methodology that CMS initially developed to implement the FY 2014 DSH allotment reductions, we estimate that the $2 billion in federal DSH allotment reductions currently scheduled for implementation in FY 2018 will have widely varying effects on individual state DSH allotments, with state DSH allotment reductions ranging from 1.2 percent to 33.5 percent (Table 1).

Proposed legislation

Section 113 of the AHCA, as passed by the U.S. House of Representatives, would eliminate FY 2018 and FY 2019 DSH allotment reductions for states that have not expanded Medicaid. The bill would eliminate DSH allotment reductions for all states beginning in FY 2020.

In addition, Section 115 of the bill would provide an additional $10 billion in federal funds over five years to increase payments to safety-net providers in states that have not expanded Medicaid. Similar to the rules for DSH payments, these safety-net payments cannot exceed providers' uncompensated care costs for Medicaid and uninsured patients. However, unlike DSH payments, states could use these funds to make

safety-net payments to any Medicaid provider, including non-hospital providers. Funding would be distributed proportionally among states based on the number of people in the state with incomes below 138 percent FPL. These payments are fully federally funded for the first four years. In the final year (FY 2022), states would need to contribute matching funds but the federal matching rate would be 95 percent.

In total, the DSH allotments and safety-net payments available to non-expansion states in FY 2018 under the AHCA would be about 50 percent higher than states' unreduced DSH allotments, and the additional safety-net payments added by the AHCA are projected to be larger than states' unreduced DSH allotments in six states: Florida, Idaho, Oklahoma, Tennessee, Utah, and Wyoming (Table 1). The DSH allotment reductions for expansion states would be unchanged from current law, totaling $1.4 billion and varying by state from 1.2 percent to 33.5 percent of states' unreduced DSH allotments.

The AHCA also proposes multiple other changes to the ACA and Medicaid policy more generally, which would likely affect the levels of uncompensated care for safety-net providers and their ability to provide care for Medicaid and low-income patients. However, it is difficult to evaluate the cumulative effects of these changes at this time.

TABLE 1. Projected Federal DSH Allotments and Safety-Net Payments under Current Law and the AHCA, FY 2018 (millions)

State	Unreduced DSH allotment	Current law		American Health Care Act (H.R. 1628), as passed by the U.S. House of Representatives			
		DSH allotment	Percent change	DSH allotment	Safety-net payments	Total	Percent change
	A	B	C = (B-A)/A	D	E	F = D+E	G = (F-A)/A
Total	**$12,141.9**	**$10,141.9**	**-16.6%**	**$10,718.6**	**$2,000.0**	**$12,718.6**	**4.7%**
Alabama	341.1	275.9	-19.1	341.1	90.3	**431.4**	26.5
Alaska	22.6	20.5	-9.4	20.5	–	**20.5**	-9.4
Arizona	112.3	97.6	-13.1	97.6	–	**97.6**	-13.1
Arkansas	47.8	47.2	-1.2	47.2	–	**47.2**	-1.2
California	1,215.9	1,044.5	-14.1	1044.5	–	**1044.5**	-14.1
Colorado	102.6	84.8	-17.3	84.8	–	**84.8**	-17.3
Connecticut	221.8	147.4	-33.5	147.4	–	**147.4**	-33.5
Delaware	10.0	9.2	-8.0	9.2	–	**9.2**	-8.0
District of Columbia	67.9	57.4	-15.5	57.4	–	**57.4**	-15.5
Florida	221.8	193.1	-12.9	221.8	339.7	**561.6**	153.2
Georgia	298.1	269.2	-9.7	298.1	176.9	**475.0**	59.4
Hawaii	10.8	9.8	-9.8	9.8	–	**9.8**	-9.8
Idaho	18.2	17.8	-2.6	18.2	26.4	**44.7**	144.9
Illinois	238.5	202.6	-15.0	202.6	–	**202.6**	-15.0
Indiana	237.1	218.3	-7.9	218.3	–	**218.3**	-7.9
Iowa	43.7	41.0	-6.2	41.0	–	**41.0**	-6.2
Kansas	45.8	37.3	-18.5	45.8	40.0	**85.7**	87.4

TABLE 1. (continued)

State	Unreduced DSH allotment	Current law		American Health Care Act (H.R. 1628), as passed by the U.S. House of Representatives			
		DSH allotment	Percent change	DSH allotment	Safety-net payments	Total	Percent change
	A	B	C = (B-A)/A	D	E	F = D+E	G = (F-A)/A
Kentucky	$160.8	$134.3	-16.5%	$134.3	–	**$134.3**	-16.5%
Louisiana	732.0	651.1	-11.0	651.1	–	**651.1**	-11.0
Maine	116.5	107.7	-7.5	116.5	19.2	**135.6**	16.5
Maryland	84.6	65.4	-22.7	65.4	–	**65.4**	-22.7
Massachusetts	338.3	260.8	-22.9	260.8	–	**260.8**	-22.9
Michigan	293.9	232.9	-20.8	232.9	–	**232.9**	-20.8
Minnesota	82.8	79.1	-4.5	79.1	–	**79.1**	-4.5
Mississippi	169.1	139.8	-17.4	169.1	65.7	**234.9**	38.9
Missouri	525.4	427.6	-18.6	525.4	91.9	**617.3**	17.5
Montana	12.6	11.3	-10.4	11.3	–	**11.3**	-10.4
Nebraska	31.4	30.4	-3.1	31.4	24.6	**56.0**	78.5
Nevada	51.3	49.1	-4.3	49.1	–	**49.1**	-4.3
New Hampshire	177.6	160.7	-9.5	160.7	–	**160.7**	-9.5
New Jersey	714.0	553.5	-22.5	553.5	–	**553.5**	-22.5
New Mexico	22.6	21.8	-3.7	21.8	–	**21.8**	-3.7
New York	1,781.5	1,531.1	-14.1	1531.1	–	**1531.1**	-14.1
North Carolina	327.2	266.1	-18.7	327.2	172.6	**499.8**	52.7
North Dakota	10.6	10.3	-2.6	10.3	–	**10.3**	-2.6
Ohio	450.6	348.4	-22.7	348.4	–	**348.4**	-22.7
Oklahoma	40.2	37.2	-7.5	40.2	66.5	**106.7**	165.6
Oregon	50.2	46.0	-8.4	46.0	–	**46.0**	-8.4
Pennsylvania	622.5	446.5	-28.3	446.5	–	**446.5**	-28.3
Rhode Island	72.1	62.0	-14.1	62.0	–	**62.0**	-14.1
South Carolina	363.2	315.2	-13.2	363.2	83.1	**446.4**	22.9
South Dakota	12.2	12.0	-1.7	12.2	12.2	**24.4**	99.4
Tennessee	53.1	37.1	-30.1	53.1	114.9	**168.0**	216.4
Texas	1,060.6	908.4	-14.4	1060.6	462.9	**1523.5**	43.6
Utah	21.8	19.5	-10.4	21.8	36.8	**58.5**	169.0
Vermont	25.0	18.8	-24.8	18.8	–	**18.8**	-24.8
Virginia	97.2	74.0	-23.8	97.2	96.4	**193.6**	99.2
Washington	205.2	146.0	-28.8	146.0	–	**146.0**	-28.8
West Virginia	74.9	61.4	-17.9	61.4	–	**61.4**	-17.9
Wisconsin	104.8	102.8	-2.0	104.8	73.0	**177.8**	69.6
Wyoming	0.3	0.2	-8.7	0.3	6.9	**7.1**	2733.8

TABLE 1. (continued)

Notes: DSH is disproportionate share hospital. FY is fiscal year. Safety-net payments are additional payments to Medicaid providers proposed under Section 115 of the American Health Care Act (AHCA, H.R. 1628). Unreduced DSH allotments for FY 2018 are projected from FY 2016 allotments and assume that DSH allotment reductions scheduled for FY 2018 do not take effect. Projected DSH allotment reductions under current law are calculated based on the DSH Health Reform Methodology that CMS initially developed to apply reductions to FY 2014 DSH allotments. Safety-net payments under the AHCA are distributed proportionally based on the number of people in the state with incomes below 138 percent of the federal poverty level.

Sources: MACPAC, 2017, analysis of the U.S. Census Bureau 2015 American Community Survey, and Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of FY 2016 DSH allotments, Congressional Budget Office projections of the Consumer Price Index for All Urban Consumers (CPI-U), 2012 Medicaid DSH audits, Medicare cost reports, and the U.S. Census Bureau 2015 American Community Survey.

Comparison of DSH allotment reductions to changes in uncompensated care

Pending DSH allotment reductions under current law are premised on the assumption that increased health coverage under the ACA would lead to reductions in uncompensated care. As reported in MACPAC's March 2017 report, early data from the first year of implementation of ACA coverage expansions suggests that hospital uncompensated care, which includes both charity care and bad debt expenses, has declined. Between 2013 and 2014, hospitals reported a $5.5 billion decline in charity care and bad debt expenses (15.2 percent). In general, hospitals in states that expanded Medicaid reported larger declines in uncompensated care than those in states that did not. However, in both expansion and non-expansion states, deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients, continued to report negative operating margins before DSH payments.

Under current law, the total amount of FY 2018 DSH allotment reductions ($2.0 billion federal, $3.6 billion state and federal) is smaller than the decline in hospital uncompensated care between 2013 and 2014 ($5.5 billion). However, because the levels of uncompensated care and DSH allotment reductions are not distributed evenly among states, the projected allotment reduction in some states is greater than the state's decline in uncompensated care. In 20 states, the projected FY 2018 DSH allotment reduction under current law (including state and federal funds) is greater than the state's decline in uncompensated care between 2013 and 2014 (Table 2).

Under the AHCA, all non-expansion states, including the nine non-expansion states projected to have DSH allotment reductions greater than the decline in the state's level of uncompensated care under current law, would be shielded from cuts in FY 2018. However, 11 expansion states would experience FY 2018 DSH allotment reductions that are greater than the state's decline in uncompensated care between 2013 and 2014.

TABLE 2. States with Projected DSH Allotment Reductions for FY 2018 Greater than Declines in Uncompensated Care between 2013 and 2014

Medicaid expansion status	Total	Projected FY 2018 DSH allotment reductions that are greater than the decline in hospital uncompensated care between 2013 and 2014		
		Number of states	Percentage of total states	States
Medicaid expansion states	**32**	11	34%	Connecticut, Delaware, District of Columbia, Hawaii, Louisiana*, Massachusetts, Nevada, New Jersey, New York, Pennsylvania*, and Vermont
Non-Medicaid expansion states	**19**	9	47	Alabama, Georgia, Kansas, Missouri, North Carolina, South Carolina, Tennessee, Texas, and Wyoming
All states and the District of Columbia	**51**	**20**	**39**	

Note: DSH is disproportionate share hospital. FY is fiscal year. Projected DSH allotments include state and federal funds. Uncompensated care is based on Medicare cost reports, which define uncompensated care as charity care and bad debt.

* Louisiana and Pennsylvania expanded Medicaid after December 31, 2014.

Source: Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of Medicare cost reports, Medicaid DSH audits, and the U.S. Census Bureau 2015 American Community Survey.

Endnote

[1] Medicare also makes DSH payments to hospitals, but its policies differ on which hospitals qualify and how much funding they receive. In this issue brief, references to DSH payments refer to Medicaid DSH payments only.

Reference

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Analyzing disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2017. Washington, DC: MACPAC. https://www.macpac.gov/publication/analyzing-disproportionate-share-hospital-allotments-to-states/.