Themes from Expert Roundtable on DSH Payments and Next Steps for MACPAC Work

Medicaid and CHIP Payment and Access Commission

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Overview

• Background on disproportionate share hospital (DSH) payments
• Roundtable themes
• Ideas for the future of DSH policy
• Next steps
Background

- States are statutorily required to make DSH payments to hospitals that serve a high share of Medicaid and low-income patients
- State DSH payments are limited by federal DSH allotments
- FY 2018 DSH allotments have been reduced by $2 billion, and DSH allotments are scheduled to be reduced by more than half by FY 2025
- CMS has not finalized its methodology for distributing DSH allotment reductions among states
Roles of DSH Payments

• MACPAC has identified multiple roles of DSH payments:
  – Offsetting unpaid costs of care for the uninsured
  – Offsetting Medicaid shortfall
  – Supporting the overall financial stability of safety net health systems

• Other sources of Medicaid funding also address similar roles:
  – Base payment rates
  – Non-DSH supplemental payments
Expert Roundtable

• In September 2017, MACPAC convened an expert roundtable to discuss the roles of DSH in the context of other sources of funding
  – Why do different types of states and hospitals use DSH funding differently?
  – How should DSH funding be structured in the future?
• A variety of states, providers, and other stakeholders participated
  – Expansion and non-expansion states
  – Public and private hospitals, a critical access hospital, a children’s hospital, and a psychiatric hospital
  – Federal officials, researchers, and a consumer representative
DSH Policies Evolved Alongside Other State Medicaid Payments

• States and hospitals value the ability to use DSH as a flexible stream of funding to support hospitals that serve a high share of low-income patients
  – DSH payments can be more targeted than increases in base payment rates for all providers
  – DSH and non-DSH payments have been used interchangeably, but only DSH payments can be made in managed care delivery systems
• The size of states’ DSH allotments affects how broadly DSH funds are distributed
• Differences of opinion about whether state DSH policies have deviated from the original intent
Effects of DSH Financing

• Compared to other Medicaid expenditures, states are much more likely to finance DSH payments with contributions from providers and local governments.

• State DSH targeting policies relate to the source of non-federal share:
  – Some states distribute DSH payments broadly to all providers that contribute to a provider tax.
  – Some states distribute DSH payments narrowly to public hospitals that provide intergovernmental transfers.
  – Some states target state-owned institutions to minimize the state funds they would otherwise need to provide.

• Concern about the effects of federalizing DSH payments.
Consequences of Uncertainty

- States and hospitals noted that uncertainty about DSH allotment reductions and other policy changes was affecting their ability to plan for the future
  - Many states had not made plans for how they were going to distribute reductions to providers
  - Some hospitals were evaluating services they may need to cut to maintain their financial viability
Ideas for the Future of DSH Policy
Raising the Minimum Eligibility Criteria for DSH Payment

• Interest in targeting DSH payments to the hospitals that need them most

• Discussion of raising the minimum eligibility criteria from a 1 percent Medicaid utilization rate to a higher standard was similar to the Commission’s prior discussion of this policy option
  – Concern that a higher standard would limit state’s flexibility to target DSH payments based on local needs
  – Rural hospitals and institutions for mental diseases may not meet higher Medicaid utilization standards
Tying DSH Payments to Quality Rather Than Costs

• Interest in using DSH funding to support improved access and quality of care for low-income patients

• Limitations of current cost-based method for determining the maximum DSH funds a hospital can receive
  – Costs outside the hospital setting are not included
  – Hospitals at their cost limit receive lower DSH payments if they are more efficient
California’s Global Payment Program

• In December 2015, California received approval to combine DSH and other funds for uncompensated care into a new global payment for safety-net hospitals that is tied to quality goals.

• Circumstances that enabled California to focus its DSH funds on access to care for the uninsured:
  – Targeting DSH payments narrowly
  – Addressing Medicaid shortfall through rate increases
  – Medicaid expansion and delivery system initiatives

• Implementation challenges to consider:
  – Accounting for costs outside the hospital setting
  – Measuring quality of care for the uninsured
Rebasing DSH Allotments

• Interest in basing DSH allotments on current measures of need rather than on historic state DSH spending

• Alternative measures of need that could be used to rebase DSH allotments
  – Number of Medicaid and/or uninsured individuals in the state
  – Level of uncompensated care (for all hospitals or for deemed DSH hospitals)

• Concern about the potential disruption of changing existing state DSH allotments
Overarching Considerations

• Phase in any policy changes to minimize disruption
  – Allow states to test new approaches rather than adding new requirements
  – Rebase DSH allotments incrementally as part of CMS’s DSH allotment reduction formula

• Consider DSH policy in the context of other Medicaid payment policies, such as non-DSH supplemental payments
Next Steps

• Staff plan to present a draft of MACPAC’s required DSH analyses at the December public meeting

• In the March 2018 report, the Commission could also elaborate on themes raised at the roundtable and comment on long-term DSH policy design issues
Considerations for Long-Term Goals of DSH Policy

- Purpose (define more narrowly or allow state flexibility)
- Distribution of funds across states (equalize or rebalance based on some objective criteria)
- Relationship to other Medicaid payments (non-DSH supplemental payments and base payments)
- Performance measures (requirements or incentives)
- Split of federal-state roles (with respect to financing, targeting)
- Transition from current policy
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