MACPAC

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

Medicaid and CHIP Payment and Access Commission

Robert Nelb

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

Roundtable Themes

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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