MACPAC

Policy Options for Structuring DSH Allotment Reductions

Medicaid and CHIP Payment and Access Commission

Robert Nelb

Overview

- Background
- Potential rebasing factors
- Comparison to policy goals
- Decision points
  - Which measure should be used to rebase allotments?
  - How quickly should rebasing be phased in?
  - Are there any other design features the Commission should consider?

Background

- Medicaid DSH payments help offset two types of hospital uncompensated care costs
  - Medicaid shortfall
  - Unpaid costs of care for the uninsured
- Medicaid DSH payments are limited by annual federal allotments
  - Allotments vary widely by state based on state DSH spending in 1992
  - The ACA included reductions to DSH allotments under the assumption that increased coverage would reduce hospital uncompensated care costs

Current Reduction Amounts

- $4 billion in FY 2020
- $8 billion a year in FYs 2021–2025
  - 57 percent of unreduced allotments in FY 2023
  - 5 percent of total Medicaid hospital spending projected for FY 2023
- Allotments return to higher, unreduced amounts in FY 2026 and subsequent years

CMS Reduction Methodology

- The statute currently requires CMS to apply reductions based on several factors
  - Larger reductions to states with low uninsured rates
  - Larger reductions to states that do not target DSH payments to hospitals with a high volume of Medicaid patients or high levels of uncompensated care
- MACPAC commented on CMS's proposed methodology in August 2017
- This methodology preserves much of the existing variation in DSH allotments and is unlikely to improve the targeting of DSH payments

Working Towards Recommendations

- At the September meeting, Commissioners expressed interest in developing a new method for structuring DSH allotment reductions
  - Based on measures other than historical spending
  - Considering statutory changes
  - Assuming no change in the amount of reductions
- Goal of voting on specific recommendations no later than the January meeting
  - FY 2020 DSH reductions take effect October 2019

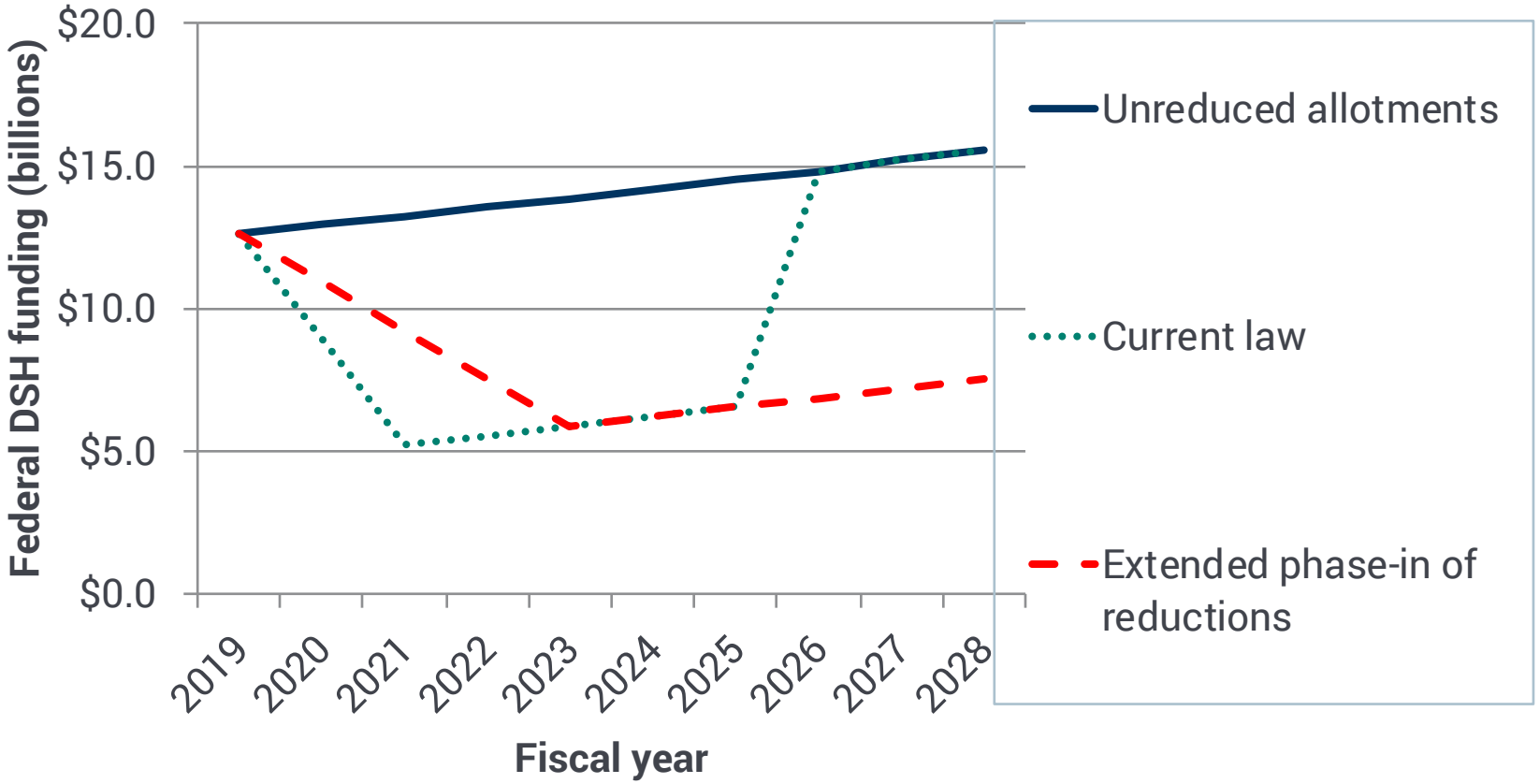
Potential Rebasing Factors

- Measures related to the number of people in a state likely to have uncompensated care costs
  - Number of uninsured individuals
  - Number of Medicaid enrollees and uninsured individuals
  - Number of non-elderly, low-income individuals
- Available data on hospital uncompensated care costs in each state have several limitations

Estimating Effects of Rebasing

- Adjusted rebasing factors based on the Medicare wage index
- Assumed that rebasing would be phased in gradually to minimize reductions for states with allotments above the rebased amount
  - Four-year phase in of DSH reductions
  - Applying reductions to unspent DSH funding first
  - Smaller increases to states with allotments below the rebased amount
  - Limit state DSH reductions to 30 percent a year

Federal DSH Funding Under Various Policy Options, FYs 2019–2028

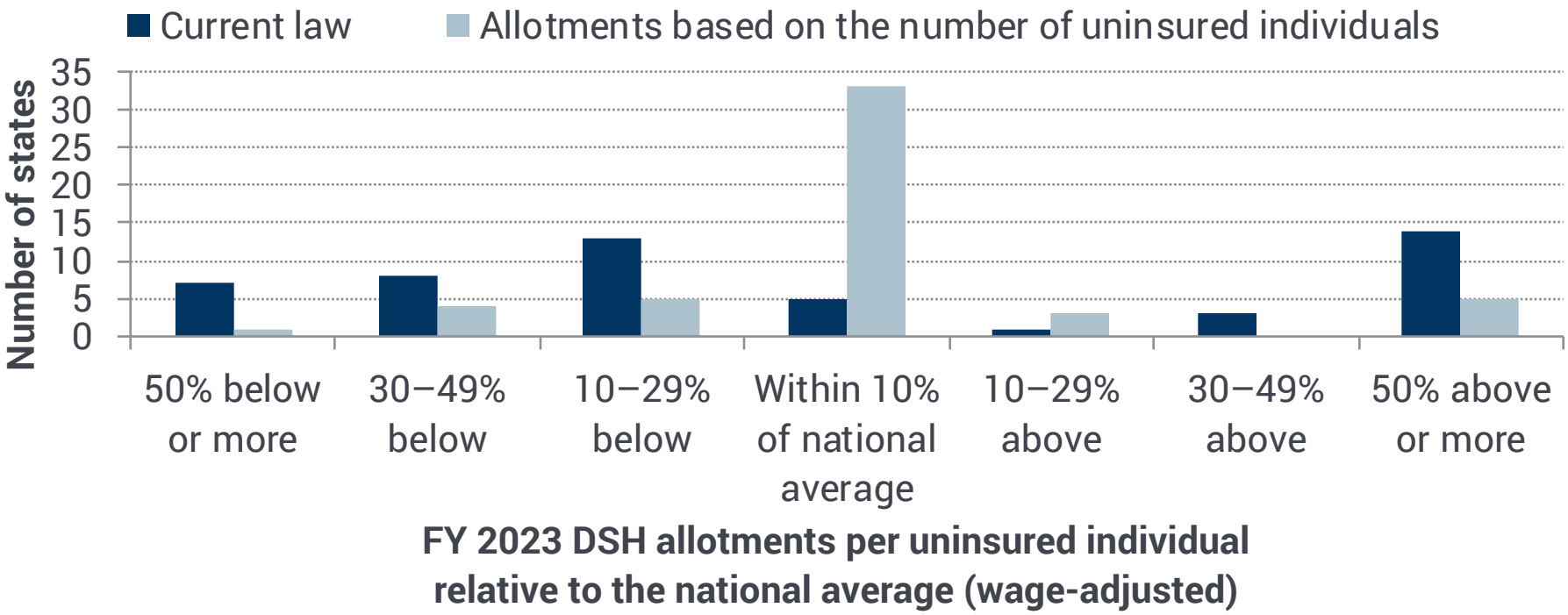


Notes: DSH is disproportionate share hospital. FY is fiscal year.
Source: MACPAC, 2018, analysis of the CMS Medicaid Budget Expenditure System and Congressional Budget Office (CBO), 2018, An update to the economic outlook: 2018 to 2028

Policy Goals

- Improving the relationship between DSH allotments and measures related to hospital uncompensated care costs
- Applying reductions to states independent of state coverage choices
- Phasing in changes in an orderly way

Rebasing Reduces Historical Variation



Notes: DSH is disproportionate share hospital. FY is fiscal year. DSH allotments per uninsured individual were adjusted to account for differences in labor costs in different geographic areas using a statewide composite of the Medicare wage index. The number of uninsured individuals in 2016 is compared to projections of DSH allotments in FY 2023. The national average DSH allotment per uninsured individual is $215. The number of states includes the District of Columbia.
Source: MACPAC, 2018, analysis of the CMS Medicaid Budget Expenditure System, 2016 American Community Survey, CMS FY 2019 inpatient prospective payment system final rule, and Congressional Budget Office (CBO), 2018, An update to the economic outlook: 2018 to 2028

Correlation to Hospital Uncompensated Care Costs

- The number of uninsured individuals is most correlated with hospital uncompensated care costs in a state
- No measure is perfectly correlated, even after adjusting for differences in hospital costs
- DSH allotments as a share of total hospital uncompensated care costs will continue to vary after allotments are fully rebased

Aggregate Percent Change in DSH Allotments, FY 2023

Medicaid expansion status as of December 31, 2016	Status quo	Allotments based on number of uninsured individuals	Allotments based on number of Medicaid and uninsured individuals	Allotments based on number of low-income individuals
Expansion states	-61%	-64%	-57%	-59%
Non-expansion states	-50%	-43%	-59%	-54%
All states	**-57%**	**-57%**	**-57%**	**-57%**

Notes: DSH is disproportionate share hospital. FY is fiscal year. Low-income individuals defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Percent change in DSH allotment is the percent change from a state's unreduced DSH allotment amount.
Source: MACPAC, 2018, analysis of the CMS Medicaid Budget Expenditure System, 2016 American Community Survey, CMS FY 2019 inpatient prospective payment system final rule, and Congressional Budget Office (CBO), 2018, An update to the economic outlook: 2018 to 2028

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Phasing in Changes in an Orderly Way

- Under all scenarios, most states would have allotments within 10 percent of the rebased amount within five years
- Some states will still have allotments below the rebased amount after 10 years because we assumed increases would be applied gradually

State and Provider Effects

- Some states may choose to minimize the effects of DSH reductions by increasing other Medicaid payments to providers
- States could also target remaining DSH funds to the hospitals that need them most

Decision Points

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