MACPAC

DSH Allotment Reductions: Proposed Recommendations

Medicaid and CHIP Payment and Access Commission

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Overview

- Background on disproportionate share hospital (DSH) allotment reductions
- Proposed recommendation package
  - Rationale
  - Design considerations
  - Expected impact
- State effects
- Other DSH policy options for future consideration
- Next steps

Background

- 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 fiscal year (FY) 2020
  - $8 billion per year in FYs 2021–2025
  - No reduction 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

Proposed Recommendation Package

Proposed Recommendation Package

- Staff have developed a package of three DSH allotment recommendations based on the discussion at the October public meeting
- Proposed recommendations include:
  - phasing in reductions more gradually over a longer period of time
  - applying reductions to unspent DSH funding first
  - distributing reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly, low-income individuals in a state

Proposed Recommendation 1

- In order to phase in DSH allotment reductions more gradually without increasing federal spending, Congress should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029

Recommendation 1: Rationale

- Mitigate disruption for DSH hospitals
- Time for states to adjust other Medicaid hospital payment policies if they so choose
- Amounts are intended to match the level of spending assumed under current law
  - The Congressional Budget Office (CBO) does not assume dollar-for-dollar savings
  - CBO's final estimate of proposed legislation can be used to calibrate reduction amounts to further minimize changes in federal spending

Proposed Recommendation 2

- In order to minimize the effects of DSH allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the U.S. Department of Health and Human Services (HHS) to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.

Recommendation 2: Rationale

- Minimizes amount of reductions to DSH funds that are currently paid to providers
  - In FY 2016, $1.2 billion in federal DSH allotments were unspent
  - The amount of unspent funds has been relatively consistent over the past several years
- Design considerations
  - Method for projecting unspent funds
  - Whether and how to account for funds that continue to be unspent after reductions take effect
  - Clarifying that reductions to unspent DSH funds do not affect DSH payments

Proposed Recommendation 3

- In order to reduce the wide variation in state DSH allotments based on historic DSH spending, Congress should revise Section 1923 of the Social Security Act to require HHS to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly, low-income individuals in a state, after adjusting for differences in costs in different geographic areas

Recommendation 3: Rationale

- The number of low-income individuals in a state relates to hospital uncompensated care costs and is independent of state coverage choices
- Other measures the Commission considered did not have reliable data sources or were highly affected by state coverage choices
- Geographic variations in hospital costs affect uncompensated care costs
- Phasing in changes gradually provides states and hospitals time to respond before the full amount of reductions takes effect

Recommendation 3: Design

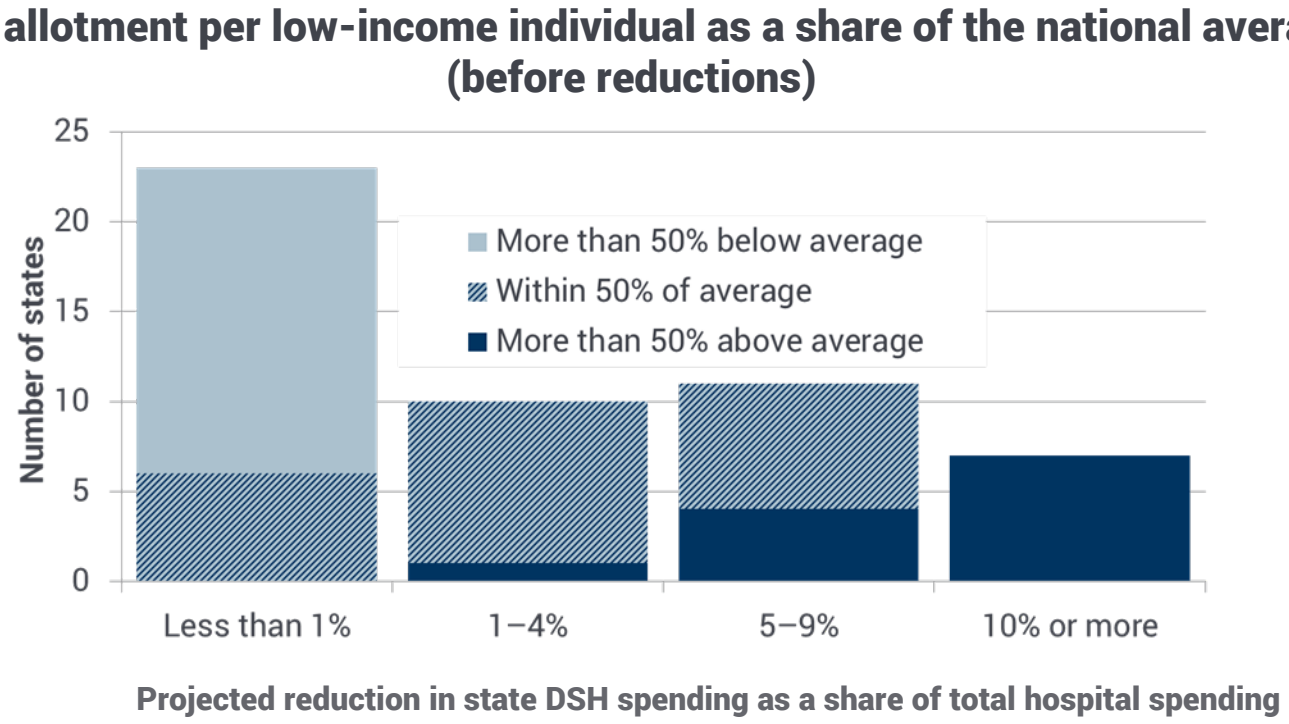
- To estimate the effects of this recommendation, we made several assumptions about how rebasing might be applied
  - Reductions to states with allotments above the rebased amount are larger than increases to states with allotments below the rebased amount
  - Maximum reduction amount of 30 percent a year
- Congress could direct CMS to define many details of the methodology through rulemaking

Expected Impact

- Federal government
  - Modest federal budget savings over the FY 2019–2029 budget period
- States
  - Larger reductions for states with unspent funds and high DSH allotments per low-income individual, compared to current law
- Providers and enrollees
  - Effects vary by state and how states respond to allotment reductions

State Effects

Reduction in State DSH Spending as a Share of Total Medicaid Hospital Spending, FY 2023



Notes: DSH is disproportionate share hospital. Low-income individual defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Reductions in DSH spending exclude reductions to unspent DSH funds. Total hospital spending includes fee-for-service base payments, supplemental payments, and an estimate of managed care payments to hospitals. 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 CMS national health expenditure data

Characteristics of States with the Largest Projected Reductions in DSH Payments, FY 2023

State	Projected reduction in DSH spending, millions (Percent of total hospital spending)		Medicaid shortfall for DSH hospitals, millions (SPRY 2014)	Share of DSH payments to deemed DSH hospitals (SPRY 2014)
	Current law	Proposed policy		
Alabama	$416 (15%)	$412 (14%)	$124	6%
Louisiana	583 (12%)	930 (19%)	525	74%
Missouri	469 (10%)	625 (14%)	—	50%
New Jersey	859 (15%)	1,110 (19%)	393	82%
New York	2,596 (8%)	3,095 (10%)	4,284	74%
Rhode Island	135 (12%)	118 (10%)	145	17%
South Carolina	347 (13%)	439 (17%)	164	39%

Notes: DSH is disproportionate share hospital. FY is fiscal year. SPRY is state plan rate year. Total hospital spending includes fee-for-service base payments, supplemental payments, and an estimate of managed care payments to hospitals and it includes state and federal funds. Table includes states with projected reductions in DSH payments greater than or equal to 10 percent of Medicaid hospital spending under the proposed policy.
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 CMS national health expenditure data

Non-DSH Payment Methods

- States may be able to pay for Medicaid shortfall using non-DSH Medicaid payment methods
  - Base payments
  - Upper payment limit (UPL) supplemental payments
  - Directed payments in managed care
- Louisiana is currently in the process of shifting about $379 million in DSH payments to base payment rate increases
- DSH payments for uninsured individuals and institutions for mental diseases (IMDs) are more difficult to offset with base payment increases

DSH Policy Options for Future Consideration

Definition of Medicaid Shortfall

- In March 2018, federal courts ruled that payments from third-party payers cannot be included in the DSH definition of Medicaid shortfall
  - Litigation about whether CMS has the authority to define Medicaid shortfall for DSH purposes is still ongoing
  - There are also other pending lawsuits about the timing of when this change should take effect
- As a result, Medicaid shortfall on future DSH audits is expected to more than double in the aggregate
  - The maximum amount of DSH payments that hospitals can receive will increase
  - The ruling could result in a redistribution of DSH funding within states that distribute DSH payments based on the amount of uncompensated care reported on DSH audits

Using DSH Funding to Support Delivery System Transformation

- California's Global Payment Program (GPP) is testing distributing DSH funds as a global payment tied to quality goals
  - Interim evaluation results are promising
  - Final evaluation results are expected in the summer of 2019
- CMS could provide enhanced technical assistance to help states to implement Section 1115 demonstrations similar to the GPP
- The model may be difficult for other states to adopt, especially when DSH funding is being cut

Next Steps

- Plan to vote at the January meeting
- Recommendations will be accompanied by a chapter that describes the Commission's analyses and alternatives considered

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