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CMS's Proposed Rule Implementing the ACA-Mandated Medicaid DSH Reductions

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OVERVIEW — *State Medicaid programs make Medicaid disproportionate share hospital (DSH) payments to hospitals to help offset costs of uncompensated care for Medicaid and uninsured patients. Unlike most Medicaid spending, annual DSH allotments for each state are capped. Under the Patient Protection and Affordable Care Act of 2010 (ACA), DSH payments will decrease starting in fiscal year (FY) 2014 and continuing through FY 2020. This paper describes the proposed rule for reducing these federal allotments, which was released on May 15, 2013, by the Centers for Medicare & Medicaid Services (CMS). Comments on the proposed rule are due July 12, 2013.*

2014 UPDATE

The Protecting Access to Medicare Act of 2014, PL 113-93, delayed the Medicaid DSH cuts until FY 2017, extended the cuts through 2024, and increased the size of the total reductions to $35.1 billion.

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State Medicaid programs make supplemental payments, known as Medicaid disproportionate share hospital (DSH) payments, to qualifying hospitals. DSH payments are intended to at least partially offset hospitals' uncompensated costs of caring for Medicaid and uninsured patients. Unlike most Medicaid expenditures, there is a limit on the federal funds allotted for DSH payments. For fiscal year (FY) 2012, the federal DSH allotment for all states and the District of Columbia is estimated to be $11.34 billion. As long as they make payments to certain hospitals that meet federal criteria, states have latitude to designate other hospitals as DSH hospitals and establish their method for allocating DSH payments.

The Patient Protection and Affordable Care Act of 2010 (ACA), which expands access to health insurance coverage through subsidized private insurance and expanded Medicaid eligibility, also directs the Secretary of the U.S. Department of Health and Human Services (HHS) to reduce the total federal Medicaid DSH allotment beginning in FY 2014, the first year coverage expansions are effective, through FY 2020. This reduction in Medicaid DSH payments to hospitals was made in anticipation of a smaller uninsured population resulting from coverage expansions. Due to the Supreme Court's June 2012 ruling in *National Federation of Independent Business (NFIB) v. Sebelius*, which made the expansion of eligibility for Medicaid for adults up to 138 percent of poverty optional for states, the coverage expansions anticipated in the ACA may not be as uniform as contemplated. The *NFIB v. Sebelius* decision did not change the Medicaid DSH reduction provision in the ACA.

On May 15, 2013, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule on its method for allocating required reductions in federal Medicaid DSH allotments to states in FY 2014 and FY 2015, according to the parameters defined in the ACA. The precise method for allocating the total reduction to each state's DSH allotment was eagerly anticipated because of the sizeable share of funding at stake: $500 million in FY 2014 to a high of $5.6 billion in FY 2019. Of particular interest was whether the allocation method would account for states' decisions regarding Medicaid

expansion. In the proposed rule for the FY 2014 and FY 2015 allotments, CMS proposes to allocate the DSH reductions using existing sources of data that predate the coverage expansions and thus do not reflect states' Medicaid coverage expansion decisions. The rule does not alter states' discretion to target their DSH dollars, but, per the ACA, allocates more of the reduction to states that do not target DSH to hospitals with high volumes of Medicaid inpatients and high levels of uncompensated care. It also allocates more of the reduction to states that have the lowest percentage of uninsured individuals.

DSH PAYMENT BACKGROUND

Federal criteria allow states wide discretion in determining which hospitals receive DSH payments and how payments are allocated to qualifying hospitals within a state.[1] States must define their criteria for determining DSH hospitals and their payment allocation formulas in their Medicaid state plans and submit them to CMS for approval. They must also submit annual independently certified DSH audits and reports to CMS as a condition for receiving federal funds for their DSH payments.[2] States' definitions of DSH-eligible hospitals must include all hospitals meeting one of the criteria set forth in federal law: (i) a Medicaid inpatient utilization rate (MIUR) that is at least one standard deviation above the mean for all hospitals in the state or (ii) a low-income patient utilization rate in excess of 25 percent. States may make other hospitals eligible to receive DSH payments, provided they have an MIUR of at least 1 percent.[3] Medicaid DSH payments to any hospital cannot exceed that hospital's total uncompensated cost of providing inpatient and outpatient services to Medicaid and uninsured patients.

For FY 2012, the federal DSH allotment for all states and the District of Columbia is estimated to be $11.34 billion; state allotments vary.[4] (See the appendix for individual state DSH allotments in FY 2012.) The Congress established a limit on the amount each state may claim from the federal government for DSH payments after rapid increases in DSH spending in the late 1980s and early 1990s caused concerns about financial accountability for DSH payments. Policies enacted to control DSH spending preserved some of the historical differences in DSH allotments across states. These differences have been regarded as inequitable by some because, rather than being set on the basis of the costs hospitals incur caring for Medicaid and uninsured

patients, the allotments to each state reflect states' past decisions to make relatively high DSH payments to hospitals in their state.[5] Some states are designated "low-DSH states" in law because their total expenditures for DSH payments for FY 2000, as reported to CMS as of August 31, 2003, were less than 3 percent of the state's total Medicaid spending during the fiscal year.[6] Low-DSH states were permitted to receive higher annual increases in DSH allotments than non-low DSH states, but their allotments remained low relative to non-low DSH states. (See the appendix for low-DSH states.)

IMPLEMENTING THE MEDICAID DSH ALLOTMENT REDUCTION IN THE ACA

The ACA directs the Secretary of HHS to reduce aggregate Medicaid DSH allotments by a specified amount each year between FY 2014 and FY 2020 (Table 1). The ACA also requires the Secretary to determine a method for allocating the annual DSH reductions to the states and directs the Secretary to account for specific factors in the allocation method[7]:

1. Smaller percentage DSH reductions are to be imposed on low-DSH states.

2. Larger percentage DSH reductions are to be imposed on states that

- have the lowest percentage of uninsured individuals;
- do not target DSH to hospitals with high volumes of Medicaid inpatients; and
- do not target DSH to hospitals with high levels of uncompensated care.

3. Reductions should take into account the extent to which a state used its DSH allotment to expand coverage under an approved Medicaid section 1115 waiver as of July 31, 2009.

On May 15, 2013, CMS released the proposed rule on its method for implementing the reductions to state Medicaid DSH allotments for FY 2014 and FY 2015.[8] The rule sets forth CMS's proposed method for calculating the DSH reductions and the sources of data for calculating the relevant metrics. The method proposed does not take into account states' decisions to expand their Medicaid programs for FY 2014 and FY 2015, and the data used to allocate the DSH reductions

TABLE 1
Aggregate Annual DSH Reductions in the ACA, Fiscal Years 2014–2020

Federal Fiscal Year	Reduction
2014	$500,000,000
2015	$600,000,000
2016	$600,000,000
2017	$1,800,000,000
2018	$5,000,000,000
2019	$5,600,000,000
2020	$4,000,000,000

Source: Social Security Act Section 1923 (f)(7)(A)(ii), available at www.ssa.gov/OP_Home/ssact/title19/1923.htm.

See The Protecting Access to Medicare Act of 2014, PL 113-93 for updated aggregate DSH reductions, www.gpo.gov/fdsys/pkg/PLAW-113publ93/pdf/PLAW-113publ93.pdf.

in FY 2014 and FY 2015 predate any ACA coverage expansions. CMS states that, in future rulemaking, it will propose the method to be used in FY 2016 and thereafter, including accounting for different state choices to expand coverage.

CALCULATING THE REDUCTIONS

The remainder of this brief summarizes the steps in CMS's proposed method and describes the data sources used in the calculations to achieve the statutorily required DSH allotment reductions. In summary, as shown in Figure 1 and described below in more detail, step 1 divides the total reduction for the year into two pots: one for the low-DSH states and the other for non-low DSH states. Step 2 further divides those group pools into three equal pools to be allocated to states in steps 3 through 5 according to the three statutorily identified factors: the Uninsured Percentage Factor (UPF), which is a measure of the uninsured in the state; the High Volume of Medicaid Inpatients Factor (HMF), which is a measure of the amount of its DSH payments a state targets to hospitals that serve a high share of Medicaid patients; and the High Level of Uncompensated Care Factor (HUF), which is a measure of the amount of its DSH payments a state targets to hospitals with a high level of uncompensated care.

STEP 1: States are separated into low DSH and non-low DSH groups, and the total DSH funding reduction for the year is allocated to each group.

The ACA required the Secretary to make smaller percentage reductions in low-DSH states than in non-low DSH states. As described above, low-DSH state designation was previously defined in statute; that definition is used in this calculation. These states, as the proposed rule notes, have had historically lower DSH allotments, relative to their total Medicaid expenditures, than non-low DSH states.[9] Seventeen states are categorized as low-DSH states in the proposed rule, and 33 states plus the District of Columbia (a total of 34) are categorized as non-low DSH states.

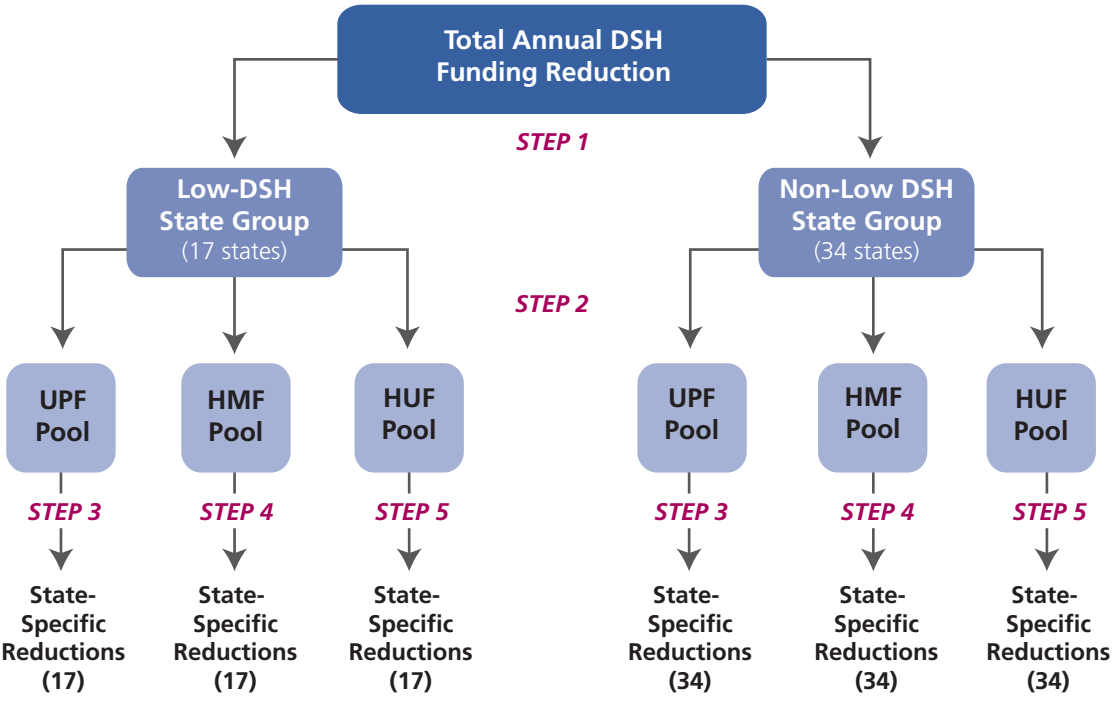
The total funding reduction for the year is allocated to the two groups—the low-DSH and the non-low-DSH group—according to the share of total unreduced DSH allocation attributable to each group. That allocation is then multiplied by a "low-DSH adjustment

factor" to lessen the share of the DSH funding reduction borne by low-DSH states and increase the share borne by non-low DSH states. The low-DSH adjustment factor is the ratio of mean DSH payments per total Medicaid spending in the low-DSH and the non-low-DSH groups, converted to a percentage.

STEP 2: The aggregate reduction amounts for both low-DSH and non-low DSH groups of states are divided into three equal pools to be assigned to individual states according to the factors prescribed in law.

In this step, CMS proposes that both groups' DSH reduction amount is divided into three equal pools which will then be allocated to states on the basis of (i) measures of each state's uninsured popula-

FIGURE 1: Allocation of DSH Funding Reductions to States in FY 2014 and FY 2015



Abbreviations: Disproportionate share hospital (DSH), Uninsured Percentage Factor (UPF), High Volume of Medicaid Inpatients Factor (HMF), High Level of Uncompensated Care Factor (HUF). The steps are explained in detail in the remainder of this document.

Source: Centers for Medicare & Medicaid Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions," Federal Register, 78, no. 94, CMS-2367-P (May 15, 2013): pp. 28551-28569, available at www.gpo.gov/fdsys/pkg/FR-2013-05-15/pdf/2013-11550.pdf.

tion, called the UPF, and the extent to which a state targets its DSH spending to hospitals with (ii) high volumes of Medicaid inpatients, called the HMF and (iii) high levels of uncompensated care, called the HUF. This step reflects CMS's decision in the proposed rule to give equal weight to these three factors specified in the ACA.

In the rule, CMS says that it considered other various weighting schemes. The agency explicitly seeks comments and proposals for alternative weighting of these three factors. It also seeks comments on the effect that different weighting schemes have on different types of hospitals.

STEP 3: For each state group, state-specific DSH allotment reduction amounts relating to the UPF pool are determined.

The UPF pool for each group of states is allocated to individual states based on each state's percentage of uninsured individuals, as identified in the most recent data from the Census Bureau's American Community Survey, weighted by the unreduced DSH allotment.

STEP 4: For each state group, state-specific DSH allotment reduction amounts relating to the HMF pool are determined.

This step allocates the second pool, the HMF pool, to each state in both groups based on states' decisions to target DSH funds to hospitals with high volumes of Medicaid patients, defined in the rule as hospitals with an MIUR of more than one standard deviation (SD) above the mean MIUR for the state. The rule proposes to rely on MIUR calculations and DSH payment amounts for each hospital from the states' most recently submitted DSH audit and reporting data. If a state targets more of its DSH funds to hospitals with MIURs less than one standard deviation above the mean MIUR for hospitals receiving Medicaid DSH funds in the state, then the state will receive relatively greater DSH reductions than it would if it targeted more DSH funds to hospitals with MIURs at least one standard deviation above the mean.

$$\text{State HMF} = \frac{\text{DSH payments to hospitals with MIURs less than 1 SD above the mean in the state}}{\text{Group total DSH payments to hospitals with MIURs less than 1 SD above the mean}}$$

STEP 5: For each state group, state-specific DSH allotment reduction amounts relating to the HUF pool are determined.

This step allocates the third pool, the HUF pool, to each state in both groups based on states' DSH funds allocated to hospitals with high levels of uncompensated care. Uncompensated care costs are costs incurred by a hospital for furnishing inpatient and outpatient hospital services to individuals with Medicaid coverage and the uninsured, less all applicable revenues for these services and excluding bad debt. According to the rule, the most recent available DSH audit and reporting data will be the data source for this calculation. For each DSH hospital, the uncompensated care level is this uncompensated care cost divided by the total costs of care for the uninsured and individuals with Medicaid coverage.[10] If a hospital exceeds the mean ratio of uncompensated care costs to total Medicaid and uncompensated care costs within the state, it is considered to have a high level of uncompensated care. As with the calculation of the HMF, if a state targets less of its DSH funds to hospitals with a high level of uncompensated care, then the state will receive relatively greater DSH reductions than it would if it targeted more DSH funds to hospitals with a high level of uncompensated care.

$$\text{State HUF} = \frac{\text{DSH payment to hospitals with uncompensated care level below the state mean}}{\text{Group total DSH payment to hospitals with uncompensated care level below the state mean}}$$

EXCLUSIONS

Some states have not distributed all their DSH funds directly to hospitals. Instead, under Medicaid section 1115 waivers, they used the funds for coverage expansions. The ACA requires that these diversions be taken into account for states having such waivers before July 31, 2009. The rule proposes to exclude the DSH funds used for coverage expansions in states with such waivers from the allocations of the HMF and HUF pools described above. The rule identifies three states—Maine, Massachusetts, and Wisconsin, and the District of Columbia, as states that may qualify to have at least a portion of their DSH funds excluded from the allocation of reductions relating to the HMF and HUF pools. For these states and the District, and other states that diverted DSH funding for other purposes or for coverage expansions not approved before July 31, 2009, the rule

proposes to assign group average HMF and HUF reduction percentages because these states have limited or no relevant data to compute the HMF and HUF. The rule asks for comment on the use of this proposed formula to allocate the reduction.

LOOKING AHEAD

The data used to allocate the reductions in the proposed rule for FY 2014 and FY 2015 will not reflect states' choices about expanding Medicaid coverage. If the allocation formula proposed for FY 2014 and FY 2015 is used in future years, states that choose to expand Medicaid would likely see higher reductions in the DSH allotments, and states that opt not to expand would see lower reductions because their uninsured rates would remain relatively higher. In addition, assuming reductions continue to be allocated in future rulemaking using the method proposed for FY 2104 and FY 2015, the rule contains incentives for states to target DSH payments to hospitals that meet the definition of providing a high volume of Medicaid inpatient and uncompensated care. However, even in states that target their DSH payments, the share of the reductions will be significant, particularly in 2018 through 2020 when the reductions will be $5 billion, $5.6 billion, and $4 billion, respectively—close to half of the current level of total DSH allotments. How specific hospitals and people served by those hospitals will be affected by these reductions, a dynamic reimbursement environment, and changes in the overall level of public and private insurance coverage beginning in FY 2014, remains to be seen. These effects will be closely watched by patient advocates, hospitals, and state and federal policymakers.

Comments on the proposed rule for allocating the ACA-mandated Medicaid DSH reductions are due July 12, 2013. The President's budget for FY 2014 proposed to delay the cuts for one year but, unless Congress intervenes, the Medicaid DSH reductions are scheduled to take effect on October 1, 2013.[11]

ENDNOTES

1. For additional information on DSH payments see Kathryn Linehan, "Medicaid Financing," National Health Policy Forum, The Basics, February 13, 2013, available at www.nhpf.org/library/details.cfm/2528.

2. U.S. Government Accountability Office (GAO), "Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed," GAO-13-48, November 26, 2012, pp. 3-4, available at www.gao.gov/products/GAO-13-48.

3. To be eligible for DSH, a hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to those services under the Medicaid state plan.

4. Centers for Medicare & Medicaid Services (CMS), "Medicaid Program; Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FYs 2010, 2011, and Preliminary FY 2012 Disproportionate Share Hospital Allotments and Limits," CMS-2384-N, *Federal Register*, 77, no. 142 (July 24, 2012): pp. 43314-43316, available at www.gpo.gov/fdsys/pkg/FR-2012-07-24/pdf/2012-17954.pdf.

5. Robert E. Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," National Health Policy Forum, Background Paper, September 14, 2004, p. 9, available at http://www.nhpf.org/library/details.cfm/2463.

6. Low-DSH states are defined in section 1923(f)(5)(B) of the Social Security Act.

7. Social Security Act Section 1923(f)(7)(B), available at www.ssa.gov/OP_Home/ssact/title19/1923.htm.

8. CMS, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions," CMS-2367-P, *Federal Register*, 78, no. 94 (May 15, 2013): pp. 28551-28569, available at www.gpo.gov/fdsys/pkg/FR-2013-05-15/pdf/2013-11550.pdf.

9. CMS, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions."

10. CMS proposes to use total cost of care provided in the hospital cost report as the denominator in this calculation in future rulemaking. Using a hospital's total cost of care as the denominator would avoid scenarios in which hospitals that provide a higher percentage of services to Medicaid and uninsured individuals and greater total qualifying uncompensated care costs do not qualify as having a high level of uncompensated care.

11. Office of Management and Budget, *Fiscal Year 2014 Budget of the United States Government*, p. 101, available at www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf.

APPENDIX Preliminary Medicaid DSH Allotments for Fiscal Year 2012

Non-Low DSH States	DSH Allotment ($ million)
Alabama	314.9
Arizona	103.7
California	1,122.7
Colorado	94.7
Connecticut	204.8
District of Columbia	62.7
Florida	204.8
Georgia	275.2
Illinois	220.2
Indiana	218.9
Kansas	42.2
Kentucky	148.5
Louisiana	732.0
Maine	107.5
Maryland	78.1
Massachusetts	312.3
Michigan	271.4
Mississippi	156.2
Missouri	485.2
Nevada	47.4
New Hampshire	164.0
New Jersey	654.3
New York	1,645.0
North Carolina	302.1
Ohio	416.0
Pennsylvania	574.8
Rhode Island	66.6
South Carolina	335.4
Tennessee	123.6
Texas	979.3
Vermont	23.0
Virginia	89.7
Washington	189.5
West Virginia	69.1

Low-DSH States	DSH Allotment ($ million)
Alaska	20.9
Arkansas	44.2
Delaware	9.3
Hawaii	10.0
Idaho	16.9
Iowa	40.3
Minnesota	76.5
Montana	11.6
Nebraska	29.0
New Mexico	20.9
North Dakota	9.8
Oklahoma	37.1
Oregon	46.4
South Dakota	11.3
Utah	20.1
Wisconsin	96.8
Wyoming	0.2

Notes: The states are categorized as non-low DSH or low-DSH according to the July 2012 final rule. The May 13, 2013 rule reversed the labels on Arkansas and Arizona. Arkansas is a low-DSH state; Arizona is not.

Sources: Centers for Medicare & Medicaid Services (CMS), "Medicaid Program; Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FYs 2010, 2011, and Preliminary FY 2012 Disproportionate Share Hospital Allotments and Limits," CMS-2384-N, Federal Register, 77, no. 142 (July 24, 2012): pp. 43314-43316, available at www.gpo.gov/fdsys/pkg/FR-2012-07-24/pdf/2012-17954.pdf*; and CMS, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions," CMS-2367-P, Federal Register, 78, no. 94 (May 15, 2013): pp. 28551-28569, available at* www.gpo.gov/fdsys/pkg/FR-2013-05-15/pdf/2013-11550.pdf.