



Q & A
Disproportionate Share Hospital Payments and the Medicaid Expansion
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Background

Charitable and safety-net hospitals have long provided uncompensated care to low-income and underserved individuals. In part to help offset the cost of this care, many of these hospitals receive funds through the Medicaid and Medicare Disproportionate Share Hospital (DSH) programs. On the assumption that the number of uninsured and underinsured people will fall precipitously beginning in 2014, the Patient Protection and Affordable Care Act (ACA) decreases the amount of DSH payments under both programs.

This reduction in DSH payments, which was not affected by the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*, will dramatically impact the financial situation of some hospitals. In states that do not expand Medicaid to all people up to 133% of the federal poverty line, the need for uncompensated care may remain relatively stable while the amount of DSH funds that were previously used to subsidize some of that care will fall substantially. This may lead some hospitals to provide less uncompensated care or aggressively pursue collection activities against uninsured individuals who receive such care. Advocates may be able to use state law and other provisions of the ACA to curb some of these practices if they occur.

DSH Questions & Answers

Q. I've heard that there are two different types of DSH programs. Is that right?

A. Yes. Medicare and Medicaid have separate DSH programs. Although the purposes of the two programs are similar, there are significant differences in how funding flows, how hospitals qualify for payments, and how payments are calculated. For example, Medicaid DSH payments are made to states, which are given great flexibility in determining a methodology for distributing the funds. In contrast, Medicare DSH payments are made directly to hospitals as adjustments to those hospitals' DRG payments in accordance with a methodology dictated by federal law.¹

¹ Medicare uses diagnosis related groups, or DRGs, to set inpatient prospective payments.

Q. Can you provide a quick overview of the Medicaid DSH program?

A. The Medicaid DSH program, first established in 1981, provides payments to states to distribute to acute care hospitals and psychiatric facilities to help defray the costs incurred by those facilities in providing uncompensated care to low-income patients.² Medicaid DSH payments are the largest source of federal funding for uncompensated care, with fiscal year 2011 allotments totaling nearly \$11.3 billion.³ Under the Medicaid DSH program, each state is reimbursed for its DSH spending at its regular FMAP rate.⁴

States may specify in their State Medicaid Plans how funds are distributed to individual hospitals and which hospitals qualify for payments.⁵ However, states are required to include all hospitals that have a Medicaid inpatient utilization rate one standard deviation or more above the mean for all hospitals in the state, or a low-income utilization rate exceeding 25 percent.⁶ Hospitals receiving Medicaid DSH funds must have a Medicaid utilization rate of at least one percent and, if the hospital offers obstetrical services, at least two obstetricians with staff privileges who serve Medicaid beneficiaries.⁷ States may specify the source of the non-federal share of DSH funds, which varies widely among states.⁸

There is wide variation in the amount of Medicaid DSH funding received, with six states - New York, California, Texas, Louisiana, New Jersey and Pennsylvania - receiving nearly half of all funds from the program.⁹ This is partly because each state's Medicaid DSH allotment is capped at either the amount of the DSH allotment for the previous year or 12 percent of the state's total Medicaid payments for the allotment year (excluding administrative costs), whichever is

² For a history of the Medicaid DSH program, see Robert E. Mechanic, *Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments*, NHPF BACKGROUND PAPER (Nat'l Health Policy Forum, Wash., D.C.), Sept. 14, 2004, at 1, available at http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf.

³ Christie Provost Peters, *Medicaid Disproportionate Share Hospital (DSH) Payments* (Nat'l Health Policy Forum, Wash. D.C.), June 15, 2009, at 1, available at http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf; Meeting Notice, 76 Fed. Reg. 148, 157 (Jan. 3, 2011).

⁴ FMAP stands for Federal Medical Assistance Percentage, the rate at which states are reimbursed for Medicaid spending. The rate is based on each state's per capita income and can vary from 50 to 83%. See 42 U.S.C. § 1396r-4. See generally 42 U.S.C. § 1396d(b) (describing formula for calculating Medicaid reimbursement rate); 74 Fed. Reg. 62,315 (Nov. 27, 2009) (rates for FY 2011).

⁵ See 42 U.S.C. § 1396r-4.

⁶ *Id.* § 1396r-4(b)(1).

⁷ *Id.* §§ 1396r-4(d)(1), (3).

⁸ These have included provider taxes, intergovernmental transfers, and general revenues. See Teresa A. Coughlin, Leighton Ku & Johnny Kim, *Reforming the Medicaid Disproportionate Share Hospital Program in the 1990s*, 22 HEALTH CARE FIN. REV. 137, 143 (2000), available at <http://www4a.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00winterpg137.pdf>.

⁹ See 42 U.S.C. § 1396r-4(f) (describing formula); Meeting Notice, 76 Fed. Reg. 148, 157 (Jan. 3, 2011) (describing current state allotments).

greater.¹⁰ Each hospital's payments cannot exceed its uncompensated care costs, and additional restrictions apply to psychiatric facilities.¹¹

Q. Can you provide a quick overview of the Medicare DSH program?

A. The Medicare DSH program was put into place in 1986.¹² Medicare DSH payments are slightly lower than Medicaid DSH outlays but are still substantial, totaling \$10.8 billion in fiscal year 2010.¹³ Medicare DSH payments serve a dual role: they compensate hospitals for higher Medicare costs associated with the provision of services to a large proportion of low-income patients and protect access to care for Medicare beneficiaries.¹⁴ Medicare DSH funds are available only to acute care hospitals that participate in the inpatient prospective payment system and flow directly from the federal government in the form of increases to the hospitals' normal DRG payment rates.¹⁵ DSH payments are made only for fee-for-service discharges, though an amount to cover projected DSH payments is included in the funding formula for payments to Medicare Advantage plans and may figure into the contract rate that the plans negotiate with hospitals.¹⁶

Hospitals qualify for Medicare DSH payments if the ratio of low-income patients treated by the hospital (called the disproportionate patient percentage, DPP) exceeds 15 percent.¹⁷ In addition, hospitals that are located in an urban area, have 100 or more beds, and can demonstrate that they derive more than 30 percent of their revenues from state and local government payments for indigent care provided to patients not covered by Medicare or Medicaid are eligible.¹⁸ The amount of the adjustment for hospitals qualifying under this alternative criteria is

¹⁰ See 42 U.S.C. § 1396r-4(f)(3)(B).

¹¹ See *generally id.* § 1396r-4(h) (outlining the method by which DSH payments to institutions for mental disease and other mental health facilities are calculated); *id.* § 1396r-4(g).

¹² See Consolidated Omnibus Reconciliation Act of 1985, Pub. L. No. 99-272, §9105, 100 Stat 82 (1985).

¹³ See JOHN R. JACOB ET AL., THE MEDICARE DSH ADJUSTMENT 7 (2012), *available at* http://www.healthlawyers.org/Events/Programs/Materials/Documents/MM12/papers/M_jacob_etal_slides.pdf.

¹⁴ See PATRICIA A. DAVIS ET AL., CONG. RESEARCH SERV., RL 41196, MEDICARE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 6 (2010).

¹⁵ See 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.

¹⁶ See BILES ET AL. THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS, COMMONWEALTH FUND ISSUE BRIEF 4 (2012), http://www.commonwealthfund.org/usr_doc/Biles_costprivatizationextrapayMAplans_970_ib.pdf.

¹⁷ The DPP is calculated as the sum of the percentage of inpatient days attributable to patients entitled to Medicare Part A who also receive Supplemental Security Income (SSI) and the percentage of total inpatient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A. See 42 U.S.C. § 1395ww(d)(5)(F)(vi); see also CMS, *Medicare Disproportionate Share Hospital*, RURAL HEALTH FACT SHEET SERIES, Nov. 2011, at 1, 2, *available at* http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//Disproportionate_Share_Hospital.pdf. For purposes of this calculation, number of beds is determined by 42 C.F.R. § 412.105(b).

¹⁸ Hospitals qualifying under the alternative method are often referred to as "Pickle" hospitals, after former Rep. J.J. Pickle, the Congressman who advocated for their inclusion. Few hospitals use this method to qualify for Medicare DSH payments.

35 percent.¹⁹ Adjustments for DPP hospitals vary with the hospital's bed count, geographic classification and other factors.²⁰ Like Medicaid DSH payments, Medicare DSH payments are unevenly distributed, with just 200 hospitals accounting for 38 percent of disbursements.²¹

Q. How does the ACA change the DSH programs?

A. The broad outlines of the programs will remain the same. However, beginning in FY 2014, the ACA dramatically decreases the amount of funding that will be provided under both DSH programs, based on the premise that the ACA reforms will result in fewer individuals receiving uncompensated care.²² To address longstanding concerns that the current mechanisms for distributing DSH funds are not well designed, the ACA also attempts to more equitably apportion DSH payments by directing them more towards hospitals that serve needier patients and are located in needier areas.²³

Q. How does the ACA reduce Medicaid DSH payments?

A. We don't yet know exactly how Medicaid DSH payments will change. Under the ACA, the Secretary of HHS is required to develop a methodology that will reduce the payments by \$14.1 billion during the period 2014 to 2019, pursuant to a schedule set out in the ACA.²⁴ These reductions increase over time, and by 2019 represent approximately a 50% reduction over baseline projections.²⁵ The methodology, which has not yet been published, must impose the largest percentage reductions on states with the lowest percentage of uninsured individuals or those that do not target their DSH payments to hospitals that either have high Medicaid volumes or high levels of uncompensated care.²⁶ It must also impose a smaller percentage reduction on low DSH states (those for which DSH

¹⁹ 42 U.S.C. § 1395ww(d)(5)(F)(iii).

²⁰ *Id.* § 1395ww(d)(5)(F)(iv); See CMS, *supra* note 17, at 4 for a chart of adjustments.

²¹ MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 73 (2007), available at http://www.medpac.gov/documents/mar07_entirereport.pdf.

²² For Medicaid DSH reductions, see Affordable Care Act (ACA), Pub. L. No. 111-148, § 2551(a), 124 Stat. 119, 312-314 (2010) (amending 42 U.S.C. § 1396r-4(f)); *id.* § 10201(e)(1), 124 Stat. at 920-922 (amending 42 U.S.C. § 1396r-4(f)); Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, § 1203, 124 Stat. 1029, 1053-1055 (amending 42 U.S.C. § 1396r-4(f)). For Medicare DSH reductions see ACA § 3133, 124 Stat. at 432-433 (amending 42 U.S.C. § 1395ww); *id.* § 10316, 124 Stat. at 946-947 (amending 42 U.S.C. § 1395ww); HCERA § 1104, 124 Stat. at 1047 (amending 42 U.S.C. § 1395ww(r)).

²³ See MEDPAC, *supra* note 21 at 78 ("It appears that the hospitals most involved in teaching and in treating low-income Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to patients unable to pay their bills."); U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-614. MEDICAID: CMS NEEDS MORE INFORMATION ON THE BILLIONS OF DOLLARS SPENT ON SUPPLEMENTAL PAYMENTS (2008).

²⁴ HCERA § 1203(a)(2), 124 Stat. at 1054 (codified at 42 U.S.C. § 1396r-4(f)(7)(B)).

²⁵ See Memorandum from Richard S. Foster, Chief Actuary, Ctr. for Medicare & Medicaid Servs. (Apr. 22, 2010), available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

²⁶ HCERA § 1203(a)(2), 124 Stat. at 1054 (codified at 42 U.S.C. § 1396r-4(f)(7)(B)(i)).

expenditures are more than zero but less than three percent of annual Medicaid expenditures), and it must take into account the extent to which DSH allotments have been used to expand coverage under a Section 1115 demonstration project.²⁷ Special treatment was included for Tennessee and Hawaii. Tennessee, which would otherwise have no DSH allotment for 2012 and 2013, will receive \$47.2 million for each of the last three quarters of FY 2012 and \$53.1 million for FY 2013.²⁸ The DSH allotment for Hawaii for the last three quarters of FY 2012 will be \$7.5 million and, thereafter, Hawaii will be treated as a low DSH state.²⁹

Q. How does the ACA reduce Medicare DSH payments?

A. Beginning in FY 2014, the ACA decreases the base Medicare DSH payment to 25 percent of current levels.³⁰ However, hospitals that continue to treat a large number of uninsured, non-elderly individuals will receive additional funding, reducing the impact of this decrease. These additional payments will be calculated on a hospital-by-hospital basis using a formula that takes into account three factors: the change in the hospital's DSH payments under the ACA, the nationwide change (from 2013) in the percentage of the uninsured under-65 population, and the percentage of uncompensated care provided by the hospital compared to all other acute care hospitals. There is no administrative or judicial review regarding any estimate the Secretary of HHS makes in determining how these factors are calculated.³¹ These changes are expected to decrease Medicare DSH expenditures by over \$22.1 billion between 2014 and 2019 - an approximately 28% reduction over baseline projections.³²

Q. Will the Supreme Court's ACA decision affect the scheduled DSH reductions?

A. No. However, the ACA assumed that many people who currently receive uncompensated hospital care would be covered by Medicaid in 2014 (or earlier, in states that choose to expand early). If states do not expand Medicaid to everyone up to 133% of the poverty line, the number of uninsured people seeking care will be much larger than expected. Both the Medicaid and Medicare

²⁷ *Id.* § 1203(a)(2), 124 Stat. at 1054 (codified at 42 U.S.C. § 1396r-4(f)(7)(B)(ii)-(iii)). Section 1115 of the Social Security Act permits the Secretary of HHS to authorize states to implement "experimental, pilot or demonstration projects" which are "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). These waivers permit the Secretary to waive certain Medicaid requirements. See 42 U.S.C. § 1315(a)(1).

²⁸ HCERA § 1203(b)

²⁹ ACA § 10201(e)(1)(A), 124 Stat. at 920.

³⁰ ACA § 3133(2), 124 Stat. 119 at 432-433 (adding 42 U.S.C. § 1395ww(r)). This is the amount that MedPAC estimated is empirically justified. See MedPAC, *supra* note 20.

³¹ 42 U.S.C. § 1395ww(r)(2). See also CONG. RESEARCH SERV., RL 41196, MEDICARE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 6 (2010). Over the years, there has been extensive litigation brought by hospitals, much of it successful, challenging various aspects of the DPP calculation.

³² See Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, Table 5 (Mar. 20, 2010). Interestingly, CMS scores the reduction at approximately \$50 billion. See Memorandum from Richard S. Foster, *supra* note 25 (table 3).

DSH calculations take the number of uninsured people into account to some extent, but payments under both programs will fall substantially even if the number of uninsured people remains stable. This will likely put even more pressure on safety net providers such as community hospitals, and may make it more difficult for uninsured and underinsured people to access care.

Q. What should advocates in states threatening not to expand Medicaid be doing now?

A. Reductions in DSH payments will begin in October 2013 (federal fiscal year 2014). Hospitals that currently receive a large amount of funding through either or both DSH programs will likely begin attempting to make up for this lost revenue long before 2013.³³ This will likely be especially true in states that do not expand Medicaid, since the number of uninsured individuals in those states is likely to remain relatively stable while funding for uncompensated care will fall dramatically. There have already been a number of reports of safety-net and other hospitals failing to provide care to uninsured and underinsured people or providing that care and then aggressively pursuing patients to recover its cost.³⁴ The reductions in DSH funding may accelerate these types of actions, particularly in non-expansion states.

Review current DSH allocations

Since hospitals in states that currently receive the largest amounts of DSH funding stand to lose the most when the cuts take effect, advocates should review their state's current allocation to see where they stand.³⁵ Particularly in states that currently receive a large amount of DSH funding, hospitals may prove effective partners in encouraging governors and legislatures to move forward with the Medicaid expansion. In states that fail to expand Medicaid as required, advocates should closely watch hospitals as the cuts take effect to ensure that

³³ See generally David Johnson, *Reductions in Medicare, Medicaid DSH Payments Will Dramatically Impact Hospital Bottom Lines*, HEALTH CARE REFORM EXPRESS, June 2010, at 1, available at <http://www.bricker.com/documents/publications/1937.pdf> ("The dramatic reduction in [DSH] payments could be a major stress to the finances of many hospitals."); NAT'L ASS'N OF URBAN HOSPS, *THE POTENTIAL IMPACT OF AFFORDABLE CARE ACT-MANDATED MEDICARE DSH CUTS ON URBAN SAFETY-NET HOSPITALS 1* (2011), available at http://www.nauh.org/component/option,com_rubberdoc/format,raw/id,1/view/doc/ (noting that changes to Medicare DSH payments represent a "large, dramatic loss of revenue for [urban safety net] hospitals.").

³⁴ See, e.g., Nina Bernstein, *Hospitals Flout Charity Aid Law*, THE NEW YORK TIMES (Feb. 12, 2012), http://www.nytimes.com/2012/02/13/nyregion/study-finds-new-york-hospitals-flout-charity-rules.html?_r=1&pagewanted=all; Jessica Silver-Greenberg, *Debt Collector Is Faulted for Tough Tactics in Hospitals*, THE NEW YORK TIMES (Apr. 24, 2012), <http://www.nytimes.com/2012/04/25/business/debt-collector-is-faulted-for-tough-tactics-in-hospitals.html>; Joseph Neff, *Triangle Hospitals Plague Financially Distressed*, NEWSOBSERVER.COM (Apr. 24, 2012, 12:00 AM), at <http://www.newsobserver.com/2012/04/24/2020343/triangle-hospitals-dun-the-financially.html>.

³⁵ See KAISER FAMILY FOUNDATION, *Federal Medicaid Disproportionate Share Hospital (DSH) Allotments*, <http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=185&cat=44> for an easy-to-read chart.

they are not engaging in efforts to reduce provision of care or engage in unlawful collection practices.

Review law governing hospital collection practices

Advocates should be aware of provisions in the ACA and state law that prohibit some of the more egregious hospital financial practices. Under the ACA, nonprofit hospitals are required to have a written financial assistance policy, and are prohibited from engaging in “extraordinary collection actions” unless and until they have made “reasonable efforts” to determine whether the patient is eligible for financial assistance.³⁶ Nonprofit hospitals are also required to limit charges for emergency or other medically necessary care provided to individuals eligible for assistance under the hospital’s financial assistance policy to the lowest amounts charged to individuals who have insurance covering such care, and gross charges are prohibited.³⁷ Many states have similar requirements.³⁸ Advocates should engage with community stakeholders, educate clients and staff, and take steps to ensure that hospitals are in compliance with the new ACA requirements as well as state laws.

Advocate for Medicaid expansion

Since many people currently receiving uncompensated care would be covered by the Medicaid expansion, advocates should take all possible steps to encourage states to adopt the Medicaid expansion as required by the ACA.

³⁶ *Id.* § 9007(a) (codified as amended at 26 U.S.C. § 501(r)(4), (6)).

³⁷ Patient Protection and Affordable Care Act § 9007(a) (codified as amended at 26 U.S.C. § 501(r)(5)).

³⁸ For more information on these new requirements and suggestions for action, see Corey Davis, National Health Law Program, *Nonprofit Hospitals and Community Benefit* (2011), available at http://www.healthlaw.org/images/stories/2011_07_08_Nonprofit_Hospitals_and_Community_Benefit.pdf (National Health Law Program, Carrboro, N.C.). The IRS recently released proposed rules regarding the new nonprofit hospital requirements and is accepting comments through September 24, 2012. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38148 (June 26, 2012).