GNYHA POSITION PAPER

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MEDICAID DSH PAYMENTS

The Medicaid disproportionate share hospital (DSH) program provides payments to safety net hospitals that serve a high proportion of Medicaid beneficiaries and uninsured patients. The payments are essential for these hospitals to partially offset their uncompensated care costs from treating low-income patients. Because DSH hospitals usually have a low percentage of commercially insured patients, they cannot "cost shift" these losses to private insurance companies.

The amount of Federal DSH funds a state can receive is limited by state-specific allotments established by the Balanced Budget Act of 1997. These allotments are updated annually by the Bureau of Labor Statistics' Consumer Price Index. Of the $13.4 billion in Federal Medicaid DSH funding allotted nationally in fiscal year (FY) 2022, New York State's Federal allocation is approximately $2 billion.[1]

As with regular Medicaid payments, states must provide local funds (the percentages vary by state) to receive Federal DSH funds. States have flexibility in determining the distribution of DSH funding to individual hospitals, but the Federal government caps the amount of DSH funding that individual hospitals can receive at their "DSH cap"—their losses from treating Medicaid patients and the uninsured.

Hospital Uncompensated Care Trends

The Affordable Care Act (ACA) cut Federal Medicaid DSH funding under the assumption that fewer uninsured Americans would result in hospitals providing less uncompensated care—but that simply has not been the case.

From 2013 to 2018, New York DSH hospitals' total uncompensated care losses increased by $2.4 billion. In 2018, New York DSH hospitals reported losing nearly $6 billion from treating Medicaid patients, representing 80% of their total reported uncompensated care for Medicaid DSH purposes (i.e., losses from treating Medicaid and uninsured patients).[2]

Congress must maintain Medicaid DSH funding at its current levels to subsidize these losses.

1 Medicaid and CHIP Payment Advisory Commission, Annual Analysis of Disproportionate Share Hospital Allotments to States, March 2022. Note: Excludes the enhanced FMAP provided to states during the COVID-19 public health emergency by the American Rescue Plan Act.

2 GNYHA analysis of Medicaid DSH cap audit data, 2013 through 2018.

How the ACA Impacted Medicaid DSH

Originally scheduled for FYs 2014–20, Medicaid DSH cuts have been legislatively delayed and restructured several times since the ACA's enactment. Most recently, Congress eliminated the FY 2021 cut and delayed the remaining cuts for two years in the Consolidated Appropriations Act, 2021 (CAA) (P.L. 116-260). Under current law, the $8 billion per year cuts are scheduled to occur from FY 2024 through 2027.

The ACA requires the Centers for Medicare & Medicaid Services (CMS) to develop a methodology to reduce Federal Medicaid DSH allotments by the above-specified amount each year. The largest reductions are to be imposed on the states with the lowest percentage of uninsured individuals and those that do not target their DSH payments to hospitals with high volumes of Medicaid patients and uncompensated care. Smaller reductions are to be imposed on low-DSH states (defined as states with total DSH payments of between zero and 3% of total Medicaid spending).

To give a sense of magnitude, under an FY 2017 CMS proposed rule to allocate Medicaid DSH reductions among states, New York would be allocated 17% of the national reduction, or nearly $1.4 billion of an $8 billion national cut.

Safety Net Hospitals Are Already Financially Distressed

Hospitals continue to face numerous post-COVID-19 financial pressures. Revenue growth has not kept pace with increased costs, and hospitals are experiencing negative year-to-date operating margins.[3] Making matters worse, inflation and labor shortages will continue to increase operating costs for the rest of the year. Congress's generous support for providers during the COVID-19 public health emergency has not blunted the full impact of their ongoing immense expense and revenue pressures.

New York State has nearly 30 voluntary hospitals already on a State "watch list" because of their precarious financial position, with many public and other voluntary hospitals also experiencing severe financial distress. The Medicaid DSH cuts could force some of New York's struggling public and voluntary safety net hospitals to reduce services or even close their doors for good.

We urge Congress to further delay the Medicaid DSH cuts for at least two years. DSH funding is essential to ensuring that financially struggling safety net hospitals can continue to serve low-income individuals and vulnerable communities.

DSH Cap Calculation Should Include Medicaid Shortfalls from Dual-Eligible Patients

The CAA changed the methodology for calculating the hospital-specific DSH limit to include only costs and payments associated with Medicaid-eligible individuals where Medicaid is the primary payer. Therefore, effective October 1, 2021 (i.e., Medicaid rate year 2021, which will be audited in 2024), the DSH cap calculation excludes Medicaid shortfalls from services provided to Medicaid-eligible beneficiaries who are dually eligible for Medicare or other coverage.

This policy will result in significant cuts to safety net hospitals. Despite the reimbursement received by secondary payers, in addition to Medicaid reimbursement, hospitals typically operate at a loss for dual-

3 Kaufman, Hall & Associates, LLC, National Hospital Flash Report, November 2022.

eligible patients. Medicare margins have become increasingly negative, and in some cases, hospitals receive no payments from Medicaid. Based on preliminary data, this policy will reduce New York hospitals' Medicaid DSH caps by an estimated 25%.

Congress should amend the CAA, Division CC, Section 203, to allow hospitals to include in their DSH cap calculation Medicaid shortfalls from Medicare dual-eligible patients and individuals dually covered by an "applicable plan" (i.e., liability insurance, no-fault insurance, or workers' compensation laws or plans).

GNYHA Position: GNYHA strongly urges Congress to 1) further delay the Medicaid DSH cuts for at least two years, and 2) allow hospitals to include in their DSH cap calculation Medicaid shortfalls from Medicare dual-eligible patients and individuals dually covered by an "applicable plan."