Medicare and Medicaid Disproportionate Share Hospital Payments: Proposed Rules

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Introduction

For thirty years, the Medicare and Medicaid programs have furnished additional payments to hospitals that furnish a disproportionate share of services to low income populations. Despite the fact that the two disproportionate share hospital (DSH) programs share a common mission, they function differently in terms of how the funds actually move to hospitals and in the formulas used to make DSH payments. The Affordable Care Act makes significant adjustments in both DSH programs beginning in 2014 in anticipation of a significant expansion in the proportion of people who have health insurance coverage. With the United States Supreme Court’s decision in 2012 in *NFIB v Sebelius*, which permits states to opt out of the Medicaid expansion without risking the loss of federal funding for their existing Medicaid programs, the downward DSH payment adjustments become an even more significant matter for hospitals that treat large volumes of low income patients.

In May, the United States Department of Health and Human Services issued two Notice of Proposed Rulemakings (NPRM; 78 Fed. Reg. 27486, May 10th (Medicare)) and (78 Fed. Reg. 28551, May 15th (Medicaid)) that together restructure DSH payments. The comment period on the Medicare DSH NPRM closes on July 25, 2013, while the comment period for the Medicaid DSH NPRM closes on July 12.

This Implementation Brief reviews the DSH changes made by the ACA as well as both sets of proposed rules.

Background

Medicare DSH

The Medicare DSH program was added as a provision of the Medicare statute as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).\(^1\) DSH is essentially an additional payment adjustment to the Medicare Inpatient Prospective Payment System (IPPS), the system used for paying Medicare acute inpatient hospitals. Under the 1985 DSH amendments,\(^2\) known as the DSH adjustment provision, hospitals qualify for a DSH adjustment using one of two methods. The first adjustment method, termed the “primary method” by CMS, is based on the proportion of low income patients served (known as the “disproportionate patient percentage” or DPP) who receive Supplemental Security Income or who rely on Medicaid coverage for some or all of their hospital care. The second method, known as the alternate method, identifies certain hospitals (known as Pickle Amendment hospitals after the legislative sponsor of the amendment) that are urban hospitals of 100 beds deriving at least 30% of their net patient

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\(^1\) Pub. L. 99-272.
revenues for inpatient care from state or local government sources, exclusive of Medicare or Medicaid.\(^3\) Pickle hospitals also qualify for DSH payments as part of their IPPS rates; this payment takes the form of a 35% add-on to their payments.\(^4\) This alternative payment method was subsequently extended to other types of hospitals, including rural hospitals and smaller urban hospitals.\(^5\) Complex formulas exist for actually computing DSH payments. These formulas involve hospital size, geographic location, and methods in the case of the primary payment method for counting low income patient days.

**Medicaid DSH**

The Medicaid DSH program, established in 1981 as part of the Omnibus Budget Reconciliation Act,\(^6\) added a provision that requires that in making payments to hospitals, state Medicaid programs “take into account the situation of hospitals that serve a disproportionate share of low income patients with special needs.”\(^7\) The law has been amended numerous times over the past 32 years to assure that funds are more targeted on hospitals serving high-need communities and to place aggregate limits on the total amount of federal funding available for DSH payments.

Hospitals must meet two basic criteria to qualify for Medicaid DSH payments. First, they must have at least two obstetricians with staff privileges who have agreed to provide care to Medicaid patients (this requirement does not apply to hospitals serving predominantly children or that do not offer nonemergency obstetrical services to the general population). The second criterion is that the Medicaid inpatient utilization rate for the hospital be at least 1%. Hospitals that meet these criteria can qualify for DSH payments if their Medicaid inpatient utilization rate (MIUR) is at least one standard deviation above the mean MIUR for the state, or if the low income utilization rate exceeds 25%. Within these parameters, states are given flexibility to target their DSH funds and establish payment methodologies.

Federal Medicaid DSH allotments are calculated annually as a general rule, adjusted for the consumer price index. The size of the allotment is limited to the amount received in the prior year (adjusted for the CPI), or 12% of the total amount of state Medicaid expenditures. Medicaid DSH payments are limited to the cost of providing inpatient and outpatient services to Medicaid and uninsured patients, minus revenues actually received for their care.\(^8\)

**The Role of Medicare and Medicaid DSH in Supporting Safety Net Hospitals**

The importance of DSH payments to hospitals that serve a high volume of low income patients hardly can be overstated. In FY 2010, Medicare DSH payments accounted for 9.7% of all Medicare expenditures on acute inpatient hospital care, which exceeded $111 billion that year.\(^9\)

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4 See Medicare NPRM, 78 Fed. Reg. at 27579.

5 Id.

6 Pub. L. 97-35.

7 SSA §1902(a)(13).

8 See generally, 78 Fed. Reg. 28532-28533 (Preamble to the Medicaid DSH NPRM).

Among members of the National Association of Public Hospitals, which represents the nation’s largest public hospitals and health systems, federal and state Medicaid DSH payments totaled $17.58 billion in 2010. Medicaid DSH payments accounted for 25% of all funds used to finance health care for uncompensated care, while Medicare DSH payments accounted for 5% of uncompensated care payments.11

Changes Made by the ACA

Anticipating a major reduction in the number of low income and uninsured Americans as a result of the ACA’s subsidized health insurance and Medicaid expansions, the law reduces funds available for both Medicare and Medicaid DSH expenditures.

Medicare

In the case of Medicare, the ACA (§3133) modified the DSH payment methodology beginning in FY 2014 to reduce by 75% the amount of DSH funds received on the basis of low income patients. Of the 75% of previous DSH payments that are withheld, funds are to be returned to hospitals, after adjustments for declines in the number of uninsured patients. In addition, for the first time, Medicare DSH funds (the remaining 75%, after adjustments for declines in uninsured patients) are to be distributed based on hospitals’ actual provision of uncompensated care in relation to the level of uncompensated care at all DSH hospitals throughout the country. Thus, the ACA’s Medicare DSH amendments not only reduced the amount of funding to be made available under DSH but also modified the DSH formula to most available funds directly on the provision of uncompensated care, on the assumption that tighter targeting would be justified as patients gained access to insurance through Medicaid and the Health Insurance Marketplace.

Medicaid

The ACA made similar, dramatic changes in Medicaid DSH. Under the Act, in 2014 annual state DSH allotments begin to drop significantly, on the theory that rising insurance coverage will dramatically reduce the need for direct financing to offset the cost of uncompensated care. The allotment adjustments equal $18.1 billion between FY 2014 and FY 2020, with the biggest reductions coming in later years.12 The ACA directs the HHS Secretary to implement these reductions by developing a DSH Health Reform Methodology (DHRM).

The Proposed Rules

The Centers for Medicare and Medicaid Services (CMS) issued proposed rules in May 2013 that would implement these broad Congressional directives.

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Medicare DSH NPRM

Under the proposed formula, beginning in FY 2014 and each year thereafter, a DSH hospital will receive two “separately calculated” payments in relation to its IPPS rate. (HHS notes in the NPRM that other special payments made to DSH hospitals, such as adjustments for capital costs, are not affected.) The first payment represents 25% of the hospital’s previous DSH payment. CMS terms this payment the “empirically justified Medicare DSH payment.” The second payment, reflecting uncompensated care, is to be determined by three separate factors:

- The first factor represents the difference between what would have been paid to hospitals under the old DSH formula and what will be paid under the new system (the 75% figure);
- The second factor is reduction in the percentage of nonelderly persons who are uninsured, using a complex formula to calculate changes in the uninsured over time; and
- The third factor represents each hospital’s share of all of the uncompensated care furnished by all Medicare DSH hospitals for that time period.

CMS notes that under the ACA, there is neither judicial nor administrative review of the new estimates flowing from the new formula.

Which hospitals will qualify for new DSH payments?

Under the NPRM, in order to qualify for an uncompensated care payment, hospitals must (1) qualify as DSH hospitals and (2) be eligible for an “empirically justified Medicare DSH payment in the year in which an uncompensated care payment is received.” This means that the uncompensated care funds are not generally available to all hospitals but are tightly targeted on Medicare DSH hospitals that qualify for empirically justified payments. The NPRM would extend the new payment system to Puerto Rico and modify the payment system used for sole community hospitals. But CMS proposes to exclude Maryland hospitals from the new payment system because, according to the agency, Maryland’s hospitals operate under a special all-payer rate system and are paid under a separate provision of the Medicare statute. The NPRM indicates that the new DSH payment methodology will apply to hospitals participating in payment bundling demonstrations but not to hospitals participating in the Department’s Rural Community Hospital Demonstration, which pays hospitals using a separate methodology.

The uncompensated care payment methodology

The most significant element of the NPRM undoubtedly is the new methodology for determining the uncompensated care factor-based payment to DSH hospitals that qualify for the payment. The NPRM

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14 Id.
15 Id.
16 Id.
17 Id. at 27580.
18 Id. at 27580-27581.
19 Id.
spells out the data that CMS will use to calculate the amount of “empirically justified DSH payments” as well as the new uncompensated care pool. CMS proposes to eliminate from the payment calculation – and thus from the total uncompensated care pool – payments that are made to hospitals proposed to be excluded from the new system.

In terms of the second factor (reduction in the uninsured), CMS explains how it intends to make the necessary adjustments. The agency states that because the statute requires consideration of the nonelderly population without exclusion, it proposes to use an estimation methodology that takes into account all uninsured U.S. residents regardless of their legal status (unauthorized immigrants in CMS parlance). Estimates of the uninsured, as well as the number of persons with health insurance, will be tied to CBO projections.

For the third and final factor (each DSH hospital’s proportion of the total amount of uncompensated care furnished by DSH hospitals), CMS proposes to focus on hospitals’ uninsured costs as well as their share of SSI and Medicaid patient care. In addition, CMS proposes to distinguish between true charity care and bad debt. A separate issue arises in connection with how to classify Medicaid, where uncompensated care is concerned. CMS notes that even though Medicaid payments may be low, it is common for hospitals to negotiate deep discounts in third party payments, and thus the fact of Medicaid’s deep discounting should not be understood as uncompensated care. At the same time, CMS points out, to not recognize Medicaid discounts as a form of hospitals’ uncompensated care costs (as is the case under the Internal Revenue Code policies governing the obligations of non-profit hospitals, which recognizes Medicaid losses as a form of uncompensated care) would potentially serve as a disincentive to expand Medicaid. CMS thus proposes an uncompensated care methodology that continues to focus, in great part, not on actually uncompensated care involving the uninsured, but also on the costs associated with treating low income patients, who may be publicly insured. The effect of this proposal is to recognize the activities of hospitals that not only treat a greater proportion of uninsured patients but that also more extensively participate in Medicaid.

**Medicaid**

CMS proposes to create a temporary formula for 2014 and 2015 only, since reliable data on the impact of the Medicaid expansion will not be available until 2016. In other words, the Medicaid expansion choices made by states in 2014 and 2015 are not taken into account, essentially because their impact cannot be measured. As a result, the $1.1 billion in slated DSH reductions in 2014 and 2015 will not capture the short term impact of states’ Medicaid expansion decisions. Also, the NPRM specifies separate pools for low DSH states (states whose annual DSH expenditures range between 0% and 3% of annual Medicaid expenditures) and high DSH states.

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20 Id. at 27583.
21 Id. at 27584.
22 Id. at 27585-25588.
23 Id. at 28553-28554.
In creating the 2014-2015 state DSH reduction methodology, the proposed rule takes into account the five statutory factors specified by Congress: (1) Low DSH states (that is, states whose DSH allotments are relatively small) receive smaller reductions; (2) states with the lowest percentage of uninsured residents receive larger reductions; (3) states that do not target their DSH payments to hospitals with the highest proportions of Medicaid patients receive larger reductions; (4) states that do not target their DSH funds to hospitals with the highest proportion of uncompensated care receive larger reductions; and (5) states that had used DSH to increase coverage under a §1115 demonstration as of July 31, 2009 and that had adjusted their DSH payments accordingly, will have these adjustments taken into account in the new DSH formula.

Under the DHRM, CMS proposes to distribute DSH allocations using a formula that gives one-third weight to the uninsured portion of the formula, and another third to the targeting factors (i.e., targeting on hospitals with high levels of uninsured and Medicaid patients). Finally, the proposed rule contains protections for states that had adjusted their DSH payments to help support the cost of expanded coverage under their §1115 demonstrations.

The proposed rule in essence attempts to mitigate the effects of non-Medicaid-expansion in the wake of *NFIB v Sebelius*, by avoiding changes that would penalize states that had enacted the expansions by essentially reducing their DSH allotments in anticipation of greater insurance coverage. This decision comes against the backdrop of a recommendation by President Obama to delay the scheduled Medicaid DSH reductions by two years, as well as legislation introduced by Representative John Lewis (D-GA) to delay the DSH reductions (H.R. 1920, The DSH Reduction Relief Act).

Table 1 of the NPRM shows each state’s reduction amount and reduced allotment under the proposed formula, as well as whether a state is a high or low DSH state. The dollar reductions for high DSH states range from $22 million in Vermont to $1.644 billion in New York. Among low DSH states, the reductions range from $238,000 in Wyoming to $100 million in Wisconsin.

### Issues

*Will the Medicare DSH formula result in more true charity care?* For the first time, the Medicare DSH program will allocate the majority of its funds based on uncompensated care factors, although the formula itself proposed by CMS also will continue to weigh the payments made to DSH hospitals in relation to their care for low income patients. Because CMS proposes to distinguish between losses attributable to charity care (discounts given to patients at the time treatment is rendered rather after debt collection efforts have been mounted), will hospitals be more likely to develop clearer charity care policies? Note that also under the ACA, hospitals that are nonprofit and that seek tax-exempt status must maintain clear financial assistance policies and face new limits in the amounts that they can charge uninsured patients. Our prior Implementation Briefs on ACA [requirements for tax-exempt hospitals](https://www.healthreformgps.org), as well as [implementing regulations](https://www.healthreformgps.org), explain these new policies. Whether the two policies in combination – more stringent financial assistance policies for uninsured patients, coupled with a better targeting of Medicare DSH funding to care for which no payment is expected – will in fact incentivize stronger uncompensated care policies at hospitals will be an important issue to watch.

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24 *Id.* at 28560.
The temporary Medicaid DSH formula. Given the absence of data on the impact of Medicaid expansions adopted in 2014, it makes sense that adjustments related to reductions in uninsured patients would need to wait. Therefore, will a near-term windfall in the form of DSH payments for states that have enacted the Medicaid expansion ultimately incentivize the remaining states to expand Medicaid?

Medicaid losses. Both the Medicare DSH formula and the methods used by Treasury/IRS to calculate nonprofit hospitals’ “community benefit” expenditures allow hospitals to calculate discounts given to Medicaid programs as part of their uncompensated care/community benefit activities. This allowance incentivizes hospital participation in Medicaid but also enables hospitals to claim both Medicare uncompensated care DSH funds as well as community benefit credits for the deep discounts they provide to Medicaid. As CMS points out, hospitals routinely deeply discount their services to high volume purchasers. Should full credit, up to the reported cost of care, be given to Medicaid discounts?