MACPAC

Next Steps for MACPAC Work on Disproportionate Share Hospital Payments

Medicaid and CHIP Payment and Access Commission

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Overview

- Background on disproportionate share hospital (DSH) payments
- Statutory requirements for MACPAC DSH report
- Findings from MACPAC's 2016 DSH report
- Targeting questions to consider
- Data collection
- Policy approaches

Background

- Medicaid DSH payments help offset hospital uncompensated care costs for Medicaid and uninsured patients
- States are statutorily required to make DSH payments to hospitals that serve a high share of Medicaid or low-income patients
- DSH payments are limited by federal DSH allotments, which are scheduled to be reduced beginning in fiscal year 2018

Statutory Requirements

- MACPAC must report annually on DSH allotments and their relationship to three factors:
  - changes in the number of uninsured individuals
  - the amount and sources of hospitals' uncompensated care costs (broadly defined)
  - hospitals with high levels of uncompensated care that also provide essential community services
- In 2017, these data will be included in MACPAC's March report to Congress

2016 DSH Report to Congress

- MACPAC's first DSH report found little meaningful relationship between current DSH allotments and measures meant to identify those hospitals most in need
- The Commission concluded that DSH payments should be better targeted to the states and hospitals that both:
  - serve a disproportionate share of Medicaid and low-income patients, and
  - have disproportionate levels of uncompensated care

2016 DSH Report to Congress

- To help inform approaches to improve the targeting of DSH payments, the Commission recommended that HHS collect and report:
  - hospital-specific data on all types of Medicaid payments, and
  - data on the sources of non-federal share necessary to determine net payments at the provider level
- Despite the lack of complete data on Medicaid hospital payments, additional analyses of DSH targeting approaches are possible

DSH Targeting Questions

- Which hospitals serve a disproportionate share of Medicaid and low-income patients?
- Which hospitals have disproportionate levels of uncompensated care?
- Which hospitals meet both criteria?

Disproportionate Share of Medicaid and Low-Income Patients

- How should Medicaid and low-income utilization be measured?
- What minimum threshold of Medicaid or low-income utilization should DSH hospitals meet?
  - Currently a 1 percent Medicaid utilization threshold
  - Deemed DSH hospitals meet a higher standard
- Should Medicaid and low-income utilization thresholds be adjusted to account for state Medicaid expansion decisions?

Disproportionate Levels of Uncompensated Care

- How should uncompensated care be measured?
  - Current DSH definition includes Medicaid shortfall and unpaid costs of care for the uninsured (both charity care and bad debt)
- How much uncompensated care should DSH payments cover?
- Should DSH pay for uncompensated care costs that could be covered under a Medicaid expansion?

Additional Targeting Considerations

- How should DSH payments relate to regular Medicaid payment rates?
  - Hospitals with high Medicaid utilization do not necessarily have high levels of uncompensated care
- How should DSH payments relate to non-DSH supplemental payments?
- How should DSH payments relate to other sources of direct and indirect support for hospitals?
  - Medicare DSH payments
  - Community benefit requirements for non-profit hospitals

Data Collection

- Medicaid and low-income utilization
  - Refining estimates to account for individuals dually eligible for Medicare and Medicaid
- Uncompensated care
  - 2014 data are now available from Medicare cost reports
- Other sources of hospital financing
  - Compiling community benefit reports from non-profit hospitals
- Hospital profiles

Policy Approaches

- Changing the formula for distributing DSH allotment reductions
- Raising the minimum eligibility requirements for DSH hospitals
- Changing the Medicaid DSH definition of uncompensated care

Next Steps

- Fall of 2016: Preliminary analyses
- December 2016: Draft report
- March 2017: Final report

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