April 13, 2023

Automatic Adjustments to Medicaid Disproportionate Share Hospital Allotments

Review of recommendations and draft chapter for June report

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Overview

- Background
- DSH policy analysis
  - Analyses of previous countercyclical DSH policies
  - DSH allotments during periods of normal economic growth
- Recommendations
- Next steps

Background

Background

- Limits to state DSH payments are set by federal allotments
  - Allotments vary widely by state and have little meaningful relationship to measures of need for DSH payments
  - Federal allotments are based on 1992 spending; annually increase by inflation
  - Limits to other Medicaid payments are set by total spending
- Each year, state FMAPs change based on state per capita income
  - FMAPs increase for states with declining per capita income and decrease for states with increasing per capita income relative to other states
  - Year-to-year changes are relatively small but they can grow over time
  - 15 states have FMAPs at the statutory minimum (50 percent) and so their FMAP can only go up if state per capita income decreases

Prior DSH Allotment Recommendations

- In 2019 the Commission made recommendations on how to structure DSH allotment reductions if they took effect
- Commission recommended that the reduction formula should improve the relationship between allotments and measures of need
  - Commission decided to use number of non-elderly low-income individuals as a measure of need because it is related to hospital uncompensated care and is not affected by state policy choices about whether to expand Medicaid
- Commission also made two recommendations to minimize disruptions to safety-net hospitals that rely on DSH payments:
  - Phasing in reductions gradually
  - Applying reductions to unspent allotments first

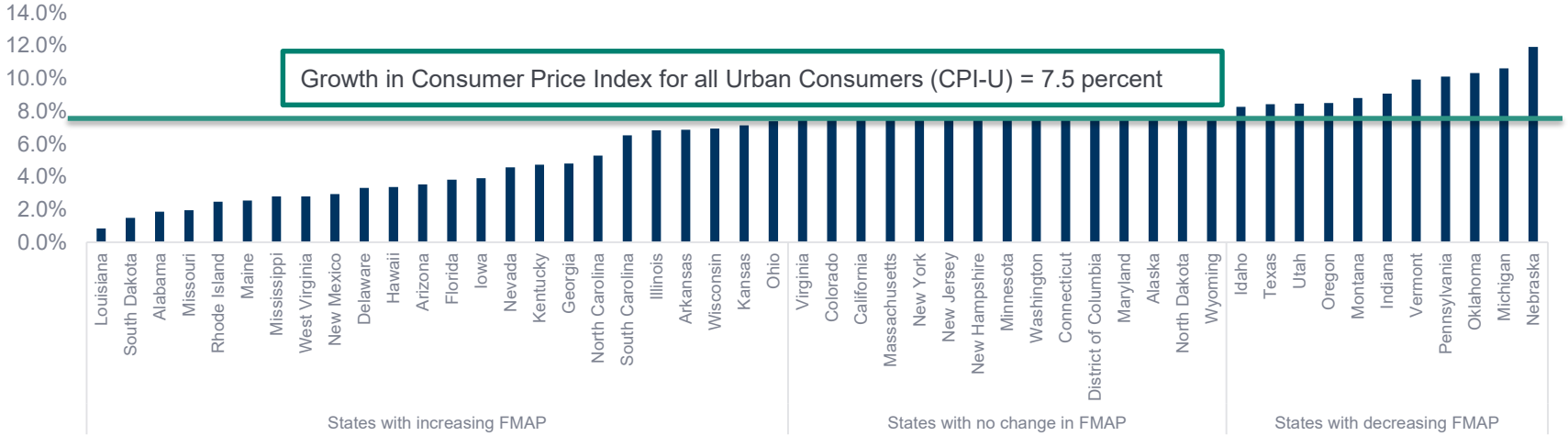
DSH Policy Analysis

Analysis of Prior Countercyclical DSH Policies

- Chapter reviews three prior countercyclical DSH policies
  - Increased federal allotment without FMAP change
  - Increased FMAP and allotment based on federal funding
  - Increased FMAP and allotment based on total funding
- Basing DSH allotments on total funding was preferred by stakeholders because it preserves DSH funding for providers, it supports states, and is relatively easy to implement
- Policy has different effects on states and providers depending on how states finance the non-federal share and decisions on whether to change other Medicaid payments

The Status Quo Results in Less Total DSH Funding for States with Increasing FMAPs

Percent Change in Total DSH Funding, FYs 2014–2019



Notes: DSH is disproportionate share hospital. FMAP is federal medical assistance percentage. Chart shows state and federal combined DSH funding percent growth between FY 2014 and 2019. Chart shows that states with increasing FMAPs between 2014 and 2019 had less total DSH funding growth when compared to states with decreasing FMAPs. The green line shows the rate inflation and total DSH funding growth under a permanent ARPA-like adjustment to DSH allotments between FY 2014 and 2019.
Source: MACPAC, 2023, analysis of Medicaid Budget and Expenditure System

Changes in DSH Funding With a Federal vs. Total Funding Basis, FY 2014-2019

Change in state FMAP	Number of states	Average percent change in federal DSH allotment		Average percent change in total available state and federal DSH funding	
		Allotment based on federal funding (Current law)	Allotment based on total funding (Proposed recommendation)	Allotment based on federal funding (Current law)	Allotment based on total funding (Proposed recommendation)
Increased FMAP	24	7.5%	11.3%	3.9%	7.5%
Decreased FMAP	11	7.5%	5.8%	9.3%	7.5%
No change to FMAP	15	7.5%	7.5%	7.5%	7.5%

Notes: FY is fiscal year. DSH is disproportionate share hospital. FMAP is federal medical assistance percentage. Under current law, DSH allotments are based on federal funding and the federal allotment grows with inflation. MACPAC's proposed recommendation would change the basis of allotments to state and federal funding, and the total funding allotment would grow with inflation. Under either policy, states must provide non-federal funding in order to spend all available state and federal DSH funds. Number of states includes the District of Columbia and excludes Tennessee which did not have a DSH allotment in FY 2014 because its allotment is set in statute under Section 1923(f) of the Social Security Act.

Source: MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

Proposed Recommendations

Proposed Recommendation 1

- In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

Rationale

- Updates MACPAC's 2019 DSH recommendation language to reflect changing the calculation of DSH allotments to a total funding basis
  - Aligning DSH allotments with measures of need is a long-standing Commission goal
  - The number of non-elderly low-income individuals in a state is correlated with state levels of uncompensated care
- Proposed recommendation order reflects the Commission's view that rebasing DSH allotments on measures of need is most important

Implications

- Federal government
  - No expected change in federal spending
- States
  - States with high levels of DSH funding per non-elderly low-income individuals would receive greater reductions compared to states with low levels of DSH funding per non-elderly low-income individuals
- Enrollees
  - Difficult to predict; depends on residency and how states respond to DSH payment reductions
- Providers
  - Difficult to predict; reductions would depend on which state the provider is located

Proposed Recommendation 2

- Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.

Rationale

- Under current law, states with increasing FMAPs because of declining per-capita income receive less DSH funding
  - States with increasing FMAPs also likely have growing rates of low-income individuals, a potential measure of need for DSH payments
- This policy also negatively affects all states when Congress increases the FMAP due to an economic recession, or other disruptive events
- Stakeholders preferred this policy approach when it was implemented during the pandemic because it preserved funding for DSH hospitals and was easy for states to implement

Implications

- Federal government
  - Congressional budget office (CBO) does not project a change in federal spending during periods of normal economic growth
  - During an economic recessions, or other disruptive events that leads to FMAP increases, federal spending would increase proportional to the FMAP increase
- States
  - States with increasing FMAPs would receive more federal support, while states with decreasing FMAPs would receive less federal support
- Enrollees
  - No direct effect; indirect effect of maintaining access to DSH hospitals by preventing reductions in DSH funding when the FMAP increases
- Providers
  - Providers would see the same amount of DSH funding even when the state's FMAP changes

Proposed Recommendation 3

- Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:
  - An eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - An upper bound of 100 percent on adjusted matching rates;
  - An increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
  - An exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).

Rationale

- Updates 2021 MACPAC recommendation that Congress adopt a countercyclical financing mechanism modeled on the prototype model developed by the Government Accountability Office (GAO)
  - GAO model uses objective and timely indicators of an economic downturn which would have been triggered during the last four recessions
  - Previous recommendation excluded DSH from a countercyclical FMAP increase because of concerns that total available funding would decline
- Including DSH allotments within the model would ensure that DSH funding is preserved when an economic recession is triggered

Implications

- Federal government
  - CBO projects federal spending will increase $10 billion in FY 2024 and $70 billion from FY 2023-2033
  - DSH provision accounts for 1.1 percent of the $70 billion estimate
  - Estimate is higher than 2021 recommendation because of an increase likelihood of recession
- States
  - Policy would provide a fiscal stimulus to states with greater financial support being sent to states with greatest need
- Enrollees
  - Maintenance of effort requirement would ensure that states have funds and an incentive to support recession-induced increased enrollment
- Providers
  - Availability of a predictable source of funding would help states delay or avoid provider payment cuts due to declines in state resources
  - DSH funding for DSH hospitals would be preserved when the FMAP is increased

Proposed Recommendation 4

- To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare and Medicaid Services (CMS) compare DSH allotments to total state Medicaid assistance expenditures in a given year before finalizing DSH allotments for that year.

Rationale

- Policy was put in place when DSH spending was 15 percent of Medicaid spending to slow DSH spending growth
  - DSH spending is now 3 percent of Medicaid spending
- This policy no longer has a practical effect on DSH allotment calculations
- Removing this requirement would finalize DSH allotments in a timelier manner and would encourage states to send out DSH payments faster without fear of payment recoupments
  - Payments to DSH hospitals would still be recouped if they exceed a hospital's uncompensated care

Implications

- Federal government
  - No effect on federal spending because no state is near the existing limit
  - Reduce administrative burden for CMS in finalizing DSH allotments
- States
  - Greater certainty over total DSH funding; DSH payments could be sent in a timelier manner
- Enrollees
  - No direct effect on enrollees
- Providers
  - DSH hospitals could receive payments in a timelier manner

Next Steps

- Chapter will be included in the Commission's June 2023 report
- Vote on recommendations on Friday

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