State Disproportionate Share Hospital (DSH) Allotment Reductions

On May 15, 2013, the Centers for Medicare and Medicaid Services published a proposed rule in the Federal Register describing the Disproportionate Share Hospital (DSH) payment reductions required by Section 2551 of the Affordable Care Act (ACA). This proposed rule contains a 60 day comment period and comments will be accepted through July 12, 2013.

ACA Changes

DSH payments are made by the federal government to states and states then allocate these payments to hospitals that serve a high volume of Medicaid patients and/or have a high volume of uncompensated care. The ACA mandates annual reductions in national aggregate DSH payments to the states for the years from 2014 to 2020. The unreduced federal allotment for 2014 is $11.7 billion and as required by the ACA, the unreduced amount for each year must be reduced on a national aggregate basis by the below amounts.

Federal Fiscal Year	Federal Reduction Amount
2014	$500,000,000
2015	$600,000,000
2016	$600,000,000
2017	$1,800,000,000
2018	$5,000,000,000
2019	$5,600,000,000
2020	$4,000,000,000

Proposed Rule

The proposed rule describes how these mandated reductions will be allocated among states for 2014 and 2015. States are still responsible for developing their own methodology for distributing DSH reductions. The preamble to the rule indicates that CMS will publish additional guidance on how the DSH reductions will be allocated post 2015 and indicates that reductions post 2015 will take into account data on the impact of the 2014 and 2015 reductions.

Reduction Allocation Methodology

The proposed DSH reduction methodology will not take into account states' decisions around implementing the Medicaid Expansion. The rule provides 10 steps that include the ACA identified 5 DSH reduction factors to calculate each states reduced DSH allocation for 2014 and 2015. Initially, states are divided into low-DSH and non-low DSH states and then these state groupings have 3 reduction factors applied with equal weight: the Uninsured Percentage factor, the High Medicaid Inpatient Volume factor and the High Uncompensated Care factor. The final DSH reduction factor, the 1115 Budget Neutrality factor applies to states with 1115 budget neutrality agreements that currently reduce their DSH. This

factor excludes DSH included as part of an 1115 budget neutrality agreement for a coverage expansion from any reduction calculations.

Factor 1: Low DSH Adjustment Factor (LDF)

The first factor that will be accounted for is the LDF. States categorized as low DSH states have historically received lower DSH allotments relative to total Medicaid expenditures than other states. In total there are 17 states[i] that qualify as low DSH states. Low DSH states and non-low DSH states are grouped separately when applying the remaining DSH reduction factors.

A greater proportion of the aggregate DSH reduction will be borne by non-low DSH states. The method of allocation of the reduction between Low and non-low DSH states is described in the proposed rule and is effectively a ratio (mean DSH in low-DSH states divided by mean DSH in high DSH states). In the proposed rule's current estimates low DSH states will experience, on aggregate, a 1.2% reduction in DSH for 2014 and a non-low DSH states will experience a 4.42% reduction.

Factor 2- Uninsured Percentage Factor (UPF)

One third of total DSH reduction will be assigned to the UPF. After the annual ACA mandated DSH reduction is allocated between low DSH and non-low DSH states, for each group one third of that amount will be assigned to the UPF and then allocated among the states in the respective group. Within the state groupings, states with more uninsured individuals will be subject to a lower DSH reduction and states with fewer uninsured individuals will be subject to higher DSH reductions. This factor is weighted by projected DSH allocation before reduction to ensure larger and smaller states are treated equally under this reduction factor. For each state in the group the weighted UPF factor would be applied to the total DSH reduction for the state group allocated to this factor and the resulting dollar amount would be the state specific DSH reduction due the UPF.

The proposed rule clarifies that to the uninsured percentage for each state will be based on the most recent 1-year estimates of uninsured reported by the Census Bureau through the American Community Survey (ACS). It is unclear what year the most-current 1-year estimates will be based on for 2014, but it is possible the most recent available data will be the 2012 ACS release based on 2011 data.

Factor 3- High Volume of Medicaid Inpatients Factor (HMF)

One third of total DSH reduction will be assigned to the HMF. After the annual ACA mandated DSH reduction is allocated between low DSH and non-low DSH states, for each group one third of that amount will be assigned to HMF. States that target DSH payments to hospitals with high volumes of Medicaid patients will receive a lesser reduction in DSH than states that do not target DSH payments to these hospitals. To help to calculate the HMF, states must submit to CMS data on the Medicaid Inpatient Utilization Rate (MIUR). For each state, the HMF is a state specific percentage determined by dividing the total state payments to non-high Medicaid volume hospitals by the aggregate sum of these payments in the state group. To reach the state specific DSH reduction due to HMF, this state specific HMF percentage is applied to the total DSH reduction allocated to each state group for this factor. A

state that pays DSH solely to high volume Medicaid hospitals would experience no DSH reduction from the application of this factor.

Factor 4- High Level of Uncompensated Care Factor (HUF)

One third of total DSH reduction will be assigned to the HUF. After the annual ACA mandated DSH reduction is allocated between low DSH and non-low DSH states, for each group one third of that amount will be assigned to HUF. For the purposes of the DSH reduction, hospitals within a state that exceed the mean ratio of uncompensated care costs are considered to have a high level of uncompensated care. Uncompensated care costs are defined in the proposed rule as a hospital specific ratio of total uncompensated care cost divided by the sum of total Medicaid cost and total uninsured cost. To calculate the HUF, first a weighted mean of state DSH hospitals uncompensated care cost (using the above definition) is determined. The uncompensated care level does not include bad debt such as uncollected copayments, coinsurance, or deductibles for those that have third party insurance. In each state, all hospitals that meet or exceed the mean uncompensated care level are considered high uncompensated care hospitals. To calculate the HUF, the percentage of payments each state makes to hospitals below the mean uncompensated care level out of the total payments made to such hospitals in the state group is calculated. This percentage is applied to the total DSH reduction allocated to this factor in the state group to reach the state specific DSH reduction due to HUF.

The proposed rule indicates that the calculation of this factor is expected to change in 2016 as more data becomes available. Currently, there are problems with the measure and it is intended in the future to include total hospital cost in place of total Medicaid and uninsured cost in the calculation of the high uncompensated care factor. The rule notes that as proposed this measure does not accurately reflect uncompensated care.

Reduction Factor 5- Section 1115 Budget Neutrality Factor (BNF)

The final DSH reduction factor is the BNF. DSH included in budget neutrality calculations for coverage expansions is excluded from the DSH reduction methodology. However, DSH included in budget neutrality for non-coverage expansion purposes would be include in the DSH reduction methodology.

Considerations

Each of the reduction factors interact with one another and it is possible that a state with a higher rate of uninsured individuals that does not target DSH payments to high volume Medicaid inpatients or high uncompensated care hospitals may be subject to a greater DSH reduction than a state with a lower rate of uninsured that targets these hospitals.

New Information Collection Requirement

To support the DSH reduction allocation, states will be required to submit information that is used to determine which hospitals are disproportionate share hospitals. This information submission will include the states mean Medicaid Inpatient Utilization Rate (MIUR) and the value of one standard

deviation above the mean MIUR. For states that do not submit the standard deviation data CMS will assume that the states MIUR standard deviation equals the highest standard deviation in the state group. Not submitting the data as request may have the effect of excluding some hospitals as disproportionate share hospitals with a high volume of Medicaid inpatients and may increase the state's DSH reduction.

Next Steps

Comments are accepted on this proposed rule through July 12, 2013. CMS requested comment on numerous provisions of the proposed rule including modifications to the methodology for 2016 and beyond, comments on readily available data sources that may improve the DSH reduction methodology, on the weighting for the reduction factors and how the current weighting may impact specific hospital types, and comments on the high uncompensated care factor.

States may want to comment on provisions of the rule including the weighting and/or calculation of the DSH reduction factors. For example, states that have decided not to expand Medicaid stand to benefit from a higher weighting for the Uninsured Percentage Factor in comparison to the High Volume of Medicaid Inpatient Factor and the High Level of Uncompensated Care Factor.

Additionally, the weighting of High Volume of Medicaid Inpatient Factor and the High Level of Uncompensated Care Factor relative to the state's uninsured rate reflects a more prescriptive approach than has been taken in the past, in which states were afforded flexibility as long as the DSH allocation methodology was consistent with Section 1923(c) of the Act. For example, rural hospitals that have not been designated critical access hospitals often struggle financially due to a lower patient base. The current methodology in some states, which provides additional support to such facilities, may be penalized under the proposed regulations.

Further, states will want to examine their current DSH reduction methodology to determine if, based on the proposed allocation of reductions, modifications to the current methodology could be possible to reduce a state's effective DSH reduction.

[i] Low DSH states include: AK, AZ, DE, HI, IA, MN, MT, NE, NM, ND, OK, OR, SD, UT, WI, WY