FACTSHEET

Medicare DSH

THE ISSUE

The Medicare Disproportionate Share Hospital (DSH) program has, since its inception in the 1980s, provided vital financial support to hospitals that serve the nation's most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and underinsured. Congress legislated these additional payments to partially address the financial burden on hospitals serving a disproportionately high percentage of low-income and uninsured patients.

Because the Affordable Care Act (ACA) was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress deemed it appropriate to cut Medicare DSH payments to hospitals, reasoning that hospitals would care for fewer uninsured patients as health coverage is expanded. Specifically, the ACA reduces Medicare DSH payments by $22.1 billion from fiscal year (FY) 2014 through FY 2019. However, with the uncertainty of the new marketplaces and Medicaid expansion, the promise of health care coverage improvements may not be realized for some years to come.

AHA POSITION

The AHA supports legislation that will mitigate the DSH cuts to allow for coverage expansions to be more fully realized.

WHY?

- **The Supreme Court decision on the ACA's Medicaid expansion will result in fewer covered individuals.** The Court's 2012 decision ruled that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. As of August 2015, 30 states and the District of Columbia are expanding their Medicaid programs. As a result, according to recent Congressional Budget Office (CBO) projections, the ACA will expand coverage to 26 million – rather than 32 million – individuals.

KEY FACTS

Even under the current levels of DSH funding, hospital costs for providing care to Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured are not fully met. Medicare on average covers only 88 cents of every dollar treating Medicare patients. And in 2013, hospitals provided $46 billion of uncompensated care.

Medicare DSH Facts

The ACA made changes to Medicare DSH payments beginning in FY 2014. Specifically, it requires that hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the traditional formula, with the remaining 75 percent flowing into a separate funding pool for Medicare DSH hospitals. This pool will be reduced as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

The Centers for Medicare & Medicaid Services (CMS) finalized its rules for implementing the new Medicare DSH policy in its FY 2014 inpatient prospective payment system (PPS).

Empirically justified DSH payments. CMS will distribute 25 percent of Medicare DSH funds in the exact manner in which Medicare DSH payments have historically been distributed: through a hospital-specific percentage add-on applied to the base diagnosis-related group (DRG) payment rates. Consequently, a hospital's DSH payments will be tied to its volume and mix of PPS cases. The add-on is determined by a formula that is calculated as the sum of two ratios: (1) Medicaid patient days as a share of total patient days; and (2) Medicare Supplemental Security Income (SSI) days as a percentage of total Medicare days.

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Uncompensated care DSH payments. CMS reduced the 75 percent pool by about $546 million in FY 2014. CMS continued these cuts in FY 2015 and decreased Medicare DSH payments by approximately $1.25 billion in FY 2015 compared to FY 2014; and in FY 2016 Medicare DSH payments were further reduced by $1.2 billion compared to FY 2015. In addition, the funds will be redistributed using inpatient days of Medicaid beneficiaries plus inpatient days of Medicare SSI beneficiaries as a proxy for measuring the amount of uncompensated care hospitals provide. CMS will distribute these payments on a per-discharge basis.

CMS considered using charity care, bad debt and other data from the hospital cost report worksheet S-10 to measure uncompensated care. However, due to concerns that the revised S-10 is relatively new and has not historically been used for payment purposes, the agency decided that its use was not appropriate at this time. The agency has indicated that it intends to propose introducing the use of S-10 data for purposes of calculating DSH payments in future rule making.