



VCU Medical Center

Office of Health Innovation

Proposed Rule: State Medicaid Disproportionate Share Hospital Allotment Reductions

Description: The statute, as amended by the Affordable Care Act, requires aggregate reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments annually from fiscal year (FY) 2014 through FY 2020. This proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement the annual reductions for FY 2014 and FY 2015.

Background

The Affordable Care Act requires annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. The aggregate annual reduction amounts are:

- \$500,000,000 for FY 2014;
- \$600,000,000 for FY 2015;
- \$600,000,000 for FY 2016;
- \$1,800,000,000 for FY 2017;
- \$5,000,000,000 for FY 2018;
- \$5,600,000,000 for FY 2019; and
- \$4,000,000,000 for FY 2020.

PPACA directs the Secretary to implement the annual DSH allotment reductions using a DSH Health Reform Methodology (DHRM). Section 1923(f)(7)(B) establishes the following five factors that must be considered in the development of the DHRM. The methodology must:

- Impose a smaller percentage reduction on low DSH States;
- Impose larger percentage reductions on states that have the lowest percentages of uninsured individuals during the most recent year for which such data are available;
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients;
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care; and
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

Major Provisions

To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount would be applied to the unreduced DSH allotment amount for its respective state. The unreduced allotment would serve as the base amount for each state to which the state-specific DSH allotment reduction amount would apply annually.

The proposed DHRM utilizes available data and a series of interacting calculations that result in the identification of state-specific reduction amounts that, when summed, equal the aggregate DSH allotment reduction amount identified by the statute for each applicable year. The proposed DHRM accomplishes this through the following summarized steps:

1. Separate states into two state groups, non-low DSH states and low-DSH states.
2. Proportionately allocate aggregate DSH funding reductions to each of these two state groups based on each state group's total unreduced DSH allotment amount.
3. Apply a Low DSH State Percentage Reduction Factor to adjust each state group's DSH funding reduction amount while maintaining the combined aggregate DSH funding reduction.
4. Divide each state group's DSH allotment reduction amount among three statutorily identified factors, the Uninsured Percentage Factor (UPF), the High Level of Uncompensated Care Factor (HUF), and the High Volume of Medicaid Inpatients Factor (HMF).
5. For each state group, determine state-specific DSH allotment reduction amounts relating to the Uninsured Percentage Factor.
6. For each state group, determine state-specific DSH allotment reduction amounts relating to the High Level of Uncompensated Care Factor.
7. For each state group, determine state-specific DSH allotment reduction amounts relating to the High Volume of Medicaid Inpatients Factor.
8. Apply a section 1115 Budget Neutrality Factor for each qualifying state.
9. Identify the state-specific DSH allotment reduction amount.
10. Subtract each state's state-specific DSH allotment reduction amount from each state's unreduced DSH allotment.

Factor 1 – Low DSH Adjustment Factor (LDF)

The first factor considered in the proposed DHRM is the Low DSH Adjustment Factor identified at section 1923(f)(7)(B)(ii) of the Act, which requires that the DHRM impose a smaller percentage reduction on "low DSH states". To qualify as a low DSH state, total expenditures under the state plan for DSH payments for FY 2000, as reported to us as of August 31, 2003, had to have been greater than zero but less than 3 percent of the state's total Medicaid state plan expenditures during the FY.

The factor is calculated and applied as follows:

1. Separate states into two groups, non-low DSH states and low-DSH states.
2. Divide each state's unreduced preliminary DSH allotment for the year for which the reduction is calculated by estimated Medicaid service expenditures for that same year.
3. For each state group, calculate the non-weighted mean of the value calculated in step 2 for states in the group.
4. Divide the average calculated in step 3 for the low DSH state group by the average calculated in step 3 for the non-low DSH state group.
5. Convert this number to a percentage. This percentage is the LDF.

6. Multiply the proportionately allocated DSH funding reductions for the low- DSH state group by the LDF percentage to determine the aggregate DSH reduction amount that would be distributed across the low DSH state group.
7. Subtract the aggregate DSH reduction amount determined in step 6 from the proportionately allocated DSH funding reduction for the low-DSH state group, and add the remainder to the aggregate DSH reduction amount that would be distributed across the non-low DSH state group.

Factor 2 – Uninsured Percentage Factor (UPF)

The second factor considered in the proposed DHRM is the Uninsured Percentage Factor (UPF) identified at section 1923(f)(7)(B)(i)(I) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that have the lowest percentages of uninsured individuals.

To determine the percentage of uninsured individuals in each state, the proposed DHRM relies on the total population and uninsured population as identified in the most recent “1-year estimates” data available from the ACS conducted by the Census Bureau. CMS will utilize the most recent ACS data available at the time of the calculation of the annual DSH allotment reduction amounts.

The proposed UPF is determined separately for each state group (low DSH and non-low DSH) as follows:

1. Uninsured Value – Using Bureau of Census data, calculate each state’s uninsured value by dividing the total state population by the uninsured in the state.
2. Uninsured Allocation Component – Determine the relative uninsured value for each state compared to other states in the state group by dividing the value in step one by the state group total of step one values. The result should be a percentage, and the total of the percentages for all states in the state group should total 100 percent.
3. Allocation Weighting Factor – To ensure that larger and smaller states are given fair weight in the final UPF, divide each state’s preliminary unreduced DSH allotment by the sum of all unreduced preliminary DSH allotments in the respective state group to obtain allocation weighting factor, expressed as a percentage. The sum of all weighting factors should equal 100 percent. Then, take this percentage for each state and multiply it by the state’s uninsured allocation component determined in step 2. The result is the allocation weighting factor.
4. For each state group, divide each state’s allocation weighting factor by the sum of all allocation weighting factors. The resulting percentage is the UPF.

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

The third factor considered in the proposed DHRM is the High Volume of Medicaid Inpatients Factor (HMF) identified at section 1923(f)(7)(B)(i)(II)(aa) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that do not target DSH payments to hospitals with the highest volumes of Medicaid inpatients.

States that have been, and continue to, target a large percentage of their DSH payments to hospitals that are federally deemed as a DSH based on their MIUR would receive the lowest reduction amounts relative to their total spending. States that target the largest amounts of DSH payments to hospitals that are not federally deemed based on MIUR would receive larger reduction amounts under this factor.

The proposed HMF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as follows:

1. For each state, classify each disproportionate share hospital that has an MIUR at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state as a High Medicaid Volume hospital.
2. For each state, determine the amount of DSH payments to non-High Medicaid Volume DSH hospitals. This data element should come from the most recently submitted and accepted DSH audit template.
3. For each state, determine a percentage by dividing the state's total DSH payments made to non-High Medicaid Volume hospitals by the aggregate amount of DSH payments made to non-High Medicaid Volume hospitals for the entire state group.
4. The result of step 3 is the HMF.

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

The fourth factor considered in the DHRM is the HUF identified at section 1923(f)(7)(B)(i)(II)(bb) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that do not target DSH payments on hospitals with high levels of uncompensated care. Each state must develop a methodology to compute this hospital-specific limit for each DSH hospital in the state.

Any hospital that exceeds the mean ratio of uncompensated care costs to total Medicaid and uninsured inpatient and outpatient hospital service costs within its state is considered a hospital with a high level of uncompensated care. The following data elements are used in the HUF calculation:

- The preliminary unreduced DSH allotment for each state;
- DSH hospital payment amounts reported for each DSH in accordance with §447.299(c)(17);
- Uncompensated care cost amounts reported for each DSH in accordance with §447.299(c)(16);
- Total Medicaid cost amounts reported for each DSH in accordance with §447.299(c)(10); and
- Total uninsured cost amounts reported for each DSH in accordance with §447.299(c)(14).

The HUF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as follows:

1. Determine each disproportionate share hospital's Uncompensated Care Level by dividing its uncompensated care cost by the sum of its total Medicaid cost and its total uninsured cost.
2. For each state, calculate the weighted mean Uncompensated Care Level.

3. Identify all hospitals that meet or exceed the mean Uncompensated Care Level as High Uncompensated Care Level hospitals.
4. For each state, determine the amount of DSH payments to non-High Uncompensated Care Level hospitals.
5. For each state, determine a percentage by dividing the state's total DSH payments made to non-High Uncompensated Care Level hospitals by the aggregate amount of DSH payments made to non-High Uncompensated Care Level hospitals for the entire state group. The result is the HUF.

Factor 5 – Section 1115 Budget Neutrality Factor (BNF)

The statute requires that CMS take into account the extent to which a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009. Under an approved section 1115 demonstration, the states may have limited authority to make DSH payments under section 1923 of the Act because all or a portion of their DSH allotment was included in the budget neutrality calculation for a coverage expansion under an approved section 1115 demonstration or to fund uncompensated care pools and/or safety net care pools.

For states that include DSH allotment in budget neutrality calculations for coverage expansion under an approved section 1115 demonstration, CMS proposes to exclude from DSH allotment reduction, for the HMF and the HUF factors, the amount of DSH allotment that each state currently continues to divert specifically for coverage expansion in the budget neutrality calculation. Amounts of DSH allotment included in budget neutrality calculations for non-coverage expansion purposes under approved demonstrations would still be subject to reduction.

The proposed DHRM would take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation by excluding amounts diverted specifically for a coverage expansion and automatically assigning qualifying states an average reduction amount (based on the state group) for any DSH allotment diverted for non-coverage expansion purposes and any amounts diverted for coverage expansion if the section 1115 demonstration was or is approved after July 31, 2009.