Securing Our Safety Net: Protect the Medicaid Disproportionate Share Hospital Program

The Medicaid disproportionate share hospital (DSH) program supports our members in their mission to provide high-quality care to under-resourced patients. **The AAMC urges Congress to (1) delay or eliminate pending cuts to the Medicaid DSH program, and (2) address the consequences of Section 203.**

What is the Medicaid disproportionate share hospital (DSH) program?

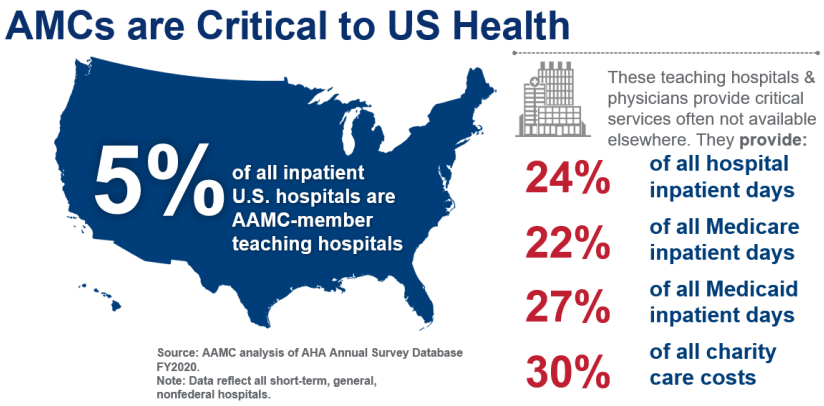
- Established in 1981, the **Medicaid DSH program** provides crucial financial support to hospitals that care for a disproportionate share of low-income patients, including Medicaid beneficiaries and the uninsured.
- These payments help to offset two types of uncompensated care: (1) the Medicaid shortfall, or the difference between the payment a hospital receives and the cost of providing care for a Medicaid beneficiary, and (2) unpaid cost of care for uninsured individuals.

How does the program work?

- Federal law requires state Medicaid programs to make DSH payments to qualifying hospitals that serve a disproportionate number of low-income patients.
- The amount of federal Medicaid DSH funds available to a state is fixed (this amount is referred to as the state's "DSH allotment"). To access this federal funding, a state must provide its own state matching funds at the same matching rate as regular Medicaid expenditures. Taken together, these federal and state funds comprise the total DSH payments available to each state.
- States have flexibility regarding how they distribute total DSH payments to individual hospitals. However, hospitals cannot receive DSH payments that exceed their uncompensated care costs (described above), which is referred to as the hospital-specific DSH limit, or "Medicaid DSH cap." In general, the Medicaid shortfall component of this cap is calculated as the difference between the costs of inpatient and outpatient hospital services provided to Medicaid-enrolled patients, minus payments received from Medicaid, and, in some cases, third-party payers (refer to: "What is Section 203 and why does it matter?").

Why is this program important to hospitals, patients, and communities?

- Medicaid does not adequately reimburse hospitals for the care they provide to enrollees, resulting in a financial shortfall.
- Although they comprise just 5% of all inpatient hospitals in the U.S., AAMC-member teaching hospitals account for 27% of all Medicaid inpatient days and 30% of hospital charity care costs.[1]
- In FY 2020, AAMC members reported a Medicaid shortfall of $8.67 billion.[2]



- Academic medical centers currently face profound financial challenges, including historic workforce shortages, supply chain disruptions, and unprecedented growth in labor costs and other expenses. The Medicaid DSH program is more important than ever in ensuring that

[1] Source: AAMC analysis of AHA Annual Survey Database, FY 2020.
[2] Source: Centers for Medicare and Medicaid Services, Hospital Cost Reporting Information System (HCRIS) Database, FY2018-FY2020 released September 30 of each associated year. AAMC Membership data, March 2023.

AAMC-member institutions can continue to fulfill their missions and care for all patients, regardless of their ability to pay.

How did the Affordable Care Act impact the Medicaid DSH program?

- The Affordable Care Act (ACA) included **significant cuts** to the Medicaid DSH program under the assumption that an expansion of coverage would reduce hospitals' uncompensated care costs and need for supplemental Medicaid DSH payments.
- This assumption has not materialized: Since the ACA's enactment, while unpaid costs of care for uninsured individuals have declined, hospitals have seen financial losses associated with Medicaid patients swell. Between FY 2018 and 2020, AAMC-member teaching hospitals reported a 46.3% increase in their Medicaid shortfall.[3]
- These Medicaid DSH cuts, which were originally scheduled for fiscal years 2014-2020, have been legislatively delayed several times since the law's enactment. Most recently, Congress eliminated the FY 2021 cuts and delayed the remaining cuts in the Consolidated Appropriations Act, 2021 (P.L. 116-260).
- Due to the delays, under current law, Medicaid DSH allotments are scheduled to be reduced by $8 billion annually in FY 2024 through FY 2027, effective Oct. 1, 2023.

What is Section 203 and why does it matter?

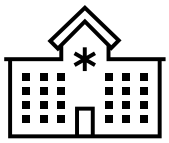
- Section 203 of the Consolidated Appropriations Act, 2021, which first took effect Oct. 1, 2021, enacted an important change in how hospitals calculate their Medicaid DSH cap.
- Under Sec. 203 hospitals are prohibited from accounting for uncompensated care delivered to individuals dually eligible for both Medicaid and a third-party coverage source when calculating their DSH cap. Under Section 203, hospitals may only count costs and payments associated with Medicaid-eligible individuals for whom Medicaid is the primary payer towards their DSH cap.
- There is a very narrow exception to this policy: Hospitals that fall in the 97th percentile with respect to the number of Medicare supplemental security income (SSI) days or Medicare SSI days as a percentage of total inpatient days. These hospitals may continue to use the prior method of calculating their Medicaid shortfall, which is defined by CMS to include all costs and payments associated with Medicaid patients, including third-party payments.
- Section 203 will negatively impact many safety-net hospitals, and in particular, those that care for a high volume of individuals dually eligible for both Medicare and Medicaid. In many cases, the reimbursement a hospital receives from both Medicaid and the third-party payer does not approach the total cost of care, particularly as Medicare margins have become increasingly negative.

How does Section 203 work in practice?

- In the below example, Hospital A qualifies for the 97th percentile exemption, and therefore, may use the pre-Sec. 203 methodology to calculate their Medicaid DSH cap.
- By comparison, Hospital B does not qualify for the exemption, and thus, cannot account for costs and payments associated with patients eligible for both Medicaid and a third-party payer source towards their DSH cap.
- **Despite their identical financial circumstances, Hospital B's Medicaid DSH cap is $20 million lower than Hospital A's under Section 203.**

[3] Source: Centers for Medicare and Medicaid Services, Hospital Cost Reporting Information System (HCRIS) Database, FY2018-FY2020 released September 30 of each associated year. AAMC Membership data, March 2023.

The Impact of Sec. 203 on Medicaid DSH Cap Calculation: *An Illustrative Example*



Hospital A: Qualifies for 97th Percentile Exemption

Hospital B: Does **Not** Qualify for 97th Percentile Exemption

	Hospital A	**Hospital B**
Costs for Uninsured	$25	$25
Costs for Medicaid Enrollees*	$100	$100
Costs for Medicaid Enrollees with Third-Party Coverage	$50	$50
Total Costs	**$175**	**$125**
Payments for Uninsured (i.e., Self-Pay)	$5	$5
Payments for Medicaid Enrollees*	$70	$70
Payments for Medicaid Enrollees with Third-Party Coverage	$30	$30
Total Payments	**$105**	**$75**
Hospital Medicaid DSH Cap (i.e., Total Costs Minus Payments)	**$70**	**$50**

Note: Costs and payments are represented in terms of millions. Numbers highlighted in green are included in the final Medicaid DSH cap calculation, whereas those highlighted in red are excluded from the final tabulation.

*Medicaid enrollees for whom Medicaid is the primary payer

For questions or more information, please contact Len Marquez, Senior Director of Government Relations & Legislative Advocacy, lmarquez@aamc.org, or Sinead Hunt, Legislative Analyst sihunt@aamc.org.