GNYHA POSITION PAPER

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MEDICAID DSH

The Medicaid disproportionate share hospital (DSH) program provides payments to safety net hospitals that serve a high proportion of Medicaid beneficiaries and uninsured patients. These essential payments help safety net hospitals partially offset their uncompensated care costs from treating low-income patients. Because DSH hospitals usually have a low percentage of commercially insured patients, they cannot "cost shift" these losses to private insurance companies.

The amount of Federal DSH funds a state can receive is limited by state-specific allotments established nearly 30 years ago. These allotments are updated annually by the Bureau of Labor Statistics' Consumer Price Index. Of the $13.4 billion in Federal Medicaid DSH funding allotted nationally in Federal fiscal year (FY) 2022, New York State's allocation was approximately $2 billion.

As with regular Medicaid payments, states must provide local funds (the percentages vary by state) to receive Federal DSH funds. While states have flexibility in determining the distribution of DSH funding to individual hospitals, the Federal government caps the amount of DSH funding that individual hospitals can receive at their "DSH cap"—their losses from treating Medicaid patients and the uninsured.

Hospital Uncompensated Care Trends

The Affordable Care Act (ACA) cut Federal Medicaid DSH funding under the assumption that fewer uninsured Americans would result in hospitals providing less uncompensated care—but that has not happened. From 2013 to 2019, New York DSH hospitals' total uncompensated care losses increased by $3.3 billion. In 2019, New York DSH hospitals reported losing nearly $6.7 billion from treating Medicaid patients, representing 82% of their total reported uncompensated care for Medicaid DSH purposes (i.e., losses from treating Medicaid and uninsured patients).

Congress must maintain Medicaid DSH funding at its current levels to subsidize these losses.

How the ACA Impacted Medicaid DSH

Since the ACA's enactment, Congress has legislatively delayed, restructured, or eliminated Medicaid DSH cuts that were originally scheduled to occur from FY 2014 through FY 2020. Congress most recently eliminated the FY 2024 cut and delayed the remaining cuts in the Consolidated Appropriations Act, 2024 (CAA). Under current law, the $8 billion annual cuts are scheduled to start on January 1, 2025, and continue at this level through FY 2027.

The ACA requires the Centers for Medicare & Medicaid Services (CMS) to develop a methodology

to reduce Federal Medicaid DSH allotments by the above-specified amount each year. The largest reductions are imposed on the states with the lowest percentage of uninsured individuals and those that do not target their DSH payments to hospitals with high volumes of Medicaid patients and uncompensated care. Smaller reductions are imposed on low-DSH states (defined as states with total DSH payments of between zero and 3% of total Medicaid spending).

To give a sense of magnitude, under an FY 2017 CMS rule to allocate Medicaid DSH reductions among states, New York alone would absorb an untenable $1.8 billion cut—17% of the national reduction.

Safety Net Hospitals Are Already Financially Distressed

Hospitals and other health care providers continue to experience enormous financial pressure after the COVID-19 pandemic. Worsening workforce shortages and rising labor and supply costs have accelerated a decades-long crisis that has severely strained many New York hospitals.

New York State has approximately 30 voluntary hospitals receiving extraordinary State subsidies because of their high Medicaid payer mix and/or precarious financial position, with many public and other voluntary hospitals also experiencing severe financial distress. The Medicaid DSH cuts could force some of New York's struggling public and voluntary safety net hospitals to reduce services or even close their doors for good.

Congress should eliminate the Medicaid DSH cuts for at least two years. DSH funding at its current level is essential to ensuring that financially struggling safety net hospitals can continue to serve low-income individuals and vulnerable communities.

DSH Cap Calculation Should Include Medicaid Shortfalls from Dual-Eligible Patients

The Federal government freezes the amount of DSH funding that individual hospitals can receive at their "DSH cap" (see above). The Consolidated Appropriations Act of 2021 changed the methodology for calculating the hospital-specific DSH limit to include only costs and payments associated with Medicaid-eligible individuals where Medicaid is the primary payer. The new calculation excludes Medicaid shortfalls from services provided to Medicaid-eligible beneficiaries who are dually eligible for Medicare or other coverage. This DSH cap policy, which went into effect earlier this year, will eventually reduce New York hospitals' Medicaid DSH caps by an estimated 25% retroactive to October 1, 2021.

Hospitals typically operate at a loss for dual-eligible patients. Medicare margins have become increasingly negative, and in some cases, hospitals receive no payments from Medicaid. The new DSH cap calculation will exacerbate safety net hospitals' financial challenges and could disrupt access to care for an extremely vulnerable patient population.

GNYHA strongly supports the Save Our Safety Net Hospitals Act (H.R. 9351), which would amend the CAA's DSH cap policy by allowing hospitals to include in their DSH cap calculation Medicaid shortfalls from Medicare dual-eligible patients and individuals dually covered by an "applicable plan" (i.e., liability insurance, no-fault insurance, or workers' compensation laws or plans).

GNYHA Position: GNYHA strongly urges Congress to 1) further delay the Medicaid DSH cuts for at least two years, and 2) pass H.R. 9351 to allow hospitals to include in their DSH cap calculation Medicaid shortfalls from Medicare dual-eligible patients and individuals dually covered by an "applicable plan."