Brookings paper misses the point on Medicaid DSH cuts included in BBBA

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A white paper (https://www.brookings.edu/essay/how-would-filling-the-medicaid-coverage-gap-affect-hospital-finances/?utm_source=BenchmarkEmail&utm_campaign=November_04_2021_Email&utm_medium=email) from the USC-Brookings Schaeffer Initiative for Health Policy on a provision in the draft Build Back Better Act (BBBA) takes serious shortcuts and overlooks how certain provisions fit into a broader, much more complex set of payment policies. Its conclusion – that hospitals would see a financial "windfall" – is flawed on several levels. To draw such a bold and flip conclusion about a massively complicated matrix of coverage and payment using strung-together data and faulty assumptions is irresponsible.

While the AHA supports addressing the Medicaid coverage gap, we believe that all of the related BBBA provisions affecting hospital payment should be weighed systematically and in terms of real-world outcomes. It's critical to acknowledge that disproportionate share hospital (DSH) payments are intended to provide support beyond just uncompensated care for the uninsured. They also address significant shortfalls for hospitals that disproportionately care for the Medicaid population, as well as preserve hospital financial stability. The hospitals and health systems serving these historically marginalized, medically-

complex and low-income populations are inarguably under reimbursed. In that context, the USC-Brookings Schaeffer analysis quickly falls apart under scrutiny. The fact is that the Medicaid DSH program and uncompensated care pool reductions are a cut to hospitals and health systems and their ability to care for patients.

First, the analysis mentions only in passing the billions in reductions to the federal DSH program and the uncompensated care pools contained in other provisions of the draft BBBA. And while these new DSH cuts would continue on into perpetuity, the coverage gains are temporary. Further, by focusing on impacts only in the aggregate, the analysis ignores that coverage gains would not correspond directly to the DSH cuts. This means a subset of already financially vulnerable providers would carry the bulk of the weight of the reductions. That hardly sounds like a “windfall.”

The analysis does correctly note that the resulting crowd-out of employer-sponsored insurance would result in very real financial losses to hospitals given the lack of incentives for employers to retain coverage. Yet serious questions go unaddressed in this analysis about the anticipated coverage gains in non-expansions states. There is significant uncertainty about whether coverage take-up will be as high in these states as it was in states that were early adopters of expansion for a number of reasons, however. For instance, early adoption states amplified federal outreach and enrollment efforts with their own; it remains to be seen whether these states will engage in or amplify federal efforts in the same way.

The analysis also uses a number of methodological shortcuts to arrive at its unrealistically high estimate of financial impact. For example, fairly specific payment data from the Medicaid and CHIP Payment and Access Commission are misinterpreted and overgeneralized. The author also ignores the fact that the Medicare cost report uncompensated care data includes bad debt. Bad debt is increasingly driven by unpaid amounts from high deductible health plans, many of which are employer sponsored insurance and will remain in place despite these new coverage expansions.

Further, the paper essentially waves a magic-wand to assume immediate, full implementation. It assumes the newly eligible will quickly enroll in coverage and access care in 2023. But history has taught us that coverage expansions take time. When the Affordable Care Act coverage expansions and DSH cuts were rolled out in 2014, uncompensated care did not drop all at once; in fact, it began to trend back up within several years (https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost). These cuts to hospitals, however, would be certain, immediate and directly on the heels of massive upheaval in the U.S. health care system as a result of the COVID-19 pandemic.

Cutting hospitals as a penalty on states that opted not to expand Medicaid is shortsighted, especially during this challenging time. Before this effort, Congress repeatedly deferred cutting funding to these critical hospitals even where expansion was in effect. The simple reality is that nearly 30 million individuals remain uninsured despite the substantial gains in coverage over the past decade. Congress has repeatedly recognized that the need for DSH and other payments for hospitals serving low-income and often high-need patients persists. And now, these same hospitals are operating in a context of historic losses

(https://www.aha.org/news/headline/2021-09-21-report-projects-us-hospitals-will-lose-least-54b-net-income-year) as a result of the COVID-19 pandemic, with many of the states targeted by this cut being among the hardest hit by the delta surge (https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9).

These cuts would penalize the very hospitals that have been providing critical care to their communities at their greatest time of need; that consistently serve high proportions of Medicaid and uninsured patients; and that have spent years ensuring that their uninsured patients get enrolled in Medicaid when eligible and even advocating for expanding coverage within their states.

We support expanding coverage to the uninsured, but it should not come at the expense of the hospitals serving our most historically marginalized communities.

Aaron Wesolowski is AHA's vice president for policy research, analytics and strategy.

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