COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

"INVESTING IN AMERICA'S HEALTH CARE"

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TESTIMONY OF THOMAS R. BARKER, J.D.

Madame Chairwoman Eshoo, Dr. Burgess, and members of the Subcommittee:

I. INTRODUCTION

Thank you for the opportunity to appear before the Subcommittee today. Thirty-eight years ago this week, I started my first job on Capitol Hill, as an intern, in this building. I could have never imagined, as I was walking into the Rayburn Building from the Capitol South Metro that morning, that I would one day have the honor of appearing before this Committee, so thank you for this opportunity.

I would like to clarify at the outset that although I was recently appointed to MACPAC, I am not appearing today on behalf of the Commission. Rather, I am speaking to you today as a health care lawyer with many years' experience representing both the government (as the chief legal officer of CMS and HHS) and health care providers and payers in private practice, and as a former professor of health care law and policy at George Washington University and Suffolk University School of Law.

I understand that the Subcommittee is in the process of considering the various Medicaid extenders that must be addressed by Congress before the end of this fiscal year. I would like to focus on one extender in particular: the disproportionate share hospital cuts that were enacted as a part of the Patient Protection and Affordable Care Act, or the ACA, in 2010. I thought it might be helpful to provide a bit of perspective on the original policy behind DSH payments overall, changes that Congress made to DSH policy to curtail perceived financing abuses in the late 1980s and early 1990s, and the DSH cuts that were enacted in the ACA. I think it is important to understand that the ACA policy was not enacted in isolation; it was part of a decades-long history in addressing the situation of hospitals that treat low-income, uninsured, and Medicaid patients.

That history may be helpful to the Subcommittee as it moves forward with an extenders package. This year, the Subcommittee is called on to address the fact that, absent Congressional action this year, Medicaid DSH payments will be cut by $4 billion this year and $8 billion per year starting in 2021 through 2025. I understand that there is general consensus among members of the Committee that the full $4 billion cut should not take effect in 2020. I

hope that my testimony is helpful to the Committee as it considers an appropriate policy with regard to DSH payments.

A. HISTORY OF MEDICAID DSH POLICY

The original DSH policy in the Medicaid program was actually written in this room during the mark-up of the Omnibus Budget Reconciliation Act of 1981. At the time, Congress was trying to provide more flexibility to States in setting Medicaid payment rates to hospitals. Prior to OBRA'81, States were generally required to pay hospitals on a reasonable cost basis. Congress, the Reagan Administration and the Governors felt that States should have more flexibility to design payment policies in Medicaid and so repealed the reasonable cost requirement. At the same time, Congress was also concerned that giving States carte blanche authority to set Medicaid payment rates could result in under-paying some hospitals, so Congress included language instructing that States take into account the needs of what became known as disproportionate share hospitals.

As passed by the House, OBRA instructed States to "take into account the special costs of hospitals whose patients are disproportionately Medicaid eligible or without third party coverage."[1] The Senate modified this language slightly and instructed States to "take into … account the atypical costs incurred by hospitals which serve a disproportionate number of low income patients."[2] In other words, whereas the House focus was hospitals that treated a disproportionate number of Medicaid and uninsured patients, the Senate focus was more generally on hospitals that treated a disproportionate number of low income patients.

Ultimately, the Senate language prevailed in conference. However, the Conference Agreement went on to note that "public hospitals and teaching hospitals which serve a large Medicaid and low-income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these situations in developing their rates."[3] The statutory language implementing this statement of Congressional intent now requires that a State plan for medical assistance "take into account … the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[4]

B. CURTAILING THE USE OF PROVIDER TAXES AND DONATIONS TO OBTAIN THE STATE SHARE OF MEDICAL ASSISTANCE

Although Congress first imposed a DSH obligation on States in 1981, it wasn't until the Omnibus Budget Reconciliation Act of 1987 that the Congress imposed specific statutory

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[1] House of Representatives, Committee on the Budget, Conference Agreement to Accompany the Omnibus Budget Reconciliation Act of 1981, H. Rept. 97-208 (July 29, 1981) at 962.
[2] *Id*.
[3] *Id*.
[4] Social Security Act § 1902(a)(13)(A)(iv).

requirements that specified, with some precision, how States were required to implement the "take into account" requirement.[5] Congress specified a minimum threshold for the types of hospitals that States were required to designate as DSH.[6] Additionally, DSH payments do not count against a State's upper payment limit, thereby giving States more flexibility in developing a payment policy for DSH hospitals.[7]

This flexibility, however, created the opportunity for States to use provider taxes and donations that contained a hold-harmless feature to derive the State share of medical assistance expenditures. DSH expenditures exploded between fiscal year 1990, when the federal share of DSH funds was $1 billion, and 1992, when the federal share of DSH funds increased to $17.4 billion.[8] Because Congress felt that some of these financing techniques were abusive, it enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.[9] Under this statute, a State is only permitted to derive its share of medical assistance via the use of provider taxes that are broad-based, uniform, and that do not contain a hold-harmless feature.[10] The statute also imposed the first statewide limitation on DSH payments that was based on DSH payments made to a state in 1992.[11]

Shortly after Congress enacted the Provider Tax statute, it imposed an additional limitation on DSH payments. As part of the Omnibus Budget Reconciliation Act of 1993, Congress imposed a hospital-specific cap on DSH payments. Under the statute, DSH payments generally cannot exceed the costs that a hospital incurs in providing care to Medicaid patients and uninsured patients.[12] Several years later, as part of the Balanced Budget Act of 1997, Congress further curtailed DSH by imposing a specific, State-by-State cap on DSH payments in

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[5] Social Security Act § 1923.

[6] *Id*. at subsection (b)(1). In general, a State must designate at least two categories of hospitals as DSH: first, any hospital with a low-income utilization rate (a fraction that reflects, in part, the amount of uncompensated care provided by the hospital) of at least 25%. Subsection (b)(1)(A). Second, any hospital with a Medicaid inpatient utilization rate greater than one standard deviation from the mean Medicaid utilization rate of hospitals in the State must be designated as DSH. Subsection (b)(1)(B).

[7] 42 C.F.R. § 447.272(c)(2).

[8] Congressional Research Service, "Medicaid Disproportionate Share Hospital Payments" (June 17, 2016) at 2.

[9] Pub. L. No. 102-234, 102nd Cong., 1st Sess., 105 Stat. 1793 (Dec. 12, 1991). The main provisions of the statute are codified at section 1903(w) of the Social Security Act.

[10] Social Security Act § 1903(w)(3)(B),(C).

[11] Pub. L. No. 102-234, *supra* n. 9, 105 Stat. at 1799 – 1802.

[12] Omnibus Budget Reconciliation Act of 1993 § 13621(b)(1), Pub. L. No. 103-66, 107 Stat. 312, 630 – 31 (Aug. 10, 1993). This requirement is codified at section 1923(g) of the Social Security Act. CMS implementation of this requirement is currently subject to litigation in multiple United States Courts of Appeal.

statute.[13] Because these caps are trended forward by inflation, the total amount of federal funds allotted for DSH in 2019 is $12.6 billion.[14]

C. ENACTMENT OF THE ACA

By the time that President Obama signed the ACA into law in 2010, there was a clear, nearly thirty-year history of DSH payments to hospitals. Although Congress had initially intended to give States broad flexibility to design a DSH payment mechanism, that flexibility began to be curtailed in 1987. That history, combined with the belief that the ACA was expected to result in a reduction of the uninsured due to the then-mandatory Medicaid expansion[15] and the availability of tax credit subsidies for qualified health plans sold on an Exchange, led Congress to believe that a reduction in the DSH allotments was warranted.[16]

As initially enacted, the ACA called for a reduction in total DSH allotments of $500 million in 2014; $600 million in 2015 and 2016; $1.8 billion in 2017; $5 billion in 2018; $5.6 billion in 2019; and $4 billion in 2020.[17] Since the enactment of the ACA, Congress has amended the DSH reduction statute multiple times; under current law, as noted above, the aggregate reductions to the DSH allotments will begin in 2020 with a reduction of $4 billion, increasing to $8 billion in 2024 and 2025. The DSH allotments would then return to their regular statutorily-assigned level in 2026.

D. OPTIONS TO ADDRESS PENDING REDUCTIONS

Congress, of course, has many options available to it to address the pending reduction of $4 billion. It could further delay the reductions; it could simply repeal the reductions; or it could phase them in and develop a new policy. Of course, these decisions must be made in the context of the federal budget deficit and the overall impact of federal and state DSH policy on safety net hospitals.

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[13] Balanced Budget Act of 1997 § 4721, Pub. L. No. 105-33, 111 Stat. 251, 511 – 12 (Aug. 5, 1997). The DSH caps are codified at section 1923(f) of the Social Security Act.

[14] Medicaid and CHIP Payment Access Commission, "Improving the Structure of Disproportionate Share Hospital Allotment Reductions" at 4 (March, 2019) (hereafter, MACPAC DSH Recommendations).

[15] In 2012, the Supreme Court, in a 7 – 2 decision, held that the mandatory ACA Medicaid expansion was unconstitutional. *NFIB v. Sebelius*, 567 U.S. 519, 575 – 88 (2012).

[16] In addition to the reductions in the Medicaid DSH allotments, Congress also revised the Medicare DSH formula by holding back 75% of otherwise-payable Medicare DSH funds and re-distributing those funds based on a hospital's uncompensated care level. *See* Social Security Act § 1886(r)(2)(C).

[17] Health Care Education and Reconciliation Act, Pub. L. No. 111-152 § 1203(a)(2), 124 Stat. 1029, 1053 – 55 (March 31, 2010). The reductions were codified (and now appear, in their current form) in section 1923(f)(7) of the Social Security Act.

One option that Congress may wish to consider is adopting the recommendations that MACPAC proposed in March of this year. The MACPAC recommendations could be implemented on a budget neutral basis and phased in more gradually than scheduled under current law. The MACPAC recommendations contain three parts:

First, rather than applying a $4 billion reduction in 2020, the MACPAC recommendation would be a $2 billion reduction in 2020, $4 billion in 2021 (rather than $8 billion), $6 billion in 2022 (rather than $8 billion), and $8 billion per year in 2023 – 2029. Under current law, the DSH reductions end in 2025; under the MACPAC recommendations, they would extend for four additional years in order to achieve budget neutrality over the 10-year budget window.[18]

The second MACPAC recommendation would be to apply reductions to States with unspent DSH allotments before applying reductions to other States. Not all 50 States are using their full DSH allotments; under this recommendation, States with unspent DSH allotments would have their allotments reduced before reducing allotments to other States.

Finally, the third recommendation would be to direct CMS to revise the State-specific DSH caps to better align the relationship between the DSH allotments in a State and the number of low-income non-elderly individuals in that State (after adjusting for hospital costs, using the Medicare area wage index, in different geographic areas). The merit in this recommendation reflects the simple fact that the current DSH allotments relate back to the level of historic DSH spending in a particular State in the early 1990s. But that historic DSH spending may bear little or no relationship to the low-income non-elderly population in that State today. Revising the formula accordingly would better correspond to the original intent of the DSH program as enacted by Congress in 1981.

II. CONCLUSION

Madame Chairwoman, Dr. Burgess and members of the Subcommittee, thank you again for the opportunity to testify before you this morning. I would be pleased to make myself available to any of you or your staffs if you have any questions or would like further information.

[18] According to the Congressional Budget Office, the MACPAC proposal would actually achieve budgetary savings ranging from $1 - $5 billion over the period. MACPAC DSH Recommendations, *supra* n. 14, at 8.