SAFE Hospitals Act

State Accountability, Flexibility, and Equity for Hospitals Act
Senator Marco Rubio

Current Federal Law: Medicaid Disproportionate Share Hospital (DSH) payments, set almost 30 years ago, are capped at the federal level, and allocations of these payments varies widely between states. Each state's DSH allocation effectively controls the amount that state can draw-down in federal Medicaid DSH payments. Hospitals are eligible for Medicaid DSH funds as long as the hospital has at least 1 percent Medicaid utilization and has at least two obstetricians available to treat Medicaid patients (with some exceptions). Hospitals cannot receive more than 100 percent of their uncompensated care costs (charity care + losses on Medicaid) – known as the "hospital specific DSH cap."

Summary of the SAFE Hospitals Act: The bill would modify Medicaid DSH allocations to more accurately reflect the states' needs. It would do so by allocating each state's DSH portion based on the state's share of the total U.S. population earning less than 100 percent of the Federal Poverty Level (FPL). For example, if 7 percent of the country's population earning less than 100 percent of the FPL lives in Florida, then Florida would be allocated 7 percent of the total Medicaid DSH funding for the country. To ensure as little disruption as possible the new formula would phase in over 10 to 15 years. The bill also prioritizes funding for hospitals that provide the most care to Medicaid and low-income patients.

Inequity in Existing DSH Allotments: The Medicaid and CHIP Payment and Access Commission (MACPAC) has produced a series of annual reports analyzing the DSH program and state allotments. MACPAC has consistently found that little to no meaningful relationship exists between states' DSH allotments and each state's level of need, stating, "[a]s in previous years, the Commission continues to find no meaningful relationship between states' DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations."[1] Furthermore, MACPAC's March 2018 report found that current DSH allocations are predominantly based on each state's DSH spending in 1992, noting "[a]lthough Congress has made several incremental adjustments to these allotments, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 still have the smallest allotments."[2]

What the SAFE Hospitals Act Does:

- Gradually changes the DSH allocation formula so states' allocations are based on the number of low-income earners living in the state, as a percentage, of the total U.S. population earning less than 100 percent of the Federal Poverty Level (FPL).
- Prioritizes DSH funding to hospitals providing the most care to vulnerable patients, while providing states with the necessary flexibility to address the unique needs of hospitals in each state.
- Expands the definition of uncompensated care to include costs incurred by hospitals to provide certain outpatient physician and clinical services, which is a change recommended by MACPAC.[3]
- Allows states to reserve some of their DSH funding allocations to be used in future years in order to give hospitals more certainty or consistency in the amount of DSH funding they can expect when planning for the future.

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[1] Medicaid and CHIP Payment and Access Commission (MACPAC). March 2018. *Report to Congress on Medicaid and Chip*. p. xi.
[2] March 2018. *Report to Congress on Medicaid and Chip*. p. 64.
[3] MACPAC. March 2017. *Report to Congress on Medicaid and Chip*. p. 111.