Medicaid Issues: DSH and Per Capita Cap

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

1. **Savings through reduction in current allotments or change to new allotments at lower Federal funding levels?**

   Admin: Retain current allotments: Minimizes reallocation across states

   Coalition: Move to new allotments: More rational allocation of funding to states.

   Other: Transition to a new allotment system over a longer period of time, which lowers the reallocation.

2. **Which providers get the money?**

   Admin: Current eligible hospitals plus FQHCs and RHCs: More flexible for states.

   Coalition: Restricted to hospitals meeting certain criteria.

   Other: If there is a special FQHC pool or set-aside, then there is less of a need to allow these providers to get payments through this DSH program.

3. **Are there federal rules that determine payment minimums and maximums for providers?**

   Admin: Yes: Current law rules.

   Coalition: Yes: [need to check]

4. **What rules would apply during the transition period if there is one?**

5. **Retain the state contribution or move to a 100% Federal program?**

   Admin: Retain state share: More money for these facilities; does not create a differential incentive between medical assistance payments and DSH payments.

   Coalition: Retain state share: [not known]

   Other: 100% Federal: Many states are not contributing real state dollars to these facilities; would allow more Federal control over payments.

TRANSITIONAL FUNDING

6. **Should state targeting be done though adjustments to the general per capita cap and DSH policies, or through special pools?**

   Admin: Pools: Easier to direct to certain states for specific purposes.

   Coalition: Not addressed.

   Other: Adjust per capita cap and DSH: The differential growth rates for states could help target funding for particular states. The DSH reductions could be moderated for certain states to minimize their reduction. This way calls less attention to special treatment for states than do pools.

7. **How is funding allocated?**

8. **Are pools 100% Federal or subject the state matching payments? Are payments from this pool considered medical assistance or DSH and thus subject to those rules?**

   Admin: In the December 7 legislation, both pools were 100% Federally funded. The uncompensated care pool payments were subject to DSH payment regulations. The undocumented persons pool was considered a grant to states for medical services for certain persons.

   Coalition: NA

PER CAPITA CAP

9. **What base to the index should be used?**

   Admin: 5-yr. average nominal gross domestic product per person: this is counter-cyclical and will give states more during a recession

   Coalition: 3-yr. average CPI: reflects current inflation

   Other: Fixed index (e.g., 5%): will be easier to score

10. **Different index for different groups?**

    Admin: No: This creates differential incentives to cross-categorize

people like the disabled

Coalition:	Yes:	States can better managed cost growth of the elderly and administration

11. Different index for different states?

Admin:	No:	Formula fight
Coalition:	No:	[not known]
Other:	Yes:	Can mitigate the inequities in the base spending. NOTE: CBO has said that it will not score state-specific indices.

12. What is the base year?

Admin:	1995:	Most recent; fewer update factors before implementation
Coalition:	Rolling:	Keeps it current
Other:	1994:	Known at this point (1995 won't be available until February or March)

13. Are administrative costs included in the per capita or are they a separate "group"?

Admin:	Included:	Treated like an admin. load in a premium; allocated by expenditures for that group
Coalition:	Own group:	[not sure; may be easier to administer / monitor]

13. Should FQHC and RHC expenditures be excluded from the cap?

Admin:	Include	
Coalition:	Include	
Other:	Exclude:	There has been discussion of "set-asides" or a certain percentage or amount of funding dedicated to these facilities. If current FQHC and RHC payments are part of the per capita cap base, then an additional set-aside implies an intent to pay these facilities more than under baseline. It might make more sense to exclude these payments from the

cap and possibly cap them as their own group (like administrative costs under the Coalition proposal).

14. Should all Medicare premium and cost sharing expenditures be excluded from the cap or just the expenditures attributable to QMB-onlies (non-dual eligibles)?

Admin: Exclude all. This is consistent with the rationale that Federal payments for a program whose costs are determined by Federal Medicare policy should not be subject to limits.

Coalition: Exclude QMB-only expenditures:
This minimizes the distortion of the per capita that occurs when you take out some of the expenditures (Medicare service expenditures) for dual eligibles who remain in the denominator of the spending per beneficiary.

15. Should the 30% expansion rule be included?

Note: The way it is drafted, it could lead to coverage of groups that could otherwise be insured.