OVERVIEW OF THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM

Prepared by the Legislative Budget Board Staff

for the House Select Committee on

State Health Care Expenditures

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Disproportionate Share Hospital (DSH) Purpose

- The Omnibus Budget Reconciliation Act of 1981 allowed states to access additional federal funds to reimburse hospitals in the form of DSH payments.
- The Medicaid DSH program provides supplemental payments to hospitals that serve large numbers of Medicaid beneficiaries and low-income or uninsured patients.
- Hospitals receive DSH payments to offset the costs not covered by payments from Medicaid, third-party reimbursement, and patient revenue collections.

DSH Program Funding

- DSH payments have the same matching rate* as medical services (60.87% federal, 39.13% state in FFY 2004).
- DSH payments, however, differ from other Medicaid payments because DSH payments do not reimburse for any specific patient's services.
- Federal appropriations for each state, plus the amount of state or local matching funds needed to draw down the total amount of available federal funds, determines the size of Texas' DSH payments.
- DSH payments may not exceed 12% of total state Medicaid expenditures.

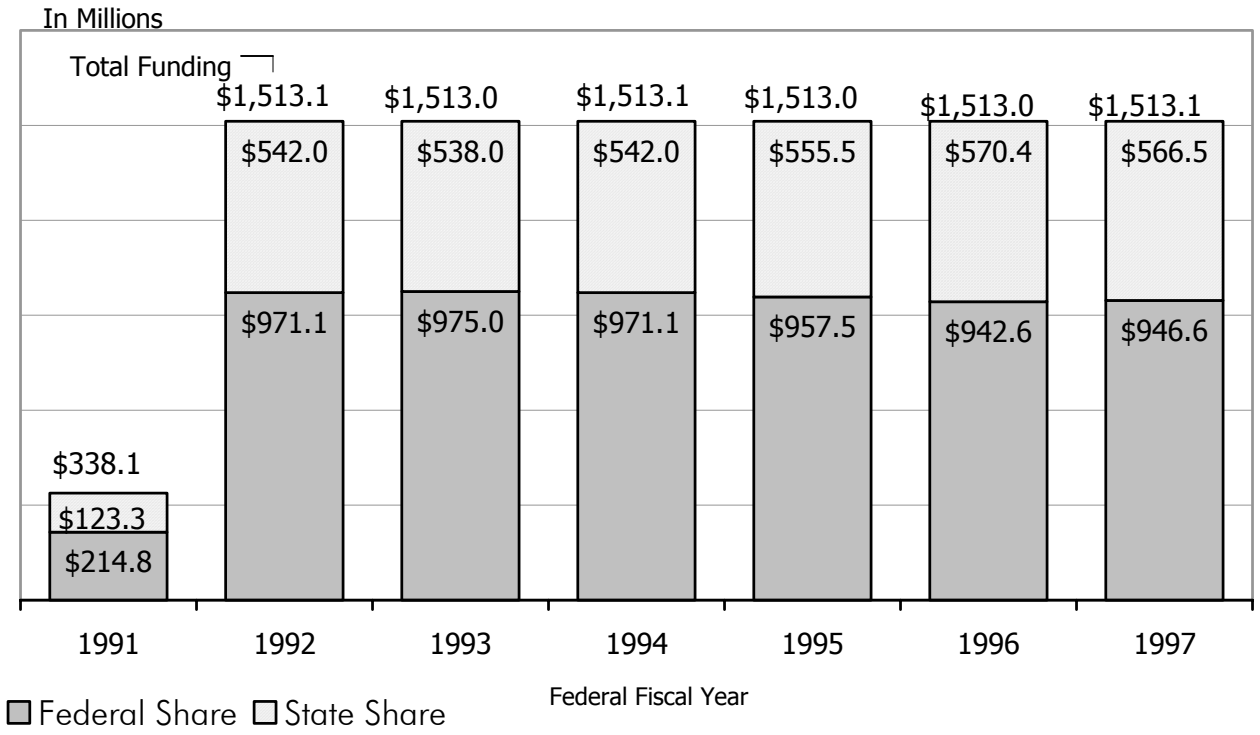
*Federal Medical Assistance Percentage, or FMAP, is based on a state's three-year average per capita income relative to the national per capita income. The enhanced FMAP related to state fiscal relief provisions does not apply to the DSH program.

DSH Program Implementation

- By the mid-1980s, very few states had implemented DSH programs.
- To increase states' participation in the DSH program, federal regulations were published in 1985 that allowed states to generate matching funds through provider taxes and donations.
- By 1992, 39 states had implemented provider taxes or provider donation programs.
- DSH payments increased nationally from $5.3 billion in FY 1991 to $17.5 billion in FY 1992.
- Texas' DSH program grew from $338.1 million (All Funds) in FY 1991 to $1.5 billion (All Funds) in FY 1992.

Texas DSH Program Funding

Figure 1
Texas Disproportionate Share Hospital Expenditures
Federal Fiscal Years 1991 - 1997



Sources: Centers for Medicare and Medicaid Services and Legislative Budget Board.

DSH Program Funding

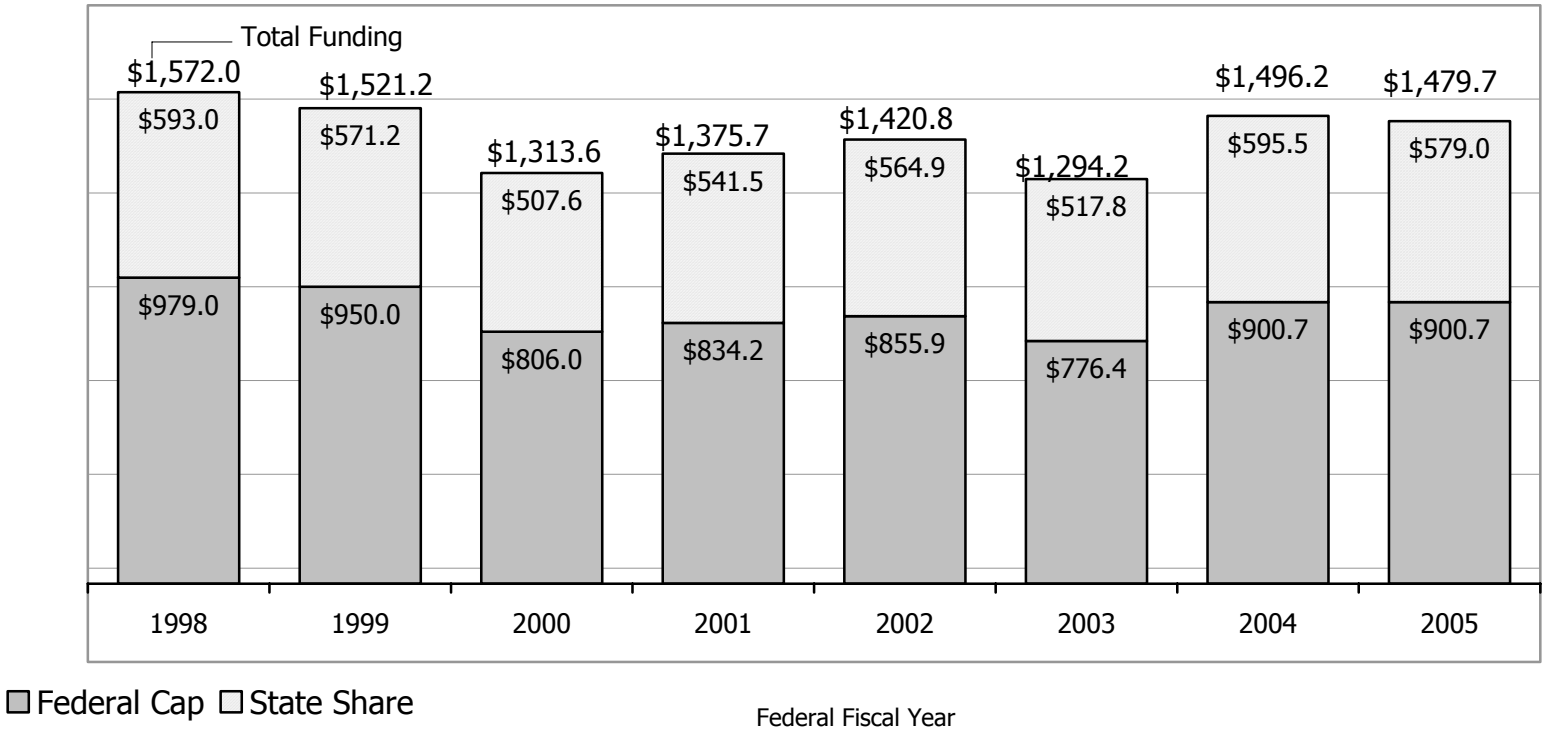
- Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 to curb the significant increase in DSH payments.
- As a result of a ban on provider donations and a cap on provider taxes, states turned to intergovernmental transfers (IGTs) as a revenue source to draw down federal funds under the DSH program.*
- Appropriations of General Revenue made to state-owned hospitals and mental health facilities are counted as match for the DSH program.
- Nine large-volume Medicaid public hospitals transfer local funds to the state to draw down DSH funds for local hospitals.

* IGTs are fund exchanges among or between different levels of government.

Texas DSH Program Funding

Figure 2
Texas Disproportionate Share Hospital Funding
Federal Fiscal Years 1998 - 2005

In Millions



Sources: Centers for Medicare and Medicaid Services and Legislative Budget Board.

DSH Program Funding

- DSH payments decreased beginning in 1999 as a result of the passage of the Balanced Budget Act (BBA) of 1997, which established new federal DSH allotments for FYs 1998-2002.
- Thereafter, state allotments would be the previous year's allocation adjusted by inflation.
- Congress later passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protections Act (BIPA) of 2000, which provided temporary relief to states by increasing state allotments for FY 2001 and FY 2002.
- For FY 2003, BIPA reverted state allocations to capped amounts in the BBA of 1997.

Recent DSH Federal Legislation

Legislative Budget Board

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

- Each state will receive a 16% increase over its FY 2003 DSH allotment.
- Thereafter, each state will continue to receive its FY 2004 allotment until it equals or no longer exceeds the allotment amount determined under the methodology of the BBA of 1997.
  - Texas will receive $900.7 million in DSH payments for FY 2004 (an increase of $124.2 million over FY 2003).
  - This annual allocation continues through FY 2010; beginning in FY 2011 this amount may be adjusted by inflation.
- State allotments will still be subject to the 12% cap.

DSH Hospital Criteria

- While Congress stipulates a minimum criteria, it provides flexibility to states to determine which hospitals are eligible for DSH funds and how these funds are distributed.
- There are qualifying criteria that determine whether a hospital receives a DSH payment.
  - Hospitals must have at least a 1% Medicaid utilization rate.*
  - Hospitals must have at least two physicians with staff privileges at the hospital, who have agreed to provide non-emergency obstetrical services to Medicaid clients.

* Medicaid Utilization Rate = the total number of inpatient days attributed to Medicaid patients divided by the hospital's total inpatient days.

DSH Federal Payment Limits

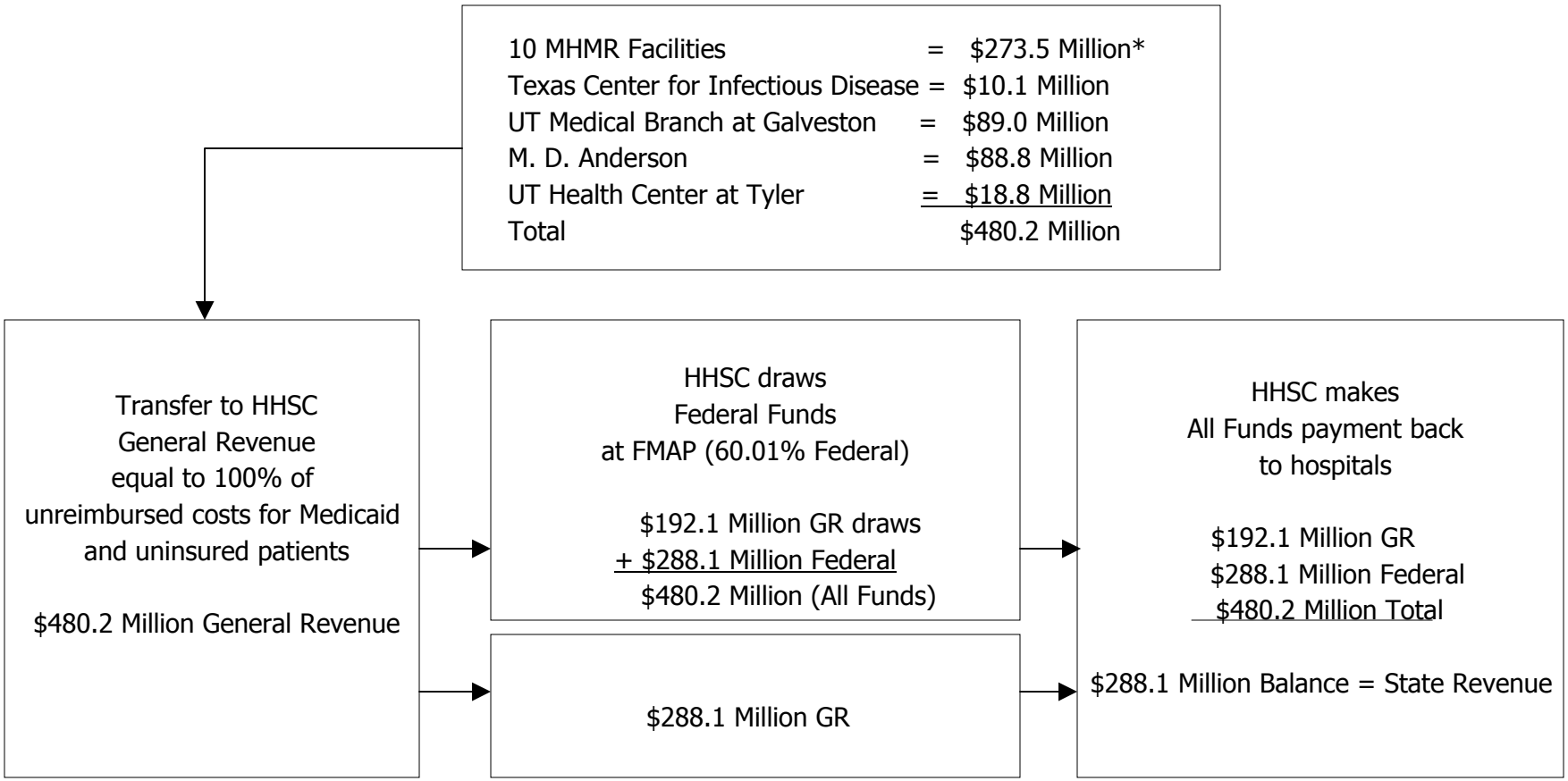
- Federal rules set out some payment limitations for DSH hospitals.
  - No hospital can receive a DSH payment that exceeds the hospital's unreimbursed costs of Medicaid and uninsured patients.
- Federal law sets a limit on DSH payments to mental health hospitals, which the federal government terms Institutions for Mental Disease (IMDs).
  - The IMD limit is the lessor of: (1) the state's total 1995 DSH amount for IMDs (All Funds) or (2) 33% of the state's DSH federal allotment.
  - Texas' IMD limit for FY 2003 was $250.2 million.

DSH Payments for State-owned Hospitals

- State-owned hospitals receive 100% of their unreimbursed costs for Medicaid or uninsured patients.
- If the payments to the state mental facilities would exceed the federal IMD limit, payments are adjusted proportionately to bring total IMD payments under the IMD limit.
- After the state-owned hospitals' payments are calculated, remaining DSH funds are available for payment to non-state DSH hospitals.

State-owned DSH Program

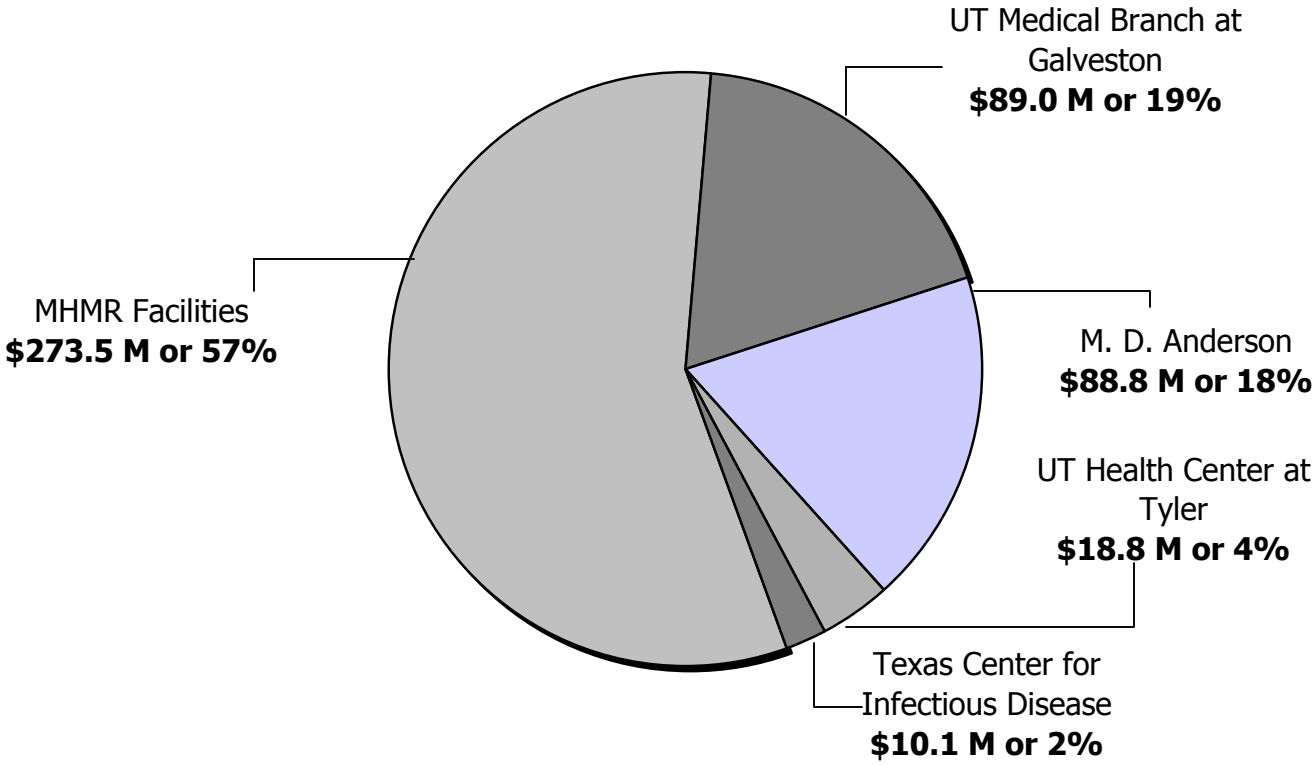
Figure 3
DSH State Transfers
Actual State Fiscal Year 2003 Amounts



*Note: SFY IMD amount exceeds FFY IMD limit due to payments based on 1 month of FFY 2002 and 11 months of FFY 2003.

Distribution of Texas State-owned Hospital DSH Funding

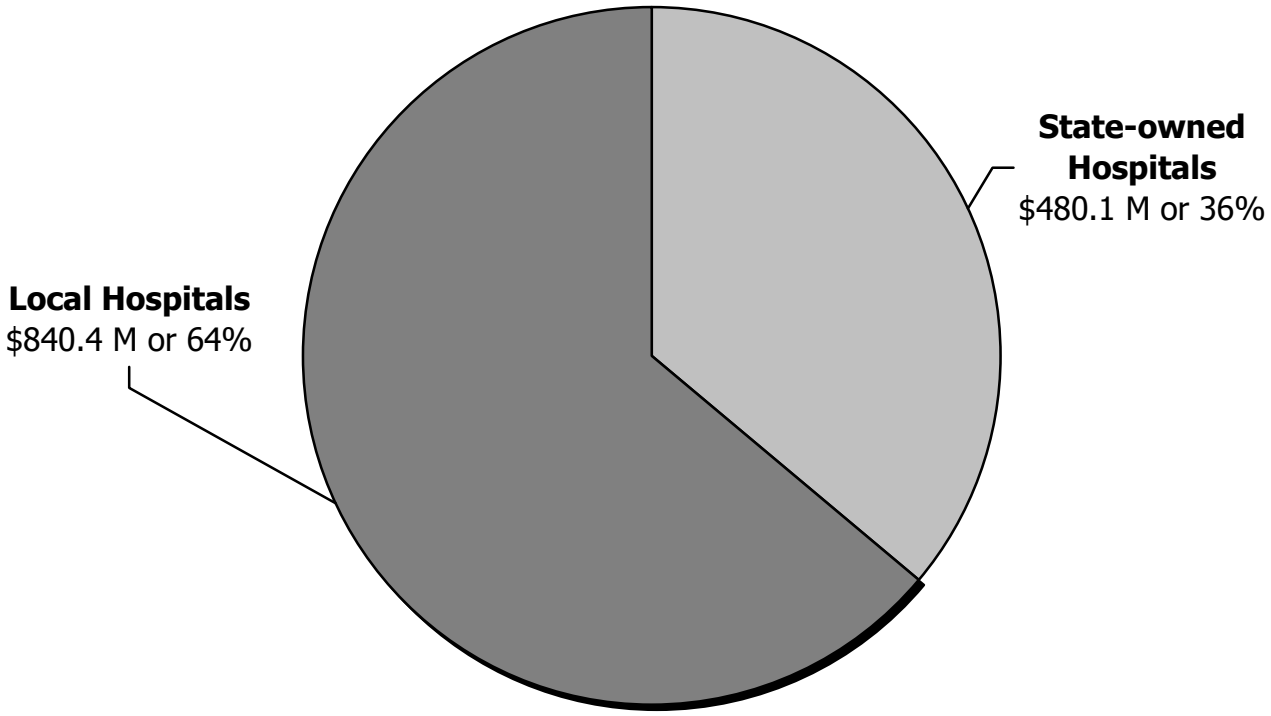
Figure 4
Distribution of Texas State-owned
Disproportionate Share Hospital Funding
State Fiscal Year 2003
Total = $480.1 M



Sources: Legislative Budget Board; Health and Human Services Commission.

Distribution of Texas DSH Funding

Figure 5
Distribution of Texas Disproportionate Share Hospital Funding
State Fiscal Year 2003
Total = $1,320.5 M



Sources: Legislative Budget Board; Health and Human Services Commission.

DSH Federal Legislation

Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991

- Banned provider donations.
- Capped provider taxes.
- Proposed provider tax criteria.
- Capped DSH payments at 1992 levels.
- Limited state DSH programs to to 12% of total Medicaid expenditures.

Omnibus Budget Reconciliation Act of 1993

- Limited participation to hospitals with at least a 1% Medicaid utilization rate.*
- Limited DSH payments to a hospital to no more than the un-reimbursed costs of Medicaid patients and low-income or uninsured patients.

* Medicaid Utilization Rate = the total number of inpatient days attributed to Medicaid patients divided by the hospital's total inpatient days.

DSH Federal Legislation

Balanced Budget Act (BBA) of 1997

- Established new federal DSH allotments to states for FYs 1998-2002. Thereafter, state allotments would be the previous year's allocation adjusted by inflation (subject to 12% cap).
- Imposed limitations on DSH payments to state mental hospitals.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protections Act (BIPA) of 2000

- Provided temporary relief to states by increasing state allotments for FY 2001 and FY 2002.
- For FY 2003, reverted state allocations to capped amounts in the BBA of 1997.
- Implemented reporting requirements.

DSH Federal Reporting Requirements

- States must submit:
  - An annual report that identifies:
    - Each DSH hospital that received a payment.
    - The amount each DSH hospital received.
  - An annual, independent certified audit that verifies:
    - Hospitals receiving DSH payments have reduced their uncompensated care costs to reflect DSH payments received.
    - The state compliance with limiting DSH payments to a hospital to no more than the unreimbursed costs of Medicaid patients and low-income or uninsured patients; the methodology used to calculate unreimbursed costs; and the records maintained by the state regarding claimed costs, expenditures and payments.