NATIONAL HEALTH POLICY
FORUM

THE BASICS

Medicaid Disproportionate Share Hospital (DSH) Payments

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Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. Medicaid DSH payments are the largest source of federal funding for uncompensated hospital care. It is expected that $11.3 billion of the projected $216 billion the federal government will spend on Medicaid in fiscal year (FY) 2009 will be for DSH payments.[1] States must make supplemental payments or adjustments to the payment rates of disproportionate share hospitals. These are in addition to the regular payments hospitals receive for providing inpatient care to Medicaid beneficiaries. While DSH-funded hospitals may receive payments from other state and local government funds, Medicaid is the largest source of public funding for many of them, especially public hospitals. Although federal Medicaid DSH funds are substantial in the aggregate, there are significant variations in the amount of federal funds each state receives and the payments states make to DSH hospitals.

FEDERAL DSH ALLOTMENTS

The federal government distributes federal DSH funds or allotments to each state based on a statutory formula.[2] (See Table 1, next page). The states, in turn, distribute their portion of the DSH funding among qualifying hospitals. States are to use their federal DSH allotments to help cover the costs of hospitals that provide care to low-income patients when those costs are not covered by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program, or other health insurance. Each state's federal allotment is capped at 12 percent of the state's total Medicaid benefits payments for the allotment year. States have up to two years to claim their DSH allotments.

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TABLE 1: Federal Medicaid DSH Allotments for FY 2009

	FY 2009 ($)		FY 2009 ($)
Alabama	$308,756,666	Montana	11,397,164*
Alaska	20,452,939*	Nebraska	28,413,868*
Arizona	101,663,780	Nevada	46,439,011
Arkansas	43,314,075*	New Hampshire	160,752,800
California	1,100,730,067	New Jersey	646,380,826
Colorado	92,878,022	New Mexico	20,452,939*
Connecticut	200,817,344	New York	1,612,814,294
Delaware	9,090,194*	North Carolina	296,205,582
District of Columbia	61,500,312	North Dakota	9,591,017*
Florida	200,817,344	Ohio	407,910,230
Georgia	269,848,306	Oklahoma	36,360,778*
Hawaii	10,000,000†	Oregon	45,450,973*
Idaho	16,504,676*	Pennsylvania	563,543,672
Illinois	215,878,645	Rhode Island	65,265,637
Indiana	214,623,536	South Carolina	328,838,401
Iowa	39,542,079*	South Dakota	11,089,783*
Kansas	41,418,577	Tennessee	305,451,928†
Kentucky	145,592,574	Texas	960,157,926
Louisiana	750,259,000	Utah	19,698,157*
Maine	105,429,106	Vermont	22,591,951
Maryland	76,561,612	Virginia	87,965,603
Massachusetts	306,246,450	Washington	185,756,043
Michigan	266,082,981	West Virginia	67,775,854
Minnesota	74,994,108*	Wisconsin	94,919,150*
Mississippi	153,123,225	Wyoming	227,254*
Missouri	475,686,084	**TOTAL**	**$11,337,262,543**

* *"Low DSH" states. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173) included special provisions in Title X, Section 1001, for the 16 states with DSH expenditures between 0 and 3 percent of total (state and federal) Medicaid spending in FY 2000, defined as low DSH states. The allotment for these states increased by 16 percent each year from FY 2004 through FY 2008, and by the Consumer Price Index-Urban (CPI-U) thereafter.*

† *Section 404 of the Tax Relief and Health Care Act of 2006 (P.L. 109-432) contained provisions permitting Tennessee and Hawaii to collect federal matching funds for payments to certain hospitals that served a high proportion of Medicaid beneficiaries and uninsured individuals during FY 2007. Previously, both Hawaii and Tennessee did not have separate DSH allotments because they had incorporated their allotments into their section 1115 Medicaid waiver programs. See* www.cbo.gov/ftpdocs/77xx/doc7714/hr6111pgo.pdf *for more details. After FY 2007, their allotments returned to $0.*

Sources: HHS.gov/Recovery, "Disproportionate Share Hospital," FY 2009, U.S. Department of Health and Human Services, available at www.hhs.gov/recovery/cms/dsh.html*; and Kaiser Family Foundation, "Federal Medicaid DSH Allotments," available at* www.statehealthfacts.org/comparetable.jsp?ind=185&cat=4.

QUALIFYING HOSPITALS AND HOSPITAL PAYMENTS

State Medicaid DSH programs and payments vary considerably. States have discretion to determine which hospitals get DSH payments and how much each of them receives. Each state must include in their Medicaid State Plan a description of the criteria used to designate hospitals as DSH hospitals and a definition of the formulas used to calculate the DSH payments.

States' definitions of a qualifying DSH hospital must include all hospitals meeting one of the statutory minimum criteria: (i) a Medicaid inpatient utilization rate[3] in excess of one standard deviation or more above the mean for all hospitals in the state, or (ii) a low-income utilization rate exceeding 25 percent. States may include other hospitals in their designation of DSH hospitals, as long as hospitals meeting the minimum criteria are included. Many states use an expanded definition of DSH, allowing additional hospitals to be designated as DSH. Some states, such as Wisconsin, designate only those hospitals that meet the minimum criteria, whereas others, such as New York, designate all or almost all hospitals. All designated DSH hospitals must have a Medicaid utilization rate of at least 1 percent.

The Medicaid statute requires states to pay DSH hospitals at least an amount calculated using the Medicare DSH payment methodology or an amount calculated using a payment methodology that increases proportionally with the hospital's low-income utilization rate. (See text box, right). Under the second option, a state's formula could vary

Medicare DSH

The primary method for a hospital to qualify for Medicare DSH is based on the hospital's DSH patient percentage (DPP) which is defined as the sum of:

- The percentage of the hospital's total Medicare patient days attributable to Medicare patients who also are federal Supplemental Security Income (SSI) beneficiaries, and
- The percentage of the hospital's total patient days attributable to Medicaid beneficiaries (excluding Medicare beneficiaries).

Hospitals whose DPP exceeds 15 percent are eligible for a DSH payment adjustment.

Large urban hospitals that can demonstrate that more than 30 percent of their total net inpatient care revenues come from state and local governments for indigent care (other than Medicare or Medicaid) also qualify for a Medicare DSH payment adjustment.

Medicare DSH payment adjustments are a percentage increase to the hospital payment rate depending on the hospital's size, urban/rural location, and status as a rural referral center or sole community hospital. For example, qualifying hospitals in urban areas with less than 100 beds, receive a 5 percent DSH payment adjustment while certain rural area hospitals receive a 4 percent DSH adjustment. DSH payment adjustments are specified in section 1886(d)(5)(F) of the Social Security Act.

Medicare DSH payments for FY 2009 are projected to be $9.8 billion.

payments to different types of hospitals, as long as all hospitals of a specific type were treated equally and adjustments were related to the hospitals' Medicaid or low-income patient volume. Most states do not use the Medicare payment methodology, and many of those that do also use another methodology for different types of hospitals.

A hospital's Medicaid DSH payments cannot exceed its total costs of providing inpatient and outpatient services to Medicaid and uninsured patients. This hospital-specific cap applies to both public and private hospitals, although Congress has raised the cap temporarily for public hospitals in the past.[4] States are required to submit to the Secretary of the U.S. Department of Health and Human Services (HHS) a detailed annual report and an independent, certified audit on their DSH payments to hospitals.

DSH AND LEVERAGING FEDERAL MEDICAID FUNDS

DSH spending grew from just under $1 billion in FY 1990 to $17.4 billion in FY 1992. Several factors—rising health care inflation, increasing Medicaid enrollment and shrinking state tax revenues due to a recession, and mandatory Medicaid eligibility expansions—strained many state Medicaid budgets in the late 1980s. As a result, many states started using special funding techniques to leverage, or maximize, federal Medicaid funds. This led to a rise in DSH payments and expansions in state DSH programs. DSH programs became the most popular mechanism to maximize federal Medicaid matching funds because, at the time, DSH allotments to states and payments to hospitals were not capped and did not need to be tied to particular beneficiaries or services. Some states took advantage of this flexibility to secure federal funds to support activities unrelated to Medicaid or health care.

Under these funding techniques, donations, provider-specific taxes, and intergovernmental transfers (the transfer of funds from different levels of governments or governmental entities to the state government, known as IGTs) were used as the state share of Medicaid spending. Once used as a state share of Medicaid spending, the donated, taxed, or transferred funds would be matched with federal Medicaid dollars and then returned to the donors or taxpayers through higher DSH payments or

higher provider payment rates. The ability to leverage federal funds without having to rely exclusively on state general funds prompted many states to develop large DSH programs.

Since 1991 Congress has enacted several laws to control federal DSH spending.[5] The first congressional action was the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). This law established upper bounds on DSH hospital payments and limited the use of donated funds and provider taxes for the purpose of claiming federal matching payments. A national limit on federal funds was set at 12 percent of Medicaid expenditures in any year, and state DSH allotments were limited to published amounts above which federal matching payments would not be available. The state published amount for each year would be based on 1992 payments.

The upper caps on DSH payments affected DSH spending, and the rapid climb in payments stopped. However, basing state allotments on the 1992 payments effectively locked into place state funding differences that reflect historical DSH spending patterns—including gains achieved through maximization efforts. As a result, funding in the current Medicaid DSH program is seen by many as inequitable across states. The capping of federal allotments based on historical program spending levels and not current need have led to per capita DSH allotments favoring a handful of states.

DSH payments are highly concentrated in a few states. Some states with large DSH programs, such as New York and California, also have large Medicaid programs. Other states, such as Louisiana, have DSH programs that account for a large share of their total Medicaid expenditures. "Low" DSH states, such as Utah, New Mexico, Oklahoma, Wyoming, North Dakota, and South Dakota, have DSH spending that accounts for less than 3 percent of their total Medicaid expenditures.

USE OF DSH FUNDS

State reporting requirements about the uses of DSH have been limited in the past. Annual reports to the Secretary of HHS on the methods used to identify and pay DSH hospitals, including children's hospitals, provide limited information regarding how DSH funds are ultimately spent. While the federal government requires

FOR MORE INFORMATION ABOUT THE MEDICAID DSH PROGRAM, SEE

Robert E. Mechanic, "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," Background Paper, National Health Policy Forum, September 14, 2004, available at www.nhpf.org/library/details.cfm/2463.

states to report hospital-specific DSH payments to the Centers for Medicare & Medicaid Services (CMS), it does not require hospital-specific information about payments back to states through provider taxes and intergovernmental transfers, making it difficult to verify whether DSH payments represent real additional dollars to cover hospitals' uncompensated care costs. The DSH program is intended to support hospitals that are critical to the health care safety net, and to preserve access to these hospitals for Medicaid beneficiaries and other low-income individuals. Shortcomings in reporting and reliable data, however, often lead to questions as to whether the intent of the program is appropriately being met.

ENDNOTES

1. This includes the 2.5 percent increase (approximately $269 million) for fiscal years 2009 and 2010 provided in the stimulus bill, The American Recovery and Reinvestment Act of 2009.

2. Section 1923(f)(3) of the Social Security Act defines the calculation of state federal allotments, which are published annually in the *Federal Register*.

3. Medicaid inpatient utilization means the total number of Medicaid inpatient days (the number of days Medicaid beneficiaries spent as a hospital inpatient) in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period.

4. For mental health facilities, DSH payments to institutions for mental diseases and other mental health facilities can be no higher than 33 percent of DSH payments made to such facilities in 1995.

5. For more detailed information on Medicaid DSH related legislation, see Jean Hearne, Congressional Research Service, "CRS Report for Congress, Medicaid Disproportionate Share Payments," January 10, 2005; available to congressional staff at www.crs.gov, Order Code 97-483.

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