Medicaid Disproportionate Share Hospital (DSH) Payments

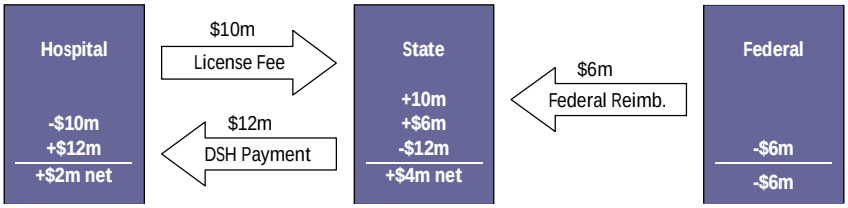
AUGUST 3, 2010

Congress established the Medicaid disproportionate share hospital (DSH) program in 1981 to help states provide financial support to hospitals that serve a significant number of low-income patients. Recognizing that safety net hospitals typically incur higher uncompensated care costs than other hospitals and rely heavily on Medicaid, which historically has low reimbursement rates, Congress authorized DSH payments to assist states in financing the programs. DSH programs have become a major source of funding for the nation's hospitals. In 2002, the federal government provided $9 billion in matching funds for state Medicaid DSH programs and $6.2 billion in direct DSH payments through Medicare. Combined, these payments represented about two-thirds of the $22.3 billion in uncompensated care costs reported by hospitals.

DSH FINANCING

Starting in the late 1980s, several states realized that it would be possible to collect money from hospitals in the form of fees, taxes, or donations, and use those funds to draw down federal matching funds in order to make DSH payments without actually expending any state dollars. Rhode Island, for example, receives money from hospitals through the hospital license fee as general revenue. It then makes a DSH payment to hospitals using a portion of the license fee revenue as the state share, which is matched by the federal government. The following diagram illustrates a very simple DSH program, assuming a 50 percent federal match (Rhode Island's base federal match rate is 52.97 percent in federal fiscal year 2011).

Figure 1: Sample DSH program (Source: Urban Institute)



States expanded this strategy throughout the 1980s and 1990s, and began to use the DSH-generated funds for purposes other than uncompensated care, or even other than health care. In response, Congress instituted several reforms. In 1991, Congress established state-specific DSH allotment caps, limiting the total amount of federal DSH funding that could be drawn down. It also required that any provider taxes be broad-based, uniformly imposed, and structured so that providers not be held harmless for the tax. Since that time, Congress has repeatedly lowered the DSH cap, only to raise it in response to concerns from state policymakers.

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UPPER PAYMENT LIMIT

With the imposition of DSH allotment caps, states sought new ways of maximizing federal funding for hospitals. One of the most common is the upper payment limit (UPL). Federal law requires that a state's Medicaid program expenditures not exceed what "would have been paid under Medicare principles." Thus, Medicare rates establish a ceiling—the upper payment limit—on Medicaid payments. In order to provide additional support to community hospitals, many states now make a supplemental payment, matched by the federal government, to bring their total Medicaid expenditures up to the UPL.

RHODE ISLAND'S DSH FORMULA

Rhode Island's DSH payments to hospitals are based on a formula, defined in RIGL 40-8.3-3. The amount paid to each hospital is the lesser of the hospital's actual uncompensated care costs, or the total chargeable services for the base year multiplied by the uncompensated care index.

- Uncompensated care costs are defined as the sum of:
  - The costs to each hospital for care attributable to charity care (free care or bad debt)
  - The hospital's "Medicaid losses" (the difference between the cost of care provided to Medicaid beneficiaries minus Medicaid reimbursements) times the uncompensated care index.
- The uncompensated care index is a percentage defined in the statute. The index is 5.30% for the years ending September 30, 2010, and September 30, 2011.
- The base year for state fiscal year 2010 is the period from October 1, 2007, to September 30, 2008. For FY2011, it is the period from October 1, 2008, to September 30, 2009.

Since FY2008, the state has also made a UPL payment.

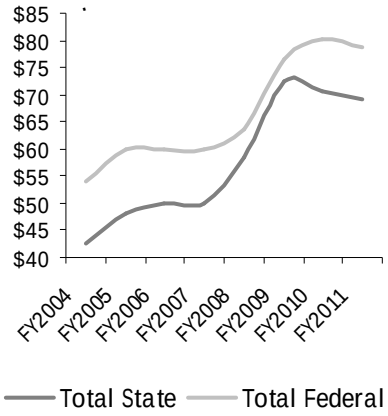


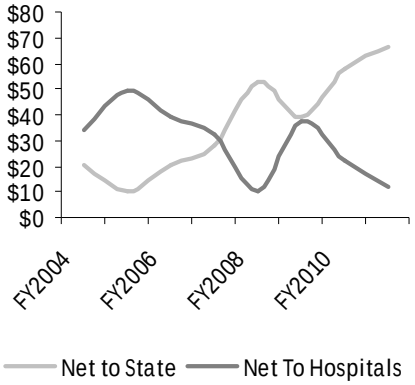
Table 1: DSH program payments to hospitals ($ in millions)

FY	Disproportionate Share (DSH) Payments			Upper Payment Limit (UPL) Payments			State-only Payment
	State	Federal	Total	State	Federal	Total	State
2004	$42.4	$54.0	$96.4	-	-	-	-
2005	48.2	59.8	108.0	-	-	-	-
2006	50.1	59.9	110.0	-	-	-	-
2007	50.1	59.9	110.0	-	-	-	-
2008	53.0	57.7	110.7	5.4	5.9	11.3	-
2009	55.6	61.7	117.3	13.3	14.7	28.0	3.4
2010	57.7	63.9	121.6	9.2	16.3	25.5	3.7*
2011	58.8	66.0	124.8	5.5	12.6	18.1	4.8
Total	**$415.8**	**$482.9**	**$898.8**	**$33.3**	**$49.5**	**$82.9**	**$11.8**

* The FY2010 payment of $3.65 million was postponed to September 30, 2010, so as to be paid in state fiscal year 2011 (but still in the hospitals' fiscal year 2010).

Table 2: Net revenue to state, net revenue to hospitals ($ in millions)

FY	Total State Payments	Total Federal Payments	License Fee Revenue	Net to State	Net to Hospitals
2004	$42.4	$54.0	$62.4	$20.0	$34.0
2005	48.2	59.8	58.6	10.4	49.4
2006	50.1	59.9	70.8	20.7	39.2
2007	50.1	59.9	78.0	27.9	32.0
2008	58.3	63.6	111.4	53.1	10.6
2009	72.3	76.4	111.4	39.1	37.3
2010	70.6	80.2	128.8	58.3	21.9
2011	69.0	78.6	135.8	66.8	11.8
Total	**$461.0**	**$532.4**	**$757.3**	**$296.3**	**$236.1**



The Eleanor Slater Hospital, which is operated by the state Department of Behavioral Health, Developmental Disabilities, and Hospitals also participates in the DSH program. The hospital makes a license fee payment to the state, and the Department of Human Services makes a DSH payment, matched by the federal government, to Eleanor Slater. The fiscal year 2010 payment for Eleanor Slater was $7.1 million.

In FY2009, the General Assembly added an additional state-only payment to hospitals, designed to offset uncompensated care expenses that did not qualify for reimbursement under the Medicaid DSH program. The payments were to be derived from the premium tax levied on health insurers: the health plans agreed to an increase in the premium tax to fund these additional payments in lieu of legislation that would have made the plans liable for hospitals' bad debt due to the increase in the number of patients with insurance who were unable to pay their co-payments and deductibles. Language in RIGL 40-8.3-5 earmarks the funding to specific hospitals. In FY2011 the funding was increased and was repurposed to compensate hospitals for lost revenue due to Medicaid rate cuts rather than for unqualified uncompensated care.

In total, between FY2004 and FY2011, hospitals will have received $993.4 million in DSH and DSH-related payments, while paying $757.3 million in licensing fees.

Table 3: Hospital license fee ($ in millions)

FY	Total State Payments	License Fee Rate	License Fee Revenue	State Net	% of License Fee
2004	$42.4	4.000%	$62.4	$20.0	32.1%
2005	48.2	3.140%	58.6	10.4	17.8%
2006	50.1	3.560%	70.8	20.7	29.2%
2007	50.1	3.560%	78.0	27.9	35.8%
2008	58.3	4.780%	111.4	53.1	47.6%
2009	72.3	4.780%	111.4	39.1	35.1%
2010	70.6	5.237%	128.8	58.3	45.2%
2011	69.0	5.465%	135.8	66.8	49.2%
Total	**$461.0**	**4.399%**	**$757.3**	**$296.3**	**39.1%**

The hospital licensing fee was increased in FY2008, without a corresponding increase in DSH payments. Since that year, the additional license fee revenue has been used as part of the broader budget-balancing solution.

In FY2011, the hospitals requested that the license fee be increased rather than accept deep cuts in their Medicaid reimbursement rates. Because Medicaid payments are federally matched, a dollar in savings to the state costs the hospital between two and three dollars (depending on the effective federal match rate), since they would lose both the state and the federal payment. An increase in the licensing fee allows the state to achieve its savings target by increasing general revenues, while reducing the negative impact on the hospitals because they do not lose the federal payments.

DSH AND HEALTH CARE REFORM

The Patient Protection and Affordable Care Act of 2010 (PPACA) included significant changes to the U.S. health care system, such as the creation of state-based insurance exchanges and expansion of Medicaid eligibility, designed to reduce the number of uninsured. As a result of these changes, Congress expects the amount of uncompensated care to decrease as PPACA's reforms are implemented.

PPACA reduces total Medicaid DHS payments to states by a total of $14.1 billion over six years, beginning in 2014. These reductions are to be carried out using a methodology that imposes the largest reductions on states that have the lowest percentage of uninsured and do not target DSH payments to hospitals based on their volume of uncompensated care or bad debt. In 2008, Rhode Island's uninsured rate was 11.3 percent, which was 14th best in the United States.

Table 4: PPACA DSH reductions

Year	Reduction
FFY 2014	$500 million
FFY 2015	$600 million
FFY 2016	$600 million
FFY 2017	$1.8 billion
FFY 2018	$5 billion
FFY 2019	$5.6 billion
Total	**$14.1 billion**

Table 5: Percent uninsured by state as of 2008 (Source: Kaiser Family Foundation)

Rank	State	Percent uninsured
1	Massachusetts	5.4%
2	Hawaii	7.9%
3	Minnesota	8.5%
4	Wisconsin	9.0%
5	Iowa	9.4%
	...	
13	Delaware	11.1%
14	Rhode Island	11.3%
15	South Dakota	11.4%
	...	
49	Florida	20.2%
50	New Mexico	23.2%
51	Texas	25.2%