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Medicaid and Medicare Disproportionate Share Hospital Programs

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Congress created the Disproportionate Share Hospital (DSH) program in the early 1980s to help hospitals offset the costs of providing care to low-income individuals. Medicaid and Medicare each have a distinct DSH program, with a unique structure and financing mechanism.

In addition to giving a brief overview of the Medicaid and Medicare DSH programs, this document will:

- Discuss the role of the state and federal governments in running the Medicaid DSH program;
- Explain how the Michigan Medicaid DSH program is financed and structured; and
- Examine the changes to the Medicaid and Medicare DSH programs under the Patient Protection and Affordable Care Act (ACA).

Federal Medicaid DSH Program

Like the Medicaid program generally, the Medicaid DSH program is a federal-state partnership, which means that:

- States have significant flexibility to structure their own DSH program;
- State DSH programs vary widely throughout the country; and
- The federal government reimburses each state for its share of DSH spending at the state's regular Federal Medical Assistance Percentage (FMAP) rate.

Under federal law, states are required to make DSH payments to all hospitals that serve more than a certain percentage of Medicaid and low-income patients (see Note 1). In order to be eligible for state DSH payments, each hospital must meet minimum federal criteria (see Note 2).[1]

There are multiple annual limits[2] to federal Medicaid DSH payments. The two most significant limits are:

1. A limit on total annual federal DSH reimbursement to each state: The cap for each state is calculated based on its DSH allotment for the previous fiscal year (FY), adjusted for inflation.

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[1] National Health Law Program. July 2012. *Q & A: Disproportionate Share Hospital Payments and the Medicaid Expansion*. http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf (accessed 7/30/13

[2] Another limit is that states may not use more than 33 percent of their annual DSH capacity to support "Institutions for Mental Diseases" or IMDs, which are primarily state-owned psychiatric facilities. Michigan's DSH payments to IMDs are not addressed in this document.

2. A hospital-specific DSH limit: A hospital's DSH payments in a given year cannot exceed its net cost of providing care to Medicaid patients and the uninsured.[3]

In order to receive federal matching funds, a state's DSH program must be independently audited each year. Beginning with payments for Fiscal Year 2011, the state is required to recover DSH payments made to any hospital in excess of its hospital-specific DSH limit.[4]

Michigan Medicaid DSH Program

The Michigan Medicaid DSH program is structured and partially financed by the state. All state DSH payments, up to Michigan's annual federal limit, are matched by the federal government at Michigan's normal FMAP rate (66.39 percent in FY2013).[5]

The Michigan legislature divides the state's share of DSH payments into two pools:

1. *Regular DSH payments*: Standard Medicaid inpatient DSH payments, made annually in a single distribution. The total amount ($45 million in FY2013) is divided among three types of providers:
    - Diagnostic Related Group (DRG) Reimbursed Hospitals;
    - Per Diem Reimbursed Hospitals and Units; and
    - Distinct-Part Rehabilitation Units.

2. *Special DSH payments*: Additional payment pools are created and reauthorized annually by the legislature. In FY2013, the legislature authorized four special DSH pools:
    - Government Provider DSH Pool: the lesser of $73,117,228 or the calculated Medicaid and uninsured inpatient and outpatient hospital uncompensated care amounts eligible for federal match;
    - Indigent Care Agreement (ICA) Pool: $88,518,500;
    - University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool: $2,764,340; and
    - Outpatient Uncompensated Care DSH Pool: $60,000,000.

Each year, the legislature determines how much funding each pool receives in the Appropriations Act that funds the Michigan Department of Community Health (MDCH). In Michigan, the state share of funding comes from four sources:

- General revenue;
- Certified public expenditures (CPE);
- Hospital provider taxes; and
- Intergovernmental transfers.

Once the MDCH receives the authorized level of Medicaid DSH funding from the state, the Michigan Medicaid agency determines how much funding each hospital will receive from each DSH pool.

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[3] Medicaid.gov. N.d. *Medicaid Disproportionate Share Hospital (DSH) Payments*. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html (accessed 7/30/13).

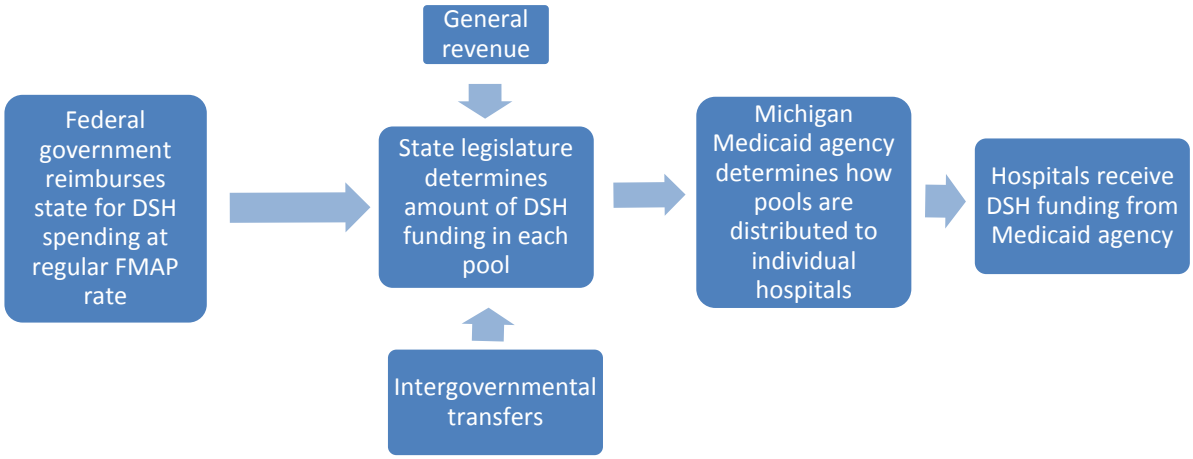
[4] U.S. Department of Health and Human Services. December 19, 2008. Medicaid Program; Disproportionate Share Hospital Payments: Final Rule. *Federal Register* 73(245): 77904–77952. http://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30000.pdf (accessed 8/5/13).

[5] U.S. Department of Health and Human Services. November 30, 2011. Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2012 through September 30, 2013: Notice. *Federal Register* 76(230): 74061–74063. http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf (accessed 8/2/13).

In order to be eligible for state DSH funding in Michigan, each hospital must complete annually:

- An Indigent Volume Report as part of its annual cost report package
- A Disproportionate Share Hospital (DSH) Eligibility status verification form

The following chart illustrates the flow of funding in the Michigan Medicaid DSH program for all but the Government Provider DSH pool:[6]



Source: Center for Healthcare Research and Transformation, July 2013.

Indigent Care Agreements and County Health Plans

In order to receive DSH funds from the ICA pool, a hospital must have an agreement with a partner health care entity, like a county health plan. In Washtenaw County, St. Joseph Mercy Health System (SJMHS) receives funding from this pool because it:

- Meets minimum federal requirements for Medicaid DSH payments; and
- Has an approved ICA with the Washtenaw Health Plan (WHP).[7]

Several counties in Michigan, including Washtenaw County, send money to the state to be spent as a DSH payment. This mechanism, called an intergovernmental transfer, allows the state to bring in additional federal matching funds without spending more general revenue.

Medicaid DSH Program Changes under ACA

On May 14, 2013, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule, explaining the reductions to Medicaid DSH payments required under the ACA. CMS finalized the proposed rule on September 18, 2013.[8] The ACA requires a total reduction in federal DSH payments for each year from FY2014 through FY2020, but the reduction to each state's annual DSH limit will vary. However, on December 26, 2013, the President signed the Bipartisan Budget Act of 2013

[6] Hospital taxes are the non-federal share for the Government Provider DSH pool.
[7] Michigan Department of Community Health. July 1, 2013. *Medicaid Provider Manual*. http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf (accessed 7/31/13).
[8] U.S. Department of Health and Human Services. September 18, 2013. Medicaid Program; State Disproportionate Share Hospital Allotment Reductions: Final Rule. *Federal Register,* 78(181): 57293–57313. http://www.gpo.gov/fdsys/pkg/FR-2013-09-18/pdf/2013-22686.pdf (accessed 10/17/13).

(H.J.Res.59), which delays the Medicaid DSH reductions required under the ACA until FY2016, and doubles the reduction amount in that year.[9] The total annual reductions required under the ACA, and updated by the budget agreement, are:

- $1.2 billion in FY2016;
- $1.8 billion for FY2017;
- $5 billion for FY2018;
- $5.6 billion for FY2019; and
- $4 billion for FY2020.

The formula to determine how much each state's DSH payments will be reduced in FY2016 and beyond will be determined once more data become available on the impact of coverage expansion provisions in the ACA. [10]

Federal Medicare DSH Program

Although the Medicaid and Medicare DSH programs serve similar purposes, there are several differences between the two programs, including how funding flows, how hospitals qualify for payments, and how payments are calculated.

Medicare DSH payments are available only to acute care hospitals that participate in the Medicare inpatient prospective payment system. Hospitals qualify for Medicare DSH payments if the hospital's percentage of low-income patients is above 15 percent (see Note 6). In addition, hospitals may be eligible for Medicare DSH payments under alternative criteria established by federal law (see Note 4).

Medicare DSH payments flow directly from the federal government to individual hospitals as increases to the hospital's normal diagnostic-related group (DRG) payments. The payment increase varies from hospital to hospital, and depends on a number of factors, including a hospital's bed count and its location.[11]

Medicare DSH Program Changes under ACA

On May 10, 2013, CMS released a proposed rule, detailing the reductions to Medicare DSH funding required under the ACA. CMS finalized the proposed rule on August 19, 2013.[12] Beginning in FY2014, the ACA reduces base Medicare DSH payments by 25 percent. In order to soften the impact of this reduction, the federal government will give a portion of the savings from the payment cut to hospitals that have the highest percentage of uncompensated care (see Note 5).[13] The changes are expected to reduce Medicare DSH spending by over $22.1 billion between 2014 and 2019.[14]

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[9] Centers for Medicare and Medicaid Services. December 27, 2013. *Medicaid Provisions in Recently Passed Federal Budget Legislation*. http://content.govdelivery.com/attachments/USCMS/2013/12/27/file_attachments/260028/CIB-12-27-13.pdf (accessed 1/21/14).

[10] U.S. Department of Health and Human Services. May 14, 2013. Medicaid Program; State Disproportionate Share Hospital Allotment Reductions: Proposed Rule. *Federal Register,* 78(94): 28551–28569. http://www.gpo.gov/fdsys/pkg/FR-2013-05-15/pdf/2013-11550.pdf (accessed 8/1/13).

[11] National Health Law Program. July 2012. *Q & A*.

[12] U.S. Department of Health and Human Services. August 19, 2013. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status: Final Rule. *Federal Register,* 78(160): 50496–51040. http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf (accessed 10/17/13).

[13] U.S. Department of Health and Human Services. May 10, 2013. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year

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Notes

1. Under federal law, states are required to provide DSH payments to all hospitals that have:
   - A Medicaid inpatient utilization rate one standard deviation or more above the mean for all hospitals in the state; or
   - A low-income (Medicaid and uninsured) utilization rate exceeding 25 percent.

2. Under federal law, in order to qualify for DSH funding, a hospital must have a Medicaid inpatient utilization rate of at least 1 percent. The hospital must also have at least two obstetricians with staff privileges, unless the hospital:
   - Serves patients that are predominantly under 18 years of age;
   - Did not offer nonemergency obstetric services to the general population as of December 22, 1987; or
   - Is a rural hospital with at least two physicians with practice privileges to perform nonemergency obstetric services.

3. The formula to determine the annual reduction to each state's DSH limit is based on five factors:
   - Low DSH payment
   - Uninsured population
   - High volume of Medicaid inpatients
   - High level of uncompensated care
   - Budget neutrality

4. Under federal alternative criteria, hospitals are eligible for Medicare DSH payments if they:
   - Are located in an urban area;
   - Have 100 or more beds; and
   - Can demonstrate that more than 30 percent of their revenue comes from state and local government payments for care provided to low-income patients not covered by Medicare or Medicaid.

5. Additional Medicare DSH payments under the ACA will be calculated on a hospital-by-hospital basis using a formula that takes into account the following factors:
   - The change in the hospital's DSH payments under the ACA;
   - The nationwide change in the percentage of the uninsured under-65 population since 2013; and
   - The percentage of uncompensated care provided by the hospital compared to all other acute care hospitals.

2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation: Proposed Rule. *Federal Register,* 78(91): 27486–27823. http://www.gpo.gov/fdsys/pkg/FR-2013-05-10/pdf/2013-10234.pdf (accessed 8/5/13).

[14] Douglas W. Elmendorf, Director of the Congressional Budget Office. March 20, 2010. Letter to Nancy Pelosi, Speaker, U.S. House of Representatives, Table 5. http://cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf (accessed 9/21/13).

6. The Medicare program uses the number of Medicaid patient days as a percentage of total patient days plus the number of Supplemental Security Income (SSI) Medicare patient days as a share of Medicare patient days to calculate a hospital's percentage of low-income patients. This means that SSI patients with both Medicaid and Medicare are weighted more heavily than individuals that only have Medicaid, while uninsured patients are not counted in calculating a hospital's percentage of low-income patients.

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