Supplemental Payment Methods Part 1: Medicaid Disproportionate Share Hospital Payments

ACHI
Arkansas Center for Health Improvement

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Medicaid financing and provider reimbursement models are extremely complex. As states expand their Medicaid programs and search for ways to control costs, understanding how public healthcare dollars flow to providers will be essential to the analysis of options. In a separate fact sheet, we have discussed how the federal government and states share in financing the Medicaid program through Federal Medical Assistance Percentages (FMAPs). This fact sheet is one of two discussing supplemental payments to providers in addition to direct payments for services. These supplemental payments—Medicaid Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments—serve to offset uncompensated care costs and augment Medicaid reimbursement rates that are lower relative to Medicare and private payer rates for comparable services. Estimates show that these payments represent more than one-third of Medicaid fee-for-service hospital payments.[1] In accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA), DSH payments will be reduced in the near future. Consequently, policymakers should carefully consider reform options that disrupt or eliminate the flow of these payments. This fact sheet provides background information on the development of Medicaid DSH payments, details the DSH payment methodology, and describes the expected DSH payment reductions under the PPACA.

INTRODUCTION

Hospitals that serve a large number of uninsured, low-income, indigent or Medicaid-eligible individuals (i.e., "disproportionate") can qualify for Medicaid Disproportionate Share Hospital (DSH) payments. Medicaid DSH payments are federal-state partnerships in which the federal government pays states to distribute supplemental payments to its hospitals for uncompensated care provided to uninsured or under-insured individuals.[2] The DSH payment program[a] originated from the Omnibus Budget and Reconciliation Act of 1981 (OBRA) to protect hospitals that provide significant amounts of uncompensated care from rising healthcare costs.[3] OBRA recognized that hospitals do not typically receive payment for services provided to uninsured patients and that Medicaid provider payment rates are lower relative to that of Medicare and private payers for comparable services. Prior to 1993, states were financially responsible for DSH payments to hospitals. In 1993, the federal government began providing funding to states for the DSH program.[4] The Medicaid DSH program currently provides the largest federal source of funds for hospital uncompensated care, and in many states, DSH payments are critical to the financial stability of many safety-net hospitals.[5]

STATE DSH ALLOTMENT

Each fiscal year (FY), states receive federally specified DSH allotments. A state's DSH allotment is dependent on the prior year's DSH allotment with an adjustment based on the percentage change in the consumer price index (CPI).[4] After CPI adjustment, allotment is capped at the greater of:[4]

1. The state's CPI-adjusted DSH allotment from the previous FY; **or**
2. Twelve percent of the state's total Medicaid payments from the previous FY

Nationally, in FY 2014, federal Medicaid DSH allotments to states totaled $11.6 billion.[6] States distribute their federal DSH allotment to eligible hospitals.

HOSPITAL ELIGIBILITY

Federal regulations require states to distribute DSH funding to the following hospitals:[4]

- Hospitals with Medicaid Inpatient Utilization (MIU) rates of at least one standard deviation (SD) above the average MIU rate for hospitals receiving Medicaid payments in the state; **or**
- Hospitals with Low-Income Utilization (LIU) rates accounting for greater than 25 percent of inpatient utilization

For a hospital to receive funding, it must have:[1]

- An MIU rate of at least 1 percent; and
- At least two obstetricians or gynecologists on staff serving Medicaid beneficiaries
  - Does not apply to hospitals in which inpatients are predominately individuals under 18 years of age or ones that do not offer nonemergency obstetric services

MIU rate represents service utilization by the Medicaid-eligible population compared to the total utilization of the hospital's services.

LIU rate represents the charity care charges and cash subsidies received relative to the hospital's total inpatient charges.

[a] Medicaid and Medicare both have DSH programs, but each has different criteria for identifying DSH Hospitals and different calculations for determining DSH payment amounts.

Additional Hospital Eligibility

Federal regulations require minimum hospital eligibility standards for DSH payment receipt; however, states have the option to incorporate additional qualifying factors for hospital DSH payment eligibility, which Arkansas has exercised.[7] The qualifying factors include:

- *Acute care hospitals located in cities within a state bordering the Arkansas state line*—eligible if the hospital has more than 850 inpatient days that Arkansas Medicaid has paid for during the cost-reporting period
- *Rural hospitals*—eligible if the hospital's MIU rate is at least one-half SD above the mean MIU rate in the state, instead of the one SD minimum required by federal regulations

Arkansas's DSH Allotment[7]

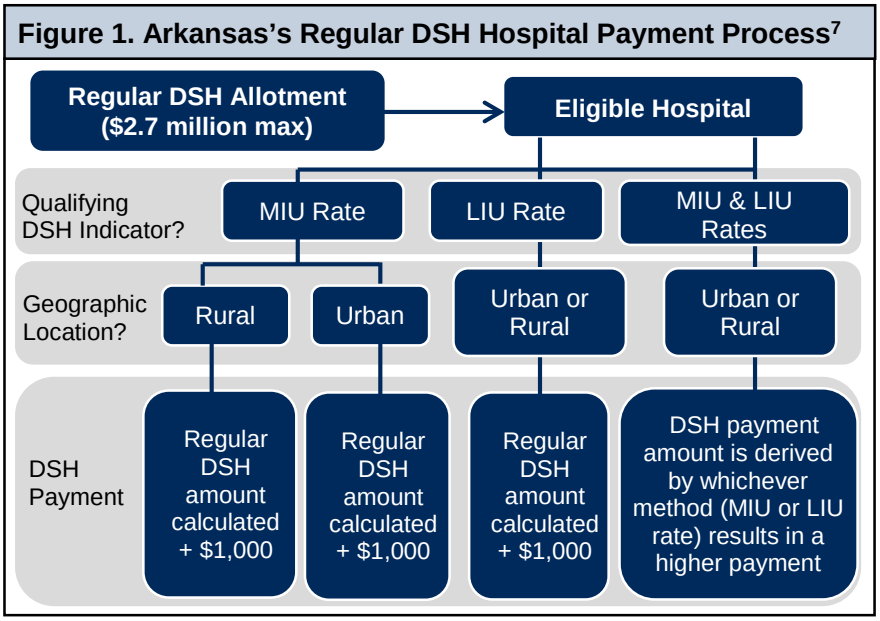
The total Arkansas DSH allotment—federal funding and state matching funds—was approximately $66 million in FY 2014. States may decide how to distribute DSH payments to qualifying hospitals, as specified in the state's Medicaid State Plan. In Arkansas, there are "regular" and "additional" DSH payment categories. The sections below provide more details about these categories and the payment process.

Regular DSH Payments

The total regular Medicaid DSH payments made to qualifying hospitals was approximately $2 million in FY 2014 with the source funding exclusively from the federal DSH allotment. Each FY—July 1 to June 30—all hospitals must submit cost report data and a Medicaid DSH eligibility form to Arkansas Medicaid.[8] The information determines whether a hospital is eligible based on MIU and LIU rates. If a hospital is eligible, the regular DSH payment is based on the cost report data. The hospital payments include the following parameters:[7]

- Receive a minimum payment of $1,000
- Additional regular DSH payment amount is dependent on how the hospital qualified (MIU or LIU rates) and if the location of the hospital is urban or rural (Figure 1 displays the payment process)
- The DSH payment amount cannot exceed the hospital's uncompensated care amount

Figure 1. Arkansas's Regular DSH Hospital Payment Process[7]



The regular DSH payment amount that hospitals qualify for is subject to reductions, depending on the amount of the federal allotment to the state and if the total annual regular Medicaid DSH payments exceed the state cap. Arkansas imposes a state cap of $2.7 million for the total annual regular Medicaid DSH payments to qualifying hospitals.[7] Therefore, the federal allotment to the state may exceed $2.7 million for Medicaid DSH payments, but the state only allows up to the $2.7 million for regular DSH payments.

Additional DSH Payments

The $2.7 million regular DSH cap includes the regular DSH funding paid to Arkansas State Operated Psychiatric Hospitals[b] and Arkansas State Operated Teaching Hospitals, but does not include supplementary DSH funding amounts reimbursed to these hospitals.[c] Arkansas Medicaid pays these hospitals "additional DSH payments" in addition to the hospital's regularly received DSH payments. The additional DSH payments distributed in FY 2014 totaled approximately $64 million, the overwhelming majority of which would not have been available except for intergovernmental transfer of funding to provide the regular state match from the University of Arkansas for Medical Sciences (UAMS). UAMS provides $20 million of its own funds to the Arkansas Department of Human Services

[b] The only State Operated Psychiatric Hospital is the Arkansas State Hospital operated by the Arkansas Department of Human Services (Arkansas DHS); therefore, it receives all additional DSH payments within its hospital classification.
[c] The only Arkansas State Operated Teaching Hospital is the University of Arkansas for Medical Sciences (UAMS); therefore, it receives all additional DSH payments within its hospital classification.

(Arkansas DHS) so that the state can draw down federal matching funds.[9] Additional DSH payments are those funds remaining after calculating the total annual regular DSH payments received by all qualifying hospitals in the state. The additional DSH allotment payable to each hospital is determined as follows:[7]

- A maximum state DSH payment amount allowed for psychiatric hospitals is provided annually by the Centers for Medicare and Medicaid Services (CMS). The additional payable amount to State Operated Psychiatric Hospitals is the difference between the annual state DSH maximum for psychiatric hospitals and the regular DSH payment amount paid to all psychiatric hospitals.
- The additional payment amount made to State Operated Teaching Hospitals is the difference between the total annual state DSH allotment and the total DSH payments made by the state to all hospitals, including the total DSH amount (regular plus additional) paid to the State Operated Psychiatric Hospitals.

For example, if the total Medicaid DSH allotment in Arkansas in FY 2014 was $66 million and the total FY 2014 regular DSH payments to all hospitals was $2 million, the state would distribute the remaining $64 million to Arkansas State Operated Psychiatric Hospitals and Arkansas State Operated Teaching Hospitals. Table 1 provides an example of how the state's DSH allotment is distributed for regular DSH and additional DSH hospital payments.

Table 1. Example of Total Annual DSH Payments in Arkansas[10]

	Payment Method	Amount*
Total State DSH Allotment	Federal DSH allotment ($46 million) plus state DSH funding ($20 million)	$66 million
Total Regular DSH Payment	Aggregate of total payments to all qualifying hospitals	$2 million
Total Additional DSH Payments Available	Difference between total annual regular DSH payments ($2 million) and total annual DSH allotment ($66 million)	$64 million
Arkansas State Operated Psychiatric Hospitals	Difference between the annual state DSH maximum amount for psychiatric hospitals ($800,000) and the regular DSH amount paid to all psychiatric hospitals ($100,000)	$700,000
Arkansas State Operated Teaching Hospitals	Difference between the total annual DSH allotment amount ($66 million) and the total of all other DSH payable amounts ($2 million + $700,000)	$63.3 million

* These are not actual amounts and only serve to demonstrate the process by which the state distributes regular and additional DSH payments.

FUTURE OF MEDICAID DSH PAYMENTS

The Patient Protection and Affordable Care Act (PPACA) requires annual reductions in total Medicaid DSH funding to states.[11] The phased DSH reductions assume increased healthcare coverage through the insurance exchanges and Medicaid expansions and reductions in uncompensated care costs for hospitals as these reductions take effect. DSH reductions were originally scheduled to begin in the federal FY 2014, but subsequently enacted legislation has delayed reductions until FY 2018.[6] In FY 2018, federal DSH funding (currently $11.7 billion) will be reduced by $2 billion and then $1 billion each year after until 2024 (see Table 2 for the reduction schedule).[12]

Table 2. Federal Reduction Schedule[12]

Fiscal Year	Reduction Amount
2018	$2.0 billion
2019	$3.0 billion
2020	$4.0 billion
2021	$5.0 billion
2022	$6.0 billion
2023	$7.0 billion
2024	$8.0 billion

In addition, the PPACA tasked the U.S. Department of Health and Human Services (HHS) with developing a methodology to allocate the reductions that meet specific requirements. However, due to the delay of federal DSH reductions, HHS will not develop and publish Medicaid DSH reduction methodology until 2016. The methodology used to reduce state allotments will consider the number of uninsured individuals in a state and a state's targeting of DSH payments to providers who serve Medicaid enrollees and uninsured individuals.[6] State Medicaid programs and hospital providers should monitor CMS announcements about the reduction methodology and assess whether it is in the state's best interest to proactively modify DSH payment policies in anticipation of the federal reductions.

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[11] Section 1923(f)(7)(A) of the *Social Security Act*, as amended by the *Patient Protections and Affordable Care Act.*

[12] *Medicare Access and CHIP Reauthorization Act of 2015* (P.L. 114-10).