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FACTS AT A GLANCE

Disproportionate Share Hospital (DSH) Program: Your Questions Answered

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Introduction

The Medicaid Disproportionate Share Hospital (DSH) program was established by the United States Congress to guarantee that states compensate certain hospitals for providing care to a disproportionate number of uninsured, indigent, and Medicaid patients. These facilities, commonly referred to as safety net hospitals, include public and private hospitals, children's hospitals, university hospital systems, and long-term mental health care institutions. The DSH program has become a critical source of funding for the substantial costs of uncompensated care provided by safety net hospitals.

The purpose of this publication is to help individuals who are unfamiliar with DSH to gain a basic understanding of the program and how it functions; it is not intended to be a comprehensive resource for all of the information needed to formulate policy relating to this complex program. This publication provides brief answers to questions regarding the DSH program, how it is funded, the financing and basic organization of Texas' DSH program, disproportionate share hospital eligibility and participation in Texas, the increased DSH reimbursement rate, the effect of recent federal legislation and rule changes on Texas' DSH program, and issues relevant to recommendations made by the office of the comptroller regarding DSH and the Medicaid upper payment limit (UPL).

Summary

Established in 1981, the DSH program grew in federal and state spending from less than $1 million to over $16 billion between 1989 and 1993. Because this explosive growth in federal DSH costs was in part due to some states' use of creative financing arrangements that exploited DSH to fund the state share of DSH payments or even finance activities normally paid from the state's general revenue, a number of federal laws were passed during the 1990s that placed significant restrictions on states' DSH programs. Perhaps the most significant of these laws was the Balanced Budget Act (BBA) of 1997, which strictly reduced the federal allotment to states' DSH programs through a five-year schedule of reductions.

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The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 provided a two-year reprieve from the BBA reductions, but the scheduled reductions resumed in federal fiscal year (FFY) 2003. However, the BIPA also increased the rate at which states may reimburse a public disproportionate share hospital from 100 percent to 175 percent of the hospital's uncompensated care costs for FFY 2003 and FFY 2004. This higher reimbursement rate gives Texas the opportunity to maximize the DSH allotment to state-owned or state-operated hospitals. Because of the rules governing DSH allotment distribution in Texas' program, the effect of adopting the higher reimbursement rate will be a shift in funds away from non-state public disproportionate share hospitals to state-owned or state-operated public hospitals.

To help affected hospitals recover this loss of DSH funds over the next two years, Texas can expand its Medicaid upper payment limit plan to compensate hospitals at the Medi*care* rate for uncompensated care costs instead of the Medic*aid* rate.

Questions and Answers About the DSH Program

What is the Disproportionate Share Hospital program and how does it work?

The DSH program reimburses hospitals serving large numbers of Medicaid beneficiaries, uninsured patients, and patients with no means to pay for care. A state makes a DSH payment to a hospital to help the hospital cover the additional costs of providing care to Medicaid patients that are not otherwise paid through Medicaid or the costs of providing care to patients unable to pay. The federal government then reimburses the state for a portion of the payment made to the hospital.

What control do states have over their DSH programs?

States are given great flexibility in the design of their DSH programs. States, among other things, determine:

- the total amount of state funds spent on the DSH program
- criteria in addition to federal requirements for determining which hospitals are eligible to receive DSH payments
- the formula for determining the amount of DSH payments to each hospital
- the distribution of payments among eligible hospitals
- any conditions imposed on hospitals that receive DSH funding

How is the DSH program funded?

The DSH program is a state-federal fund matching program. Disproportionate Share Hospital program costs are shared by the state and federal governments at the same rate as other Medicaid spending. In Texas, the rate is 59.99 percent federal funds to 40.01 percent state funds for FFY 2003 and 60.22 percent federal funds to 39.78 percent state funds for FFY 2004. Disproportionate Share Hospital funds are separate from and in addition to other Medicaid funds received by the state.

How much money does Texas receive for DSH?

The total amount of money contributed by the federal government to reimburse a state for a portion of the state's DSH spending is capped by federal law. A state can determine the total amount available for the state's DSH program based on the amount of the federal contribution and the state's Medicaid matching rate. This combination of federal and state funds is known as the DSH allotment. States can spend above the allotment but do not draw down federal matching funds on that spending.

- In FFY 2002, Texas had $1.422 billion available for distribution to disproportionate share hospitals. This amount includes both state and federal dollars (known as "all funds"). The federal contribution was $856 million, and the state contributed the remaining $566 million.
- The projected maximum federal DSH contribution for state fiscal year (SFY) 2003 is $776 million. The projected federal contribution for SFY 2004 will drop to $756 million[1] due to cuts in federal DSH funding from the Balanced Budget Act of 1997.

How does Texas raise the money for its share of the DSH program?

The state share of Texas' DSH program funds is composed of a combination of money from state-owned hospitals and intergovernmental transfers from the nine largest public hospitals in the state (eight hospital districts and one municipal hospital). With the money transferred from the nine largest DSH-eligible hospitals added to money from state-owned facilities, Texas maximizes the amount available to be matched by the federal government and therefore available for distribution to disproportionate share hospitals across the state.

What hospitals are DSH-eligible?

Disproportionate share hospitals (also known as "dispro" hospitals) can be private or public, nonprofit or for-profit.

- A public hospital is owned, operated, or leased by a governmental entity, including a municipality, county, hospital district, or the state. State-owned or state-operated hospitals include state teaching hospitals, such as Texas Tech University Health Sciences Center; state chest hospitals, such as the South Texas Health Care System; and facilities operated by the Texas Department of Mental Health and Mental Retardation. Examples of public hospitals that are not owned or operated by the state are hospitals in the Bexar County Hospital District, Val Verde Memorial Hospital in Del Rio, and Llano Memorial Hospital.
- Private hospitals can be nonprofit or for-profit. A private, nonprofit hospital must meet certain community benefit and charitable care requirements that entitle the hospital to certain tax exemptions (see Subchapter D, Chapter 311, Health and Safety Code). Examples of private hospitals that receive DSH payments are Baylor University Medical Center in Dallas, Hermann Hospital in Houston, the Cook Children's Medical Center in Fort Worth, and Highland Health System in Lubbock.

Hospitals in Texas qualify for DSH funds in one of three ways. An eligible hospital must have a disproportionate:

(1) total number of inpatient "days" for Medicaid patients;

(2) percentage of all inpatient days for Medicaid patients; or

(3) percentage of inpatient days for low-income patients.

Texas has designated three University of Texas teaching hospitals and all children's hospitals as disproportionate share hospitals provided they meet federal and state qualification guidelines. In SFY 2002, 169 hospitals qualified for DSH reimbursement, with other facilities awaiting determination of eligibility. Those qualified include:

- 92 public hospitals
- 45 private, nonprofit hospitals
- 32 for-profit hospitals

What conditions on DSH participation are imposed by federal law?

Federal law requires that states classify certain hospitals as DSH-eligible based on the facility's Medicaid inpatient utilization rate or "low-income utilization rate."[2] However, this determination does not guarantee that the hospital will receive DSH payments.

There are only two *federal* statutory conditions to qualify for the DSH program:

(1) at least one percent of a facility's total inpatient days must be attributable to Medicaid patients; and

(2) if the hospital offers obstetrical services, the hospital must provide at least two obstetricians with staff privileges who agree to serve Medicaid beneficiaries.

Are there any conditions on participation imposed by Texas?

With certain exceptions for specific types of hospitals, participation in Texas' DSH program is contingent on a number of conditions relating to:

- indigent patient eligibility criteria
- the ratio of charity charges to the DSH payment
- posting requirements informing patients of DSH eligibility and available charity care
- DSH funds reporting and records maintenance
- annual assessments of community health care needs with demonstration of DSH fund use
- reports on availability of nonemergency primary care
- active participation in development of regional trauma system
- obstetrical care requirements
- disqualification for certain hospital districts and city/county hospitals whose local revenue exceeds DSH funds received

How are hospitals reimbursed?

The DSH program in Texas first reimburses hospitals of the Texas Department of Health and mental health facilities operated by the Texas Department of Mental Health and Mental Retardation at their adjusted hospital-specific limits. The non-state public and private disproportionate share hospitals are then reimbursed with the lesser of the remaining annual DSH allotment or their adjusted hospital-specific limits.[3]

State-owned teaching hospitals are reimbursed from a separate fund.[4]

Are there any federal restrictions on the amount of DSH payments to hospitals?

There are two caps on the amount of DSH payments that can be made to hospitals:

- A limit is imposed by federal law on the maximum amount of DSH funds that can be paid to mental health facilities and institutions for mental diseases (IMDs). Texas' DSH spending on IMDs is limited to the lower of the amount spent in FFY 1995 or 33 percent of the DSH allotment. In FFY 2000, Texas' DSH spending on IMDs was limited to 19.3 percent of the total allotment.

- A limit is imposed by federal law on the amount an individual hospital can receive under DSH. The amount of money a hospital receives cannot exceed the sum of:

  (1) the hospital's unreimbursed Medicaid costs (the Medicaid shortfall); and

  (2) the hospital's uncompensated care costs (meaning the costs of treating patients without insurance or another means to pay).

  Hospitals can be reimbursed for up to 100 percent of the sum of these costs; this is the DSH reimbursement rate of 100 percent.

What is the "increased" DSH reimbursement limit?

Responding to perceived abuses in some states' DSH program financing methods, the United States Congress reduced federal spending for DSH in the Balanced Budget Act of 1997. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 provided relief to state DSH programs from the reductions mandated by the BBA. One way BIPA provided relief was through a temporary increase in the DSH reimbursement rate from 100 to 175 percent of uncompensated care costs for SFY 2003 and SFY 2004. The increased reimbursement rate applies to all public hospitals, including those owned or operated by the state.

What would adopting the 175 percent rate for the next two years mean for Texas?

Taking advantage of the increased DSH reimbursement rate would not affect the amount of federal funds available for the DSH program.

As discussed above, Texas reimburses state-owned or state-operated dispro hospitals for the maximum amount allowed by federal law and then distributes the remainder of the allotment to other hospitals. Adopting the increased rate would shift a larger portion of the DSH allotment from non-state facilities to state hospitals. The office of the comptroller estimates this would bring in $192 million over the 2003-2004 biennium to state disproportionate share hospitals.

If Texas chooses to reimburse state disproportionate share hospitals at the 175 percent rate, the shift in DSH funds will decrease the share of DSH funds available to non-state dispro hospitals.

Can the loss to non-state disproportionate share hospitals be mitigated?

Two options available to reduce the potential loss of DSH funds to non-state public hospitals are to:

(1) adopt a broader Medicaid upper payment limit plan; or

(2) weight the formula of DSH funds distribution to the advantage of certain hospitals.

What is the Medicaid upper payment limit (UPL)?

The federal government has allowed states to reimburse hospitals for certain uncompensated care provided under Medic*aid* at an amount equal to what Medi*care* would have paid for the same service, which is typically a higher amount. This is called the Medicaid "upper payment limit."

The upper payment limit is financed like all other Medicaid programs, with both state and federal matching funds. States use intergovernmental transfers to contribute funds for use under UPL.

Does Texas have a UPL plan?

Texas has adopted a limited UPL plan that covers only the urban, public hospital districts in Harris, Tarrant, Dallas, El Paso, Ector, Lubbock, Nueces, Travis, and Bexar counties that are below the UPL cap. Texas also makes UPL payments to public hospitals in rural counties with a population of less than 100,000.

How does Texas pay for UPL?

Texas provides its UPL contribution to be matched by federal funds through intergovernmental transfers from the same local hospital districts covered by its UPL plan. The Health and Human Services Commission reports that these districts received $24.9 million in additional federal funds in SFY 2001 and $105 million in SFY 2002.

How has federal legislation affected UPL?

Due to perceived abuses of the UPL rule to redirect federal funds to non-health-related programs in state budgets, the BIPA of 2000 changed the way UPL is calculated. The act instructed the U.S. Secretary of Health and Human Services and the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to publish a rule that would:

(1) establish three separate UPL categories for state-owned or state-operated hospitals, private hospitals, and public, non-state hospitals; and

(2) set specific transition periods for states to phase out UPL financing arrangements that do not comply with new regulations, depending on the effective date of the respective state's program—the older the program, the longer the period of transition.

Does Texas' UPL plan comply with the new federal regulations?

Texas' UPL plan complies with BIPA and federal regulations adopted in 2002 and has gone a step further to address recent federal government concerns, mandating that all UPL funds received by the state be used to either enhance payments to hospitals or support medical teaching facilities.

What is the UPL reimbursement rate?

The UPL reimbursement rate is 100 percent of the Medi*care* payment level. This reimbursement is for uncompensated costs of providing qualifying inpatient and outpatient services, nursing facility services, intermediate care facility services for the mentally retarded (ICFs-MR), and clinic services.

How can a broader UPL plan help disproportionate share hospitals?

A broader UPL plan would reimburse as many eligible hospitals as possible, including disproportionate share hospitals, at the higher Medi*care* payment level. This could offset some of the loss in DSH funds created if Texas adopts the increased DSH reimbursement rate.

Federal Legislative Actions Since 1991

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

- Texas' DSH program allotment is capped at $1.513 billion in all funds per federal fiscal year
- changes are made in funding mechanisms used to finance states' share of DSH program: provider taxes are restricted, provider donations are prohibited, and intergovernmental transfers are permitted
- state DSH allotment caps are adopted

The Omnibus Budget Reconciliation Act (OBRA) of 1993

- DSH payments to hospitals are limited to amount of uncompensated care costs
- dispro hospitals are required to serve a minimum of one percent Medicaid patients to remain eligible

- amount of DSH funds is capped for individual hospitals
- effectively shifts distribution of Texas' DSH funds from state hospitals to non-state local hospitals, resulting in a reduction of approximately $248 million in DSH payments to state facilities between SFY 1995 and SFY 2002

The Balanced Budget Act (BBA) of 1997

- federal contributions to DSH programs are limited on a state-specific basis and reductions scheduled for five years
- federal funds contributed to Texas' DSH program are reduced from $947 million in FFY 1997 to an expected $765 million in FFY 2003
- DSH payments to institutions for mental disease (IMDs) are reduced and capped at 33 percent of a state's DSH allotment

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

- reductions in DSH funds are postponed for two years, until FFY 2003
- DSH reimbursement rate is increased from 100 percent to 175 percent of uncompensated care costs for FFY 2003 and FFY 2004
- states' DSH allotments are changed
- DSH allotments for states with extremely low DSH funding are increased
- new rules regarding states' UPL programs are adopted
- separate UPL categories for state and non-state hospitals are created
- UPL payment rate for non-state hospitals is increased

Notes

1. Reductions in Texas' DSH allotment scheduled by the Balanced Budget Act of 1997 are effective for the first time in FFY 2003. According to the BBA, Texas' federal contribution for a given year is calculated by taking the previous year's allotment (in this case the FFY 2002 allotment set out in the act) and increasing that amount by the percentage change in the consumer price index for all urban consumers (CPI-U - all items; U.S. city average) for the previous year. The percentage change in the CPI-U for 2002 is 2.4. However, the BBA also restricted any states' DSH allotment from exceeding the greater of the allotment for the previous year or 12 percent of total Medicaid spending by the state.

2. The low-income utilization rate is unique to the DSH program. The rate is the result of the following computation: ((Title XIX inpatient hospital payments plus inpatient payments received from state and local governments) divided by (gross inpatient revenue multiplied by cost-to-charge ratio)) plus ((total inpatient charity charges minus inpatient payments received from state and local governments) divided by (gross inpatient revenue)).

3. A hospital-specific limit is the sum of the following: the Medicaid shortfall and the cost of services to uninsured patients. The adjusted hospital-specific limit is the hospital-specific limit trended forward to adjust to inflation.

4. State-owned teaching hospitals receive monthly disproportionate share payments based on the following formula: (monthly charity charges of the state-owned teaching hospital) divided by (total monthly charity charges of all state-owned teaching hospitals multiplied by available fund). If the adjusted hospital-specific limit for a state-owned teaching hospital is less than the result of that formula, the state hospital will receive 100 percent of its adjusted hospital-specific limit.

Sources

1 T.A.C. Section 355.8065 (1993).

1 T.A.C. Section 355.8067 (1996).

42 U.S.C. Section 1396r-4.

42 C.F.R. Part 447.

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