History of the Medicaid Disproportionate Share Hospital (DSH) Program 1981–2009

Jim Frizzera, Principal
Health Management Associates
Established the Medicaid disproportionate share hospital (DSH) adjustment.

Required States to set Medicaid reimbursement rates for hospital inpatient services that take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

Section 1923 of the Social Security Act.
In 1983, HCFA limited a State’s aggregate Medicaid payments for inpatient hospital services to no more than the amount that would have been paid under Medicare payment principles.

By 1985, only about one-third of all States had established specific DSH payment methodologies.

- Clarified limit on Medicaid inpatient hospital payments was not applicable to Medicaid DSH payments.
- Express permission to make Medicaid DSH payments without limitation.
Omnibus Budget Reconciliation Act of 1987 (OBRA 87) (P.L. 100–203)

- Required States to submit State plan amendments authorizing Medicaid DSH payments – 1923(a).
- Deemed hospitals eligible for DSH based on Medicaid or low-income utilization rate threshold – 1923(b).
- Required minimum payment adjustment equal to Medicare or in proportion to the increase in a hospital’s Medicaid utilization rate – 1923(c).
- Must have at least 2 obstetricians with staff privileges that agree to provide obstetric services to Medicaid patients – 1923(d).
Omnibus Budget Reconciliation Act of 1990 (OBRA 90) (P.L. 101–508)

- Proportionate increased adjustment may also apply to a hospital’s low-income utilization rates – 1923(c).
- Permitted separate DSH payment methodologies according to type of hospital – 1923(c).
- Extended prohibition on changing the treatment of voluntary contributions and provider-specific taxes, which was enacted under the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100–647).

- First piece of stand-alone Medicaid legislation in program history.
- Medicaid DSH expenditures had increased from slightly less than $1 billion in 1989 to more than $17 billion by 1992.
- Imposed restrictions on provider-related donations and health care-related taxes –1903(w).
- Imposed ceiling on national DSH spending (12 percent of Medicaid spending) – 1923(f).
- Imposed ceiling on State DSH spending (based on FY 1992 DSH spending) – 1923(f).
Omnibus Budget Reconciliation Act of 1993 (OBRA 93) (P.L. 103–66)

- Imposed hospital-specific limits on Medicaid DSH payments under section 1923(g) to:

  “…..the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under the title, other than this section and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.”

- State or local payments for indigent services not considered third party payments.

- Must have at least 1% Medicaid utilization rate to qualify as a DSH hospital 1923(d).
Defined calculation of Medicaid utilization rate.

Defined method of calculating the hospital–specific DSH limit (Medicaid shortfall and uninsured cost).

Defined costs eligible under the hospital–specific DSH limit.

Defined uninsured patients.

Defined High DSH hospital – able to receive 200% of limit during SFY 2005.

- Required States to report the name of each hospital qualifying for a DSH payment and the amount of the DSH payment made to each hospital – 1923(c).
- Phased-down Medicaid DSH allotments between FYs 1998 and 2002 and limited FY 2003 allotment to prior FY DSH spending increased by percentage growth in CPI – 1923(f).
- Limited Medicaid DSH payments made to institutions for mental diseases (IMDs) and other mental health facilities – 1923(h).
- Requirement for direct payment – DSH payment must be made directly to a hospital and cannot be included in managed care capitation rates – 1923(i).

- Increased Medicaid DSH allotments in FY 2000 through FY 2002 for DC, MN, NM, and WY.

- Clarified that the enhanced Federal matching rate under SCHIP was not applicable to Medicaid DSH payments.
Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (P.L. 106-554)

- Continued State Medicaid DSH allotments for FY 2001 and FY 2002 at the FY 2000 level.
- Permitted States to make Medicaid DSH payments up to 175% of public hospitals’ uncompensated care costs for a 2-year period beginning with FY after September 30, 2002.
- Inclusion of Medicaid managed care days in MIUR and Medicaid managed care payments in LIUR – 1923(b).
August 16, 2002 – State Medicaid Director Letter

- Required offset of Medicaid “profit” against uninsured costs when calculating the hospital-specific DSH limit.

- Uncompensated care cost of inmates of correctional facilities not included in the hospital-specific DSH limit – considered wards of the State.

- Clarified calculation of MIUR and LIUR.

- Subsequent allotments limited to greater of 2004 Medicaid DSH allotment or prior year allotment increased by percentage growth in CPI–U.
- Low DSH – Increased FY 2003 Medicaid DSH allotment by 16% for FYs 2004–2008
- Required States to annually:
  - report each facility that received a DSH payment; and
  - obtain an independent certified audit of their DSH programs to verify DSH payments are made within the hospital–specific DSH limits – 1923(j).

- Prospective adjustment to DC DSH allotment from $32 million to $49 million for FY 2006 and subsequent years
Established Medicaid DSH allotments for Tennessee and Hawaii – 1923(f)

AL, CA, IL, LA, MO, NC, OH, TX, VA, and WA.

OIG final report indicated nine of ten States did not comply with the hospital-specific DSH limits and that DSH payments exceeded the hospital-specific DSH limits by approximately $1.6 billion ($902 million Federal share).

Basis of finding related to lack of reconciliation and unallowable costs included in calculation of hospital-specific DSH limit.
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111–3)

- Extended Medicaid DSH allotments for Tennessee and Hawaii through December 31, 2012 – 1923(f)

- Provided temporary Medicaid DSH allotment increase for FY 2009 and 2010.
- FY 2009 – existing FY 2009 Medicaid DSH allotment increased by 2.5%.
- FY 2010 – “enhanced” FY 2009 Medicaid DSH allotment increased by 2.5% (unless the increase due to inflation would be higher for FY 2010)
# DSH Allotments for Fiscal Year 2009

From the American Recovery and Reinvestment Act (ARRA)

<table>
<thead>
<tr>
<th>States / Territories</th>
<th>FY 2009 DSH Allotment Prior to ARRA</th>
<th>FY 2009 DSH Allotment Under ARRA</th>
<th>Amount Of Increase In DSH Allotment</th>
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Medicaid Disproportionate Share Hospital (DSH) Reporting and Audit Requirements

Effective January 19, 2009
Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted on December 8, 2003.

MMA added section 1923(j)(1) to the Social Security Act (the Act) to require States to report additional information about their Medicaid DSH programs.

MMA added section 1923(j)(2) of the Act to require States to have their Medicaid DSH payment programs independently audited and to submit the independent certified audit annually to the HHS Secretary.
States must identify each disproportionate share hospital that received a Medicaid DSH payment adjustment for the preceding FY and the amount of the DSH payment adjustment made to such hospital for the preceding FY.

Authorizes the Secretary of HHS to determine other information necessary to ensure the appropriateness of the DSH payment adjustment.
Independent Certified Audit – 1923(j)(2)

The independent certified audit must verify 5 elements:

- **Verification 1** – the extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed Medicaid DSH expenditures.

- **Verification 2** – Medicaid DSH payments to each hospital comply with the hospital-specific DSH limit.

- **Verification 3** – only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid and uninsured individuals are included in the hospital-specific DSH limit.
Independent Certified Audit – 1923(j)(2)

- **Verification 4** – the State included all Medicaid payments, including supplemental payments, in the calculation of the hospital-specific DSH limit.

- **Verification 5** – The State has separately documented and retained a record of all its Medicaid costs and claimed Medicaid expenditures, uninsured costs in determining Medicaid DSH payment adjustments, and any payment made on behalf of the uninsured from DSH payment adjustments.

- Federal matching payments are contingent upon a State’s submission of the annual DSH report and independent certified audit.
The Centers for Medicare and Medicaid Services (CMS) issued a notice of proposed rulemaking to implement the Medicaid DSH reporting and auditing requirements of MMA on August 26, 2005. (Federal Register/Vol. 70, No. 165)

CMS issued the Medicaid DSH reporting and auditing final regulation on December 19, 2008. (Federal Register/Vol. 73, No. 245)

The final rule became effective 30 days after publication or January 19, 2009.
The final regulation identifies the Medicaid State plan rate year as the time period to which the audits will apply.

Medicaid State plan rate year – one uniform time period under which all States must estimate uncompensated care costs in order to make Medicaid DSH payments.

Recognition of varying fiscal periods between hospitals and States.
“Independent certified audit” – conducted by an auditor that operates independently from the Medicaid agency or subject hospitals (Single State Audit Agency or other CPA firm that operates independently).

Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice.

Certification includes a review of the State’s audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital’s specific DSH limit in the Medicaid State plan rate year under audit.
- Identified that the Medicaid State plan rate year 2005 and 2006 audits must be completed no later than the last day of FFY 2009 (September 30, 2009).

- Each subsequent audit must beginning with Medicaid State plan rate year 2007 must be completed by the last day of the FFY ending 3 years from the Medicaid State plan rate year under audit. (i.e., 2007 audit must be completed by September 30, 2010)

- Each audit report must be submitted to CMS within 90 days of the completion of the independent certified audit.
The final regulation identified 17 data elements necessary to fulfill the auditing and reporting requirements.

Primary sources and source documents from which States will draw data necessary to complete the independent certified audit:

a. approved Medicaid State plan for the State plan rate year under audit;

b. State Medicaid Management Information Systems (MMIS) payment and utilization data;

c. Medicare 2552–96 cost report or subsequent Medicare defined hospital cost report tool; and,

d. DSH hospital audited financial statements and hospital accounting records.

General DSH Auditing and Reporting Protocol – provides States, hospitals, and auditors with guidance to utilize information from each source and develop the methods under which costs and revenues will be determined.
Established a transition period to avoid immediate adverse fiscal impact and to ensure a period for developing and refining reporting and auditing techniques.

Findings of audits for Medicaid State plan rate years 2005 – 2010 will be used only for the purpose of determining prospective hospital-specific eligible uncompensated care estimates and associated Medicaid DSH payments.
Findings from 2005 and 2006 Medicaid State plan rate year audits must be taken into account for determining 2011 uncompensated care costs and associated Medicaid DSH payments.

Findings associated with Medicaid State plan rate years 2007 through 2010 must be similarly considered for Medicaid State plan rate years 2012 through 2015.

Medicaid DSH payments that exceed the hospital-specific DSH limits in Medicaid State plan rate year 2011 must be returned to the Federal government or redistributed by States to other qualifying hospitals.
Hospitals that do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from other uncompensated costs will need to modify accounting systems.

Only inpatient and outpatient hospital charges associated with individuals with no source of third party coverage for such services can be applied to the Medicare cost report for purposes of calculating the uninsured component of the hospital-specific DSH limit.
Hospitals must ensure no duplication of eligible charges exist in their accounting records and must make that information available to the auditor for certification.

States and auditors will need to work with hospitals to develop a methodology that can be applied to hospital accounting records to properly calculate uncompensated care costs incurred in furnishing inpatient and outpatient hospital services for individuals without health insurance coverage or other third party coverage.
Physician services generally not included in the hospital–specific DSH limits – generally not considered hospital service costs in either Medicare or Medicaid.

Physician services are separately recognized as professional costs in the Medicare cost report and are removed from inpatient and outpatient hospital costs as part of the hospital cost allocation step-down process.

Physician services that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital–specific DSH limit.
Bad debt is a non-payment on behalf of an individual with third party coverage and is not an eligible cost under the hospital-specific DSH limit (unpaid co-pays or deductibles, denied health insurance claims, payer discounts afforded to health insurers or other third party payers).

Individuals “who have health insurance (or other third party coverage)” broadly refers to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer.
Miscellaneous – Noteworthy clarifications provided in the final regulation:

- All Medicare (including DSH and GME) and Medicaid revenue must be taken into account when determining the Medicaid uncompensated care cost attributable to dually eligible individuals.

- Section 1011 payments attributable to inpatient and outpatient hospital services provided to aliens with no source of third party coverage must be offset against such costs in the calculation of the hospital-specific DSH limit.
Sources:

2. August 17, 1994 Dear State Medicaid Director Letter from Sally K. Richardson
3. August 16, 2002 Dear State Medicaid Director Letter from Dennis G. Smith
4. CRS Report for Congress; Medicaid Disproportionate Share Payments; January 10, 2005
5. Analysis of Joint Distribution of Disproportionate Share Hospital Payments: Overview of DSH Funding Policies; HHS/ASPE/OHP
7. Medicaid Program: Disproportionate Share Hospital Payments; Final Rule (Federal Register/Vol. 70, No. 165)