ARIZONA STATE SENATE

Forty-ninth Legislature, First Regular Session

PROGRAM PRESENTATION

Disproportionate Share Hospital Payment Program

Background

The Medicaid Disproportionate Share Hospital (DSH) Payments Program was established by Congress in the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) to support hospitals that serve large numbers of Medicaid and low-income patients. Hospitals with a high proportion of Medicaid patients often also have many uninsured patients and low numbers of privately insured individuals, and therefore may be limited in their ability to shift the costs of uncompensated care to the privately insured. OBRA 1981 also changed how Medicaid payments to hospitals were calculated and Congress was concerned that the change might harm hospitals that served large numbers of Medicaid patients. As a result, the legislation required states to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care.

Federal Requirements

Under the DSH program, a state makes a separate payment to a hospital in addition to its standard Medicaid reimbursement. After the state makes the DSH payment, the federal government reimburses the state for part of the cost of the payment, based on the state's Medicaid matching rate.

Federal law allows a hospital to be considered a DSH hospital if the hospital has a Medicaid inpatient utilization rate (the share of total inpatient days attributable to Medicaid patients) of at least one percent and has at least two obstetricians with staff privileges who agree to serve Medicaid patients (excluding children's hospitals). In addition, the hospital must serve a specified proportion of Medicaid or low-income patients. Within federal guidelines, states have flexibility in the structure of their DSH programs and states may include additional hospitals in their definition of an eligible hospital as long as the criteria is more generous than the minimum federal standards.

Over time, Congress has enacted adjustments to the DSH program, including restricting the types of fund sources states can use as the state's share of DSH payments, setting state-specific allotments of federal DSH funding, capping total DSH payments at 12 percent of total Medicaid benefits payments and establishing a formula to determine the maximum DSH funding each hospital may receive.[1] States are then free to determine how to direct their funding to hospitals as long as the methodology does not violate federal requirements.

[1] In the early 1990s, many states began using fund sources such as provider taxes, donations and intergovernmental transfers to finance the state's share of DSH payments without having to use actual state dollars. In addition, states were making payments to certain facilities in excess of the facilities' uncompensated care burden in order to funnel the monies back through the state. Many congressional changes to the DSH program have limited the states' abilities to use these creative financing mechanisms.

Arizona's DSH Program

Administered by the Arizona Health Care Cost Containment System (AHCCCS), Arizona's DSH program was first established by the Legislature in 1991. In Arizona, there are four groups eligible for DSH payments. Neither state statute nor AHCCCS rule specifies the eligibility criteria; rather, the qualifications are enumerated in AHCCCS policy. The first two groups are based on the federal requirements; the last two are state options that include county, state and private hospitals:

- hospitals whose Medicaid inpatient utilization rate is at least one standard deviation above the state's mean Medicaid inpatient utilization rate.
- hospitals with a low-income utilization rate of more than 25 percent.
- acute care general hospitals that have either a low-income utilization rate greater than the statewide average or provide at least 1 percent of total Medicaid days in the state.
- State, county and certain special health care district hospitals (currently, the Arizona State Hospital and the Maricopa Medical Center).

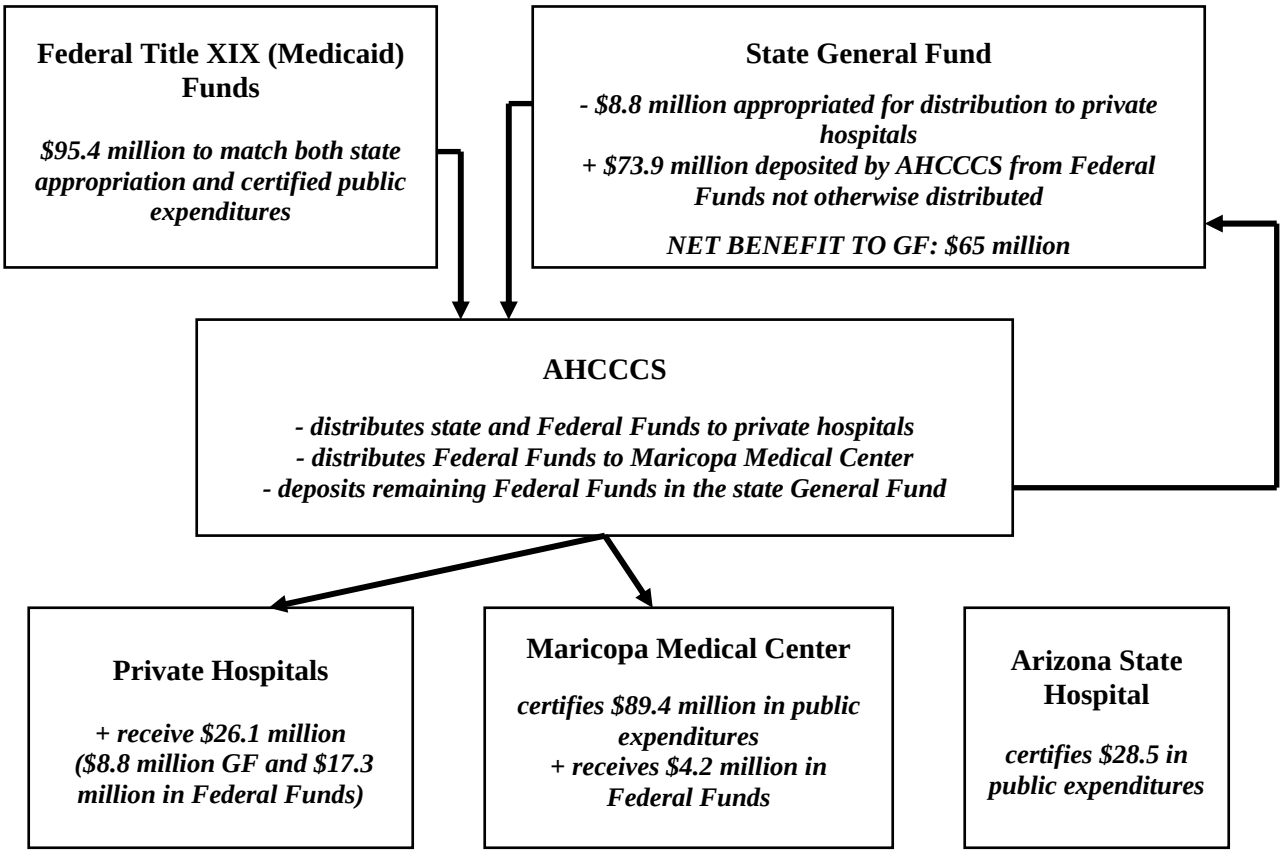
Prior to FY 2007-2008, the DSH funding mechanism was as follows: each year, the Legislature appropriated the total funds available for DSH payments (federal Title XIX Medicaid funds and state General Fund monies) to AHCCCS. A footnote in the General Appropriation Act distributed the total amount from AHCCCS to qualifying private hospitals, the Maricopa Medical Center and the Arizona State Hospital. The Special Health Care District (which oversees the Maricopa Medical Center) retained a small portion of the payments for uncompensated care ($4.2 million) and transferred the remainder to Maricopa County. One of the annual budget reconciliation bills required the remainder amount to be withheld from the county's transaction privilege tax (TPT or sales tax) revenue distribution. In the case of the Arizona State Hospital, the funding essentially passed through and reverted back to the state General Fund.

As part of its 2006 waiver renewal, the federal government began to require AHCCCS to utilize a different DSH mechanism for the Arizona State Hospital and Maricopa Medical Center beginning in FY 2007-2008. Under the new mechanism, the two entities will each certify that they have expended monies that would qualify as DSH expenditures (known as a "certified public expenditure" or CPE) in an amount at least equal to the amount budgeted for DSH expenditures[2]. As the state Medicaid agency, AHCCCS draws down federal matching monies, which essentially serve as a reimbursement of the federal government's share of providing those services (at the standard Medicaid rate). According to the federal government, the state then has the discretion whether to distribute those funds to the Arizona State Hospital and Medical Center and how much to distribute. The FY 2007-2008 budget requires the two entities to provide documented certification of expenditures. AHCCCS must then distribute $4.2 million to the Maricopa Medical Center (which is equivalent to the distribution in prior years) and deposit the remaining federal funds into the state General Fund. The Arizona State Hospital does not receive a distribution. The net benefit to the state General Fund under the old and new mechanisms remains the same (barring any policy, matching rate or other changes to the program).

[2] If the amount is less than budgeted, AHCCCS must determine if the calculation methodology was correct. If the methodology is incorrect, Maricopa Medical Center does not receive its distribution.

DSH Funding Flow Chart

The following flow chart demonstrates the current DSH mechanism.



Fiscal Information

According to the Joint Legislative Budget Committee (JLBC), the FY 2008-2009 budget adjustments adopted January 31, 2009, eliminates $13,124,500 of DSH payments from the FY 2008-2009 budget.

Committee Activity

The Healthcare and Medical Liability Reform Committee reviewed the DSH payment program on Wednesday, February 11, 2009. The Deputy Director of AHCCCS presented an overview of the DSH program, payment methodology, funding stream and the results of the FY 2008-2009 budget adjustment to DSH (see attached PowerPoint). Finally, representatives from University Medical Center, Maricopa Integrated Health System, Flagstaff Medical Center, Phoenix Children's Hospital, Yuma Regional Medical Center and St. Joseph's Hospital provided testimony about DSH and its impact on hospitals.

FY 2008-2009 Budget Action

According to JLBC, the FY 2008-2009 budget adjustment enacted on January 31, 2009, eliminates $13,124,500 of DSH payments to hospitals. This amount is composed of $8,922,200 of DSH funds that had been appropriated for private hospitals, and $4,202,300 that had been allocated to Maricopa Integrated Health System.

Attachments

1) PowerPoint Presentation: "Disproportionate Share Hospital Payments (DSH)." Presented by Tom Betlach, Deputy Director of AHCCCS, to the Healthcare and Medical Liability Reform Committee on February 11, 2009.
2) "*Arizona Health Futures: Deconstructing DSH*." Linda Cannon, St. Luke's Health Initiatives. July 2003.
3) United States Government Accountability Office. Letter to The Honorable Max Baucus, Chairman, Committee on Finance, United States Senate. February 4, 2009. www.gao.gov.

Prepared by Senate Research
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