DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT PROGRAM

INTRODUCTION

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.
DSH Payment Program

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. States are then free to determine how to direct their funding to hospitals as long as the methodology does not violate federal requirements.

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 (Laws 1991, 4th S.S., Chapter 3). 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 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 Maricopa County 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 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. 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. Beginning in FY 2008, the

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.

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.
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budget requires the two entities to provide documented certification of expenditures. AHCCCS then distributes $4.2 million to the Maricopa Medical Center (which is equivalent to the distribution in prior years) and deposits 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).

In FY 2010, the Legislature appropriated $4.2 million to the Maricopa Medical Center and $26.1 million to private hospitals. Due to state budget shortfalls, the Legislature reduced the appropriation of DSH funds to private hospitals to $500,000, the minimum amount required by federal law to maintain the program (Laws 2010, 3rd S.S., Chapter 10 and Laws 2010, 7th S.S., Chapter 1). In addition, the Legislature authorized political subdivisions, tribal governments and state public universities to make voluntary DSH contributions in FY 2010. Entities that make voluntary contributions in an amount sufficient to qualify for federal matching funds may designate eligible hospitals to receive the funds (Laws 2010, Chapter 86). In FY 2010, local, county and tribal governments and public universities contributed $22.7 million.

The following flow chart demonstrates the current DSH mechanism, based on the expected amounts in FY 2010.

**DSH FUNDING FLOW CHART**

**Federal Title XIX (Medicaid) Funds**
- $89.2 million to match both state appropriation and certified public expenditures

**Voluntary Contributions**
- $22.7 million generate Federal matching funds

**State General Fund**
- $171,300 appropriated for distribution to private hospitals
- $41 million deposited by AHCCCS from Federal Funds not otherwise distributed

**NET BENEFIT TO GF: $40.8 million**

**AHCCCS**
- distributes state and Federal Funds and voluntary contributions to private hospitals
- distributes Federal Funds to Maricopa Medical Center
- deposits remaining Federal Funds in the state General Fund

**Private Hospitals**
- receive $500,000 ($171,300 GF and $328,700 in Federal Funds)
- receive $66.4 million ($22.7 million in contributions and $43.7 million in Federal Funds)

**Maricopa Medical Center**
- certifies $63.7 million in public expenditures
- receives $4.2 million in Federal Funds

**Arizona State Hospital**
- certifies $28.5 million in public expenditures
ADDITIONAL RESOURCES

- Title XIX of the Social Security Act, Sections 1092 and 1923 (42 U.S.C. 1396a and 42 U.S.C.1396r-4)

- Arizona Revised Statutes: § 36-2903.01(P)


- Annual Appropriations Report, Joint Legislative Budget Committee
  www.azleg.gov/jlbc.htm


- “The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues,” Teresa A. Coughlin and David Liska, The Urban Institute, October 1997