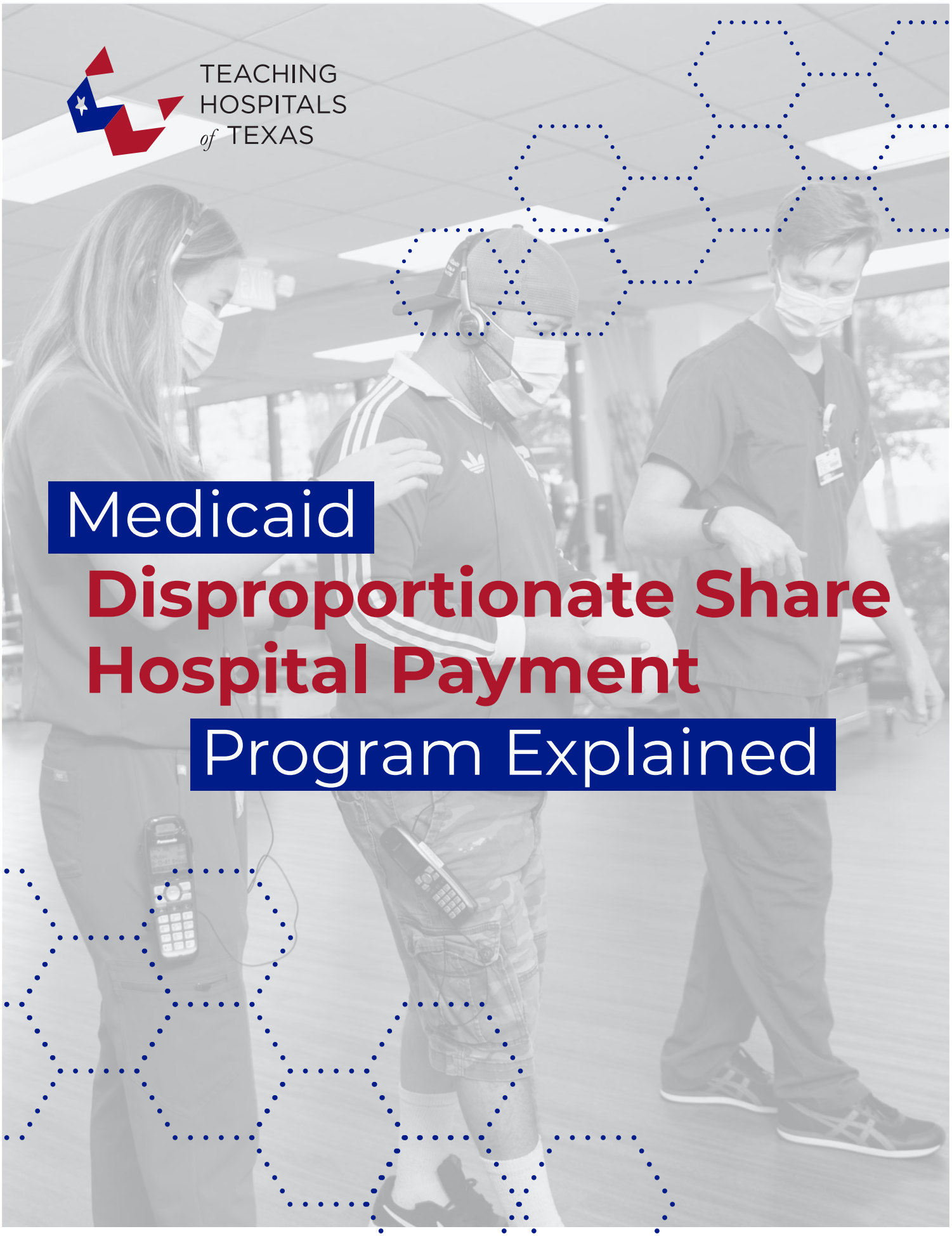
TEACHING HOSPITALS of TEXAS



Medicaid Disproportionate Share Hospital Payment Program Explained

Established in 1981, the Medicaid disproportionate share hospital payment program provides funding to hospitals that provide a disproportionate share of a state's care for those who are uninsured and those with Medicaid. In Texas, the Medicaid DSH program is one of only two Medicaid supplemental payment programs that help support hospitals' costs of providing uninsured care, making it critical in a state with an uninsured rate of more than 18 percent.[1]

In federal fiscal year 2020, 172 Texas hospitals received $1.8 billion in Medicaid DSH payments.

Future DSH payments may be reduced, however. The Patient Protection and Affordable Care Act (ACA)[2] included reductions to state Medicaid DSH allotments equal to $18.1 billion between federal fiscal years 2014 and 2020. These reductions assumed that the ACA would increase the number of individuals with health insurance (in part through Medicaid expansion), which, in turn, would reduce uncompensated care costs and the need for DSH payments. While these reductions have been postponed numerous times since 2020, they are slated to occur beginning FFY 2024 through FFY 2027 at a much larger amount than originally proposed: $32.0 billion.[3] Additional reductions of 12.5 percent to DSH allotments for non-expansion states, like Texas, were included in the U.S. House of Representatives' version of the Build Back Better legislation but deleted in the U.S. Senate's version.

Definition, Intent, and Statutory Requirements

Medicaid DSH payments are:

- Authorized by Congress to support hospitals that provide a "disproportionate share" of healthcare for patients without health insurance and patients with low-paying Medicaid coverage.
- Intended to maintain and improve access for Medicaid and uninsured patients.
- Required under the Social Security Act. [4]

Federal law establishes an annual DSH allotment for each state and includes an annual inflator. From its allotment of $1.84 billion in 2020, Texas made $1.8 billion in DSH payments ($1.24 billion in federal funds and $677 million in state funds)[5] to 172 hospitals (163 non-state owned and nine state-owned hospitals).

The state determines how it will distribute DSH funds based on hospitals' volume of unreimbursed Medicaid and uninsured costs, within federal DSH criteria.

[1] Uncompensated care payments authorized under Texas' Medicaid 1115 Waiver are the only other supplemental Medicaid payments that help defray hospital's costs of providing healthcare to uninsured Texans.
[2] ACA; P.L. 111-148
[3] For a review of changes to DSH reductions and current law, see: https://crsreports.congress.gov/product/pdf/IF/IF10422
[4] Sec. 1923. [42 U.S.C. 1396r-4]
[5] Includes additional funds from 6.2% increase in the federal match rate due to the COVID-19 Public Health Emergency.

Eligibility and Conditions of Participation

To be eligible for DSH payments, a hospital must submit a completed application and meet one of the following requirements:

1) Have significant Medicaid utilization.
2) Have significant low-income, uninsured utilization.
3) Have significant total Medicaid days.

Other mandatory requirements include:

1) Maintain at least two physicians who have agreed to provide nonemergency OB services.[6]
2) Have a Medicaid inpatient utilization rate of at least one percent.
3) Have or be pursuing a trauma facility designation.[7]

Funding of the Non-federal Share of DSH Payments

As a supplemental payment authorized under the Medicaid program, DSH payments must be funded with both federal and non-federal funds. Federal funds are not available without submission of required non-federal funds.

The non-federal share of Texas' hospitals' DSH payments is provided through inter-governmental transfer (IGT) of funds from public entities, typically taxing hospital districts. Five large public hospital systems, known as "transferring hospitals",[8] provide the required non-federal funds for both themselves and all private hospitals. All other public hospitals provide the non-federal share for themselves. Private hospitals do not provide any funds to support the non-federal share of DSH payments.

State DSH Allocation Methodology

A state's DSH allotment is allocated across eligible DSH hospitals, with state-owned hospitals having preference. Distribution of remaining non-federal funds is based on the amount of IGT transferred by each hospital, including IGTs made by "transferring hospitals" for private hospitals. Private hospitals, which do not contribute to the non-federal share, are not eligible for non-federal funds.

After allocation of the non-federal funds, distribution of the associated federal allotment is based primarily on the sum of each hospital's (public and private) Medicaid and low-income days associated with Medicaid and uninsured patients. Any remaining funds are allocated to

[6] Requirement does not apply to children's hospitals.
[7] Requirement does not apply to children's hospitals or Institutions for Mental Diseases (IMDs)
[8] Parkland Health in Dallas, Harris Health in Houston, University Health in San Antonio, UMC El Paso, and John Peter Smith in Fort Worth provide IGT to support private hospital DSH payments.

rural public hospitals. No hospital may receive DSH payments over its DSH "cap," or hospital-specific limit (HSL).

Individual Hospital DSH Caps (Hospital-specific Limits)

Federal regulations subject each individual hospital receiving DSH payments to a hospital-specific limit (HSL). The HSL is intended to ensure a participating hospital does not receive DSH and other supplemental payments greater than the sum of its Medicaid shortfall and unreimbursed costs for uninsured patients. For hospitals receiving DSH payments, their total Medicaid payments cannot exceed their total allowable Medicaid and uninsured costs.

When repaid to them through their DSH allocation, the nearly $300 million that transferring hospitals IGT for private hospitals' DSH payments counts as a Medicaid payment, reducing the transferring hospitals' HSL and limiting their access to other Medicaid funding under the 1115 Waiver Uncompensated Care (UC) program and other Medicaid programs. Transferring hospitals and other public hospitals that IGT for their own DSH payments also have their HSLs reduced by the repayment of these IGT amounts.

The result is that hospitals that support the state's DSH program with their IGTs — public hospitals — could be penalized by a reduction in their access to other Medicaid funding with no similar reduction for private hospitals that do not contribute IGTs.

DSH Audit

Federal law requires that states submit an independent audit and an annual report describing DSH payments made to each hospital and identifying those hospitals that received DSH payments above their HSL. The state is required to recoup any payments exceeding the HSL. Recouped funds are redistributed to hospitals with remaining HSL room.

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