Medicaid Disproportionate Share Hospital Payments

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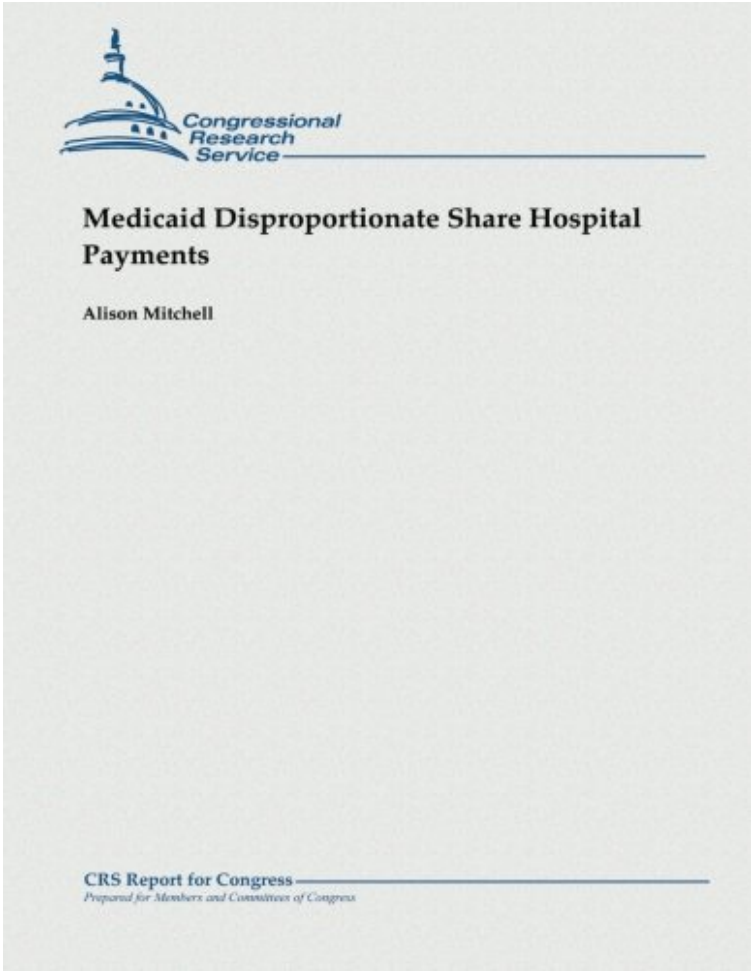

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Alison Mitchell : Medicaid Disproportionate Share Hospital Payments before purchasing it in order to gage whether or not it would be worth my time, and all praised Medicaid Disproportionate Share Hospital Payments:

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. This provision is intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance. As with most Medicaid expenditures, the federal government reimburses states for a portion of their Medicaid DSH expenditures based on each statersquo;s federal medical assistance percentage (FMAP). While most federal Medicaid funding is provided on an open-ended basis,

federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. In FY2012, federal DSH allotments totaled $11.3 billion. The health insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) are expected to reduce the number of uninsured individuals in the United States, which means there should be less need for Medicaid DSH payments. As a result, the ACA included a provision directing the Secretary of the Department of Health and Human Services to make aggregate reductions in federal Medicaid DSH allotments for each year from FY2014 to FY2020. The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) extended the DSH reductions to FY2021. The Supreme Courtrsquo;s decision regarding the ACA Medicaid expansion does not impact these DSH reduction amounts, but statesrsquo; decisions about implementing the ACA Medicaid expansion could impact the allocation of the DSH reductions across states. While there are some federal requirements that states must follow in defining DSH hospitals and calculating DSH payments, for the most part, states are provided significant flexibility. One way the federal government restricts statesrsquo; Medicaid DSH payments is that the federal statute limits the amount of DSH payments for Institutions for Mental Disease and other mental health facilities. Since Medicaid DSH allotments were implemented in FY1993, total Medicaid DSH expenditures (i.e., including federal and state expenditures) have remained relatively stable. Over this same period of time, total Medicaid DSH expenditures as a percentage of total Medicaid medical assistance expenditures (i.e., including both federal and state expenditures but excluding expenditures for administrative activities) dropped from 13% to 4%. This publication provides an overview of Medicaid DSH. It includes a description of the rules delineating how state DSH allotments are calculated and the exceptions to the rules, how DSH hospitals are defined, and how DSH payments are calculated. The DSH allotment section includes information about how the ACA DSH reductions may be allocated among the states, and the possible implications of the Supreme Courtrsquo;s decision regarding the ACA Medicaid expansion. The DSH expenditures section shows the trends in DSH spending and explains variation in statesrsquo; DSH expenditures. Finally, the basic requirements for state DSH reports and independently certified audits are also outlined.