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Report to the Honorable Ronald D. Coleman, House of Representatives

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MEDICAID

The Texas Disproportionate Share Program Favors Public Hospitals

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GAO

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The Honorable Ronald D. Coleman
House of Representatives

Dear Mr. Coleman:

This report responds to your interest in how the congressionally established Medicaid disproportionate share hospital (DSH) program affects hospitals in Texas.[1] As you know, this national program was established in 1981 to provide for the possibility of additional Medicaid payments to hospitals that serve large numbers of Medicaid and other low-income patients.[2] Such hospitals can face a significant financial burden because Medicaid reimbursements to health care providers are usually lower than other insurers. Rendering care to low-income patients who do not qualify for Medicaid can also cause a significant financial burden for these hospitals.

The Omnibus Budget Reconciliation Act of 1987 gives states minimum criteria and formulas for identifying hospitals that qualify for Medicaid disproportionate share status and for calculating the amount of each hospital's payment.[3] States can develop their DSH programs within the broad discretion provided, and a few states, including Texas, have received or are seeking exemptions from the federal requirements.[4]

Texas uses a unique formula[5] that it developed in 1986 to identify hospitals eligible for its Dispro I program[6] and to calculate the amount of each

[1]In a December 1992 letter, we described states' use of various formulas to identify their hospitals that qualify for Medicaid disproportionate share status and to determine the amount of additional funds they receive. We also described the Texas disproportionate share program. See Medicaid: Disproportionate Share Policy (GAO/HRD-93-3R, Dec. 22, 1992).

[2]The program was established under provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (P.L. 97-35).

[3]OBRA-87 (P.L. 100-203). The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-300), incorporated the OBRA-87 disproportionate share provisions into the Social Security Act.

[4]The Medicare Catastrophic Coverage Act of 1988 allowed Texas a 3-year exemption, beginning July 1, 1988, as long as its aggregate payment amount was not less than what it would have been if the state had to meet all OBRA-87 requirements. The 3-year exemption later became permanent under OBRA-90.

[5]Texas' formula was developed by the Texas Department of Human Services (TDHS). This department administers the Medicaid program with assistance under a contract with the National Heritage Insurance Company (NHIC).

[6]Texas, like some other states, has established multiple DSH programs. Although Texas currently has four DSH programs, this letter focuses on Dispro I because it is the most comprehensive and uses the 1986 formula. In state fiscal year (SFY) 1992, the Dispro I program provided about $221 million to 118 of Texas' 424 Medicaid hospitals.

hospital's additional Medicaid payment. The Dispro I formula includes three factors: Medicaid days, which measures hospital care provided to Medicaid beneficiaries; Medicare/Medicaid dual eligible days, which measures care provided to beneficiaries eligible for both programs; and additional indigent days. Texas bases its calculation of additional indigent days on the amount of local and state non-Medicaid revenue each hospital receives. Texas officials told us they developed the additional-indigent-days factor for the formula because hospitals did not consistently generate the specific data needed to directly measure charity care provided to low-income patients in the state.

In anticipation of possible changes to the program being considered by the Texas state legislature, you asked us to assess the formula Texas uses in its Dispro I program and its effect on hospitals qualifying for program funds. You also asked us to describe how other states measure the amount of care their hospitals provide to all of their low-income patients and the approach they take in collecting and validating hospital data.

Results in Brief

We found that use of the existing Texas Dispro I formula favors public hospitals that receive a relatively large amount of state and local revenue. The formula for the Dispro I program does not give full credit to the charity care provided by hospitals with a significant charity care burden but relatively little state and local revenue—such as some private hospitals.

To analyze the effect of additional indigent days as a factor in the Texas formula on the 424 hospitals participating in the Texas Medicaid program, we performed an analysis that only considered Medicaid and Medicare/Medicaid dual days. We found that 40 hospitals, all public, that received Dispro I funds in SFY 1992 would not have qualified for funding based solely on Medicaid and Medicare/Medicaid dual eligible days. On the other hand, 31 hospitals that did not qualify would have—24 of those hospitals were nonprofit or proprietary hospitals.

Nine state psychiatric hospitals provide a striking example of the effect the additional-indigent-days calculation has on determining disproportionate share status and payments. All nine hospitals had state and local revenue exceeding 70 percent of their total inpatient charges. They represent 8 percent of the hospitals qualifying for the Dispro I program, but received a total of over $96 million or 44 percent of total Dispro I funds. In our analysis, they would not have qualified for any

Dispro I program funds based solely on Medicaid and Medicare/Medicaid dual eligible days.

We selected four states—Florida, Louisiana, Michigan, and Virginia—that have established qualifying formulas that include a measure of charity care provided to their low-income patients. Three of the four states' payment formulas also consider this measure. All four have defined charity care and instituted requirements for hospitals to report data on the amount of care provided. Three of the states have established mechanisms to audit the data annually, and the other state occasionally audits the data.

Background

Enacted in 1965 as title XIX of the Social Security Act, Medicaid is a federally aided, state-administered medical assistance program that served about 30 million low-income people in fiscal year 1992, with combined federal and state expenditures of $119 billion. At the federal level, the program is administered by the Health Care Financing Administration (HCFA), which is part of the Department of Health and Human Services. Within a broad legal framework, each state designs and administers its own Medicaid program and sets eligibility standards and coverage policies.

As previously stated, federal law specifies minimum criteria and formulas for identifying disproportionate share hospitals and calculating payments. The federal law provides two ways hospitals may qualify for disproportionate status. First, a hospital may qualify based on its Medicaid inpatient utilization rate which includes Medicaid and Medicare/Medicaid dual eligible days. Alternatively, a hospital may qualify based on its low-income utilization rate, which includes a consideration of charity care, state and local revenues, and other factors.[7] As discussed later in our report, states may choose one or more of three basic payment formulas.

The Texas Disproportionate Share Program

Texas established its first DSH program—Dispro I—in 1986 and since 1990 has added three additional disproportionate share programs. For SFY 1992, Texas hospitals were reimbursed $1.1 billion by the Medicaid program for services provided to Medicaid beneficiaries. In addition, 155 or 37 percent

[7]Under federal criteria a hospital is deemed a disproportionate share hospital if (1) the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or (2) the hospital's low-income utilization rate exceeds 25 percent. Generally, a qualifying hospital must have at least two physicians with staff privileges at the hospital who have agreed to provide nonemergency obstetric services to Medicaid beneficiaries.

of its hospitals received payments that totaled about $1.4 billion from the four DSH programs.[8]

All hospitals participating in Texas' Medicaid program can apply for Dispro I funds. The Dispro I program paid about $221 million to 118 hospitals for SFY 1992. For the same year, the Dispro II program paid about $336 million to three state teaching hospitals, the Dispro III program paid about $831 million to 24 hospitals designated as "significant Medicaid providers," and the Dispro IV program paid about $44 million to 91 rural hospitals.[9] The Dispro IV program uses the same formula as the Dispro I program in qualifying hospitals. Appendix I identifies the amount of disproportionate share payments hospitals received from each of the four programs in SFY 1992.

We focused our work on the SFY 1992 Texas Dispro I program because it is the most comprehensive of the four DSH programs and it uses additional indigent days as a factor in measuring care provided to low-income patients. To perform our analyses, we interviewed HCFA officials in Baltimore and Dallas, reviewed federal law pertaining to the Medicaid disproportionate share program, and interviewed Texas officials who administer the state's four DSH programs.

We also interviewed officials of three hospital districts that receive payments from the Texas DSH programs and reviewed related documents. We also obtained and analyzed the Texas database for the SFY 1992 Dispro I program.

Appendix II contains a further discussion of our methodology. Our work was performed from January through March 1993 in accordance with generally accepted government auditing standards.

Texas' Dispro I Formula Favors Public Hospitals

The Dispro I formula gives substantial weight to the factor of additional indigent days. This factor excludes nontax-supported charity care. That is, only charity care paid for with state and local revenue is recognized as indigent care and included in Texas' Dispro I formula. Because the additional-indigent-days factor is calculated on the basis of each hospital's revenue from state and local governments in relation to its total charges to all inpatients, the formula favors many public hospitals. This is particularly true for state psychiatric hospitals that receive substantial state revenue

[8]Some hospitals received payments from more than one Texas disproportionate share program.

[9]The 24 hospitals were selected because they had the highest number of Medicaid days in SFY 1989.

and for public hospitals that receive a significant amount of local revenue, such as from property taxes. Table I shows the distribution by type of hospitals receiving Dispro I payments in SFY 1992.

Table 1: Distribution of Hospitals by Type Receiving Dispro I Payments Under Texas Formula, SFY 1992

Type of hospital	Number (percent) of hospitals among those qualifying for the Dispro I program		Number (percent) of all Medicaid hospitals[a]	
Hospital districts[b]	56	(48)	126	(30)
State hospital	12	(10)	13	(3)
County, city, city-county	16	(14)	32	(8)
Nonprofit	17	(14)	131	(31)
Proprietary	17	(14)	116	(27)

[a]We could not determine the hospital type for 6 of the 424 Medicaid hospitals.

[b]Hospital districts are local entities that receive property taxes and operate a hospital or hospital system serving indigent persons. Each hospital district is counted as a hospital.

As shown, 72 percent of the hospitals receiving Dispro I funds are public hospitals. Nonprofit and proprietary hospitals receive relatively little state and local revenue. Therefore, only those treating a proportionately high number of Medicaid inpatients will receive Dispro I payments. The formula works to the disadvantage of a nonprofit or proprietary hospital that provides charity care not paid for with state and local revenue.

How the Formula Determines Hospitals Qualifying for the Dispro I Program

The Texas disproportionate share formula attempts to measure the amount of care that each hospital provided to Medicaid and other low-income patients. The formula determines each hospital's disproportionate share days by combining the number of days of care provided to Medicaid, Medicare/Medicaid dual eligible, and indigent inpatients. The disproportionate share days as a percentage of the hospital's total days of care provided to all inpatients generates a ratio used as a score to identify hospitals qualifying for the Dispro I program. The Texas Dispro I formula is as follows:

$$\frac{\text{Medicaid days} + \text{Medicare/Medicaid dual days} + \text{additional indigent days}}{\text{Total patient census days}}$$

Texas applies this formula to all hospitals participating in the Medicaid program and ranks them according to their score. The state selects a minimum of 25 percent of the hospitals,[10] and those selected are defined as disproportionate share hospitals qualifying for payments. For SFY 1992, 118 hospitals were selected for the Medicaid Dispro I program out of the 424 hospitals participating in Texas' Medicaid program.

Data on Medicaid and Medicare/Medicaid dual eligible days are readily available. However, the indigent days factor is a proxy measure for charity care that Texas developed in 1986 because no reliable and consistent source of charity care information existed for all hospitals. Indigent days are calculated based on each hospital's state and local revenue as a percentage of the amount billed to all of its inpatients—referred to in this report as gross inpatient charges.[11] The factor for indigent days is calculated as follows:

$$\frac{\text{State and local revenue}^{12}}{\text{Gross inpatient charges}} \times (\text{Total patient census days} - [\text{Medicaid days} + \text{Medicare/Medicaid Days}])$$

As the formula shows, the more state and local revenue a hospital receives in relation to its gross inpatient charges, the more credit the hospital receives in the calculation of indigent days because the ratio of state and local revenue to gross inpatient charges increases. Even if a hospital provides charity care, it only receives credit in the formula if the charity care was compensated through local or state non-Medicaid funds.

[10]Texas only selects from among those hospitals meeting the federal requirement of having at least two physicians with staff privileges at the hospital who have agreed to provide nonemergency obstetric services to Medicaid beneficiaries. However, hospitals ceasing nonemergency obstetrical services before December 22, 1987, are exempt from the two-physician rule and can qualify for program funds. In addition, Texas includes in Dispro I all children's hospitals that participate in the Medicaid program.

[11]Gross inpatient charges are the hospital charges for all inpatients and do not represent what was actually collected. Although the state uses the term gross inpatient revenue from the HCFA Medicare/Medicaid Hospital Cost Report, we prefer the term gross inpatient charges because it more closely represents what is actually being measured.

[12]Excluding Medicaid funds.

Formula for Determining Actual Payments to Hospitals

Once hospitals qualify for the Dispro I program, they receive an allocated share of the Dispro I funds. The amount allocated to each hospital is based on its disproportionate share days, as shown in the following formula:

$$\frac{\text{Medicaid days + Medicare/Medicaid dual days + additional indigent days for a particular hospital}}{\text{Medicaid days + Medicare/Medicaid dual days + additional indigent days for all disproportionate share hospitals}} \times \text{Allocated fund}$$

The total amount of funds allocated among the 118 disproportionate share hospitals for SFY 1992 was $221,276,407. Of this, about 64 percent or $141.6 million was federal matching funds. To demonstrate how the Dispro I formula works, appendix III shows the TDHS computation of eligibility and payments for three hospital districts for SFY 1992.

Significance of Additional Indigent Days on Dispro I Eligibility and Payments

Texas officials said that the state added the additional-indigent-days factor to its Medicaid-days and Medicare/Medicaid-dual-eligible-days factors because the three combined best represent the care provided to low-income patients in the state. To assess the impact of additional indigent days on the formula, we eliminated this factor and made calculations based solely on Medicaid and Medicare/Medicaid dual eligible days. We ranked the hospitals according to their new ratio to determine the hospitals that would qualify for the Dispro I program if the additional-indigent-day factor was eliminated from the formula.[13]

In considering only Medicaid and Medicare/Medicaid dual eligible days, 40 of the 118 hospitals that received Dispro I payments for SFY 1992 would not have qualified and received funds because they had relatively few such days. All of the 40 are public hospitals. On the other hand, 31 hospitals that

[13]TDHS officials believe that our analysis, which uses only Medicaid and Medicare/Medicaid dual eligible days to rank hospitals, is inappropriate because it excludes consideration of care provided to non-Medicaid low-income patients. However, the factors used in our analysis—Medicaid days and Medicare/Medicaid dual eligible days—are the same factors used in one of the two federally specified formulas states without statutory exemption are required to use to qualify hospitals for disproportionate share payments. While we agree that our analysis does not recognize care provided to non-Medicaid low-income patients, we believe our analytical approach is valid to demonstrate the impact the additional-indigent-days factor has on Texas hospitals qualifying for the Dispro I program. It is important to understand, however, that we are not advocating the approach we used in our analysis as a substitute for the Texas formula.

did not qualify for the Dispro I program under Texas' formula would have qualified absent the additional-indigent-day factor. Twenty-four of the 31 are nonprofit or proprietary hospitals. Table 2 compares the distribution by type of hospital receiving Dispro I funds under the Texas formula and, in our analysis, where additional indigent days were not considered.

Table 2: Comparison of Distribution of Hospitals by Type Receiving Dispro I Payments Under Texas Formula and With Additional Indigent Days Omitted, SFY 1992

	Number (percent) qualifying under Texas formula		Number (percent) with additional indigent days omitted[a]	
Type of hospital				
Hospital district	56	(48)	37	(34)
State hospital	12	(10)	0	(0)
County, city, city-county	16	(14)	14	(13)
Nonprofit	17	(14)	32	(29)
Proprietary	17	(14)	26	(24)

[a]Included 109 of 118 hospitals because the 9 psychiatric hospitals were included as a special set of hospitals under OBRA-89 rules. However, they do not qualify in our analysis, and, therefore, only 109 hospitals would participate in the Dispro I program.

Nine state psychiatric hospitals provide a striking example of the substantial weight the calculation of additional indigent days has on the Dispro I formula. All nine had state and local revenue exceeding 70 percent of total inpatient charges. They represent 8 percent of the hospitals qualifying for the Dispro I program and received a total of over $96 million or 44 percent of total Dispro I funds. In our analysis, they would not have qualified for any Dispro I program funds based solely on Medicaid and Medicare/Medicaid dual eligible days.[14]

The impact of additional indigent days on hospitals qualifying for Dispro I funds is directly related to the percentage it makes up of the hospitals' disproportionate share days. Our analysis showed that additional indigent days accounted for 59 percent of the total disproportionate share days for the 118 hospitals that received Dispro I payments for SFY 1992, with Medicaid days and Medicare/Medicaid dual eligible days combined accounting for 41 percent. Breaking this down by hospital type, the percentage that additional indigent days made up of disproportionate share days was 36 percent for hospital districts, 95 percent for state

[14]In commenting on our report, TDHS officials said that uncompensated care data for these hospitals suggest that they would have received comparable funds under a broader definition of charity care. The officials noted that the nine hospitals entered the program only after the Omnibus Budget Reconciliation Act of 1989 made them eligible, and the hospitals first received Dispro funds for SFY 1992.

hospitals, 16 percent for city and county hospitals, 5 percent for nonprofit hospitals, and 1 percent for proprietary hospitals.

Our findings were similar to those discussed in a January 1993 report by the Texas Legislative Budget Board. According to the Board's report, the formula's

"failure to consider non-governmental sponsored charity care in identifying Dispro hospitals overlooks a substantial portion of all uncompensated care reported in Texas, and could change the distribution of Dispro payments in Texas."

The report also pointed out that some hospitals that provide high portions of Medicaid care but that do not qualify for disproportionate share funds in Texas would qualify in other states because of the formulas they use.

Texas Recognizes That Dispro I Formula Favors Public Hospitals

TDHS officials developed the indigent care proxy and included it as a factor in the Dispro I program formula because of problems in defining charity care. They believe that a formula based on Medicaid alone does not appropriately reimburse hospitals for all of the charity care they provide. They said that a Medicaid-driven formula may result in payments that do not adequately compensate hospitals that have a very high charity care burden but only a moderate Medicaid patient burden.

The officials said that, although not intentional, the Dispro I formula is weighted in favor of public hospitals.[15] For example, hospital districts receive property taxes that are included as part of state and local revenue in calculating additional indigent days. The officials, nevertheless, believe the formula and its use of indigent care is equitable because public hospitals provide a large amount of charity care and many nonprofit hospitals qualify for Dispro I funds. In commenting on our report, TDHS officials said that nonprofit and proprietary hospitals provide charity care, but not at the same level as public hospitals.[16]

[15]HCFA regional officials, in commenting on our report, said it is not uncommon for state formulas to favor public hospitals.

[16]TDHS officials elaborated by stating that the results of our analysis showing that additional indigent days accounted for 59 percent of the total disproportionate share days for Dispro I hospitals for SFY 1992 is consistent with the patterns in uncompensated care provided by public versus private and nonprofit hospitals. According to the officials, disproportionate share public hospitals provide about 53 percent of the uncompensated care provided by all Medicaid participating hospitals in the state. Our analysis of the disproportionate share data we obtained from TDHS shows that public hospitals received 71 percent of the $1.4 billion paid to Texas hospitals under all four Dispro programs for SFY 1992.

Some States Include a Measure of Charity Care in Their Formulas

As stated earlier, Texas is exempt from having to use the federal disproportionate share payment formulas. Texas uses a unique formula for its Dispro I program, which includes the indigent care proxy Texas developed because hospitals did not have reliable and consistent data needed to directly measure the charity care they were providing. Most states, on the other hand, use one or more of three basic payment formulas specified in federal law: (1) the Medicare formula, (2) proportionally increasing payments based on a measure of the hospitals' Medicaid or low-income patients, and (3) alternative payment adjustments. Information regarding each of these formulas is found in appendix IV.

We contacted four states that use alternative payment adjustment formulas and that have developed a measure of charity care for their programs. Florida, Louisiana, Michigan, and Virginia obtain charity care data from hospitals. Florida, Louisiana, and Virginia have established mechanisms to audit this data annually, while Michigan occasionally audits it. Our discussion of these states describes their approaches to measuring charity care and using the data in their formulas. We did not assess the reliability of the data or the effect of the formulas on the types of hospitals qualifying for and receiving disproportionate share funds. Appendix V describes these states' formulas in more detail.

Florida and Virginia measure charity care by considering the patient's ability to pay. In Florida, charity care is hospital care that is not compensated and is provided to persons whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level. Charity care in Florida does not include patient charges that the hospital ultimately writes off as bad debt. In Virginia, charity care is uncompensated hospital care that is provided to a person whose gross annual family income is equal to or less than 100 percent of the federal nonfarm poverty level.

Louisiana and Michigan consider charity care as care provided by a hospital that subsequently does not receive reimbursement. Louisiana generally defines charity care as inpatient charges not reimbursed by Medicare, Medicaid, commercial insurance, or billed to the patient, and also excludes bad debt. Michigan uses the term uncompensated care in its formula instead of charity care. Uncompensated care includes bad debt and charity care, and specifically excludes professional courtesy care, staff discounts, third-party discounts, and disputed billings.

Although they have different measures of charity care, each of the four states attempts to determine the actual dollar amount of charity care or uncompensated care provided by hospitals in their state. Each state requires hospitals to maintain documentation to support the amount of charity or uncompensated care they report.

Florida requires hospitals to report charity care as separate supplemental information and to submit that information along with Medicaid cost reports to the Department of Health and Rehabilitative Services on an annual basis. Michigan requires hospitals to submit Indigent Volume Reports, which contain uncompensated care information, and their Disproportionate Share Eligibility Forms along with their annual Medicaid cost reports to the Medical Services Administration.

At the end of each fiscal year, Virginia hospitals are required to file a statement of charity care, including charity care charges and other cost information that may be required by the Virginia Department of Medical Assistance Services. Louisiana officials stated that they require hospitals to submit their annual Medicaid cost reports and ledgers identifying revenues and charges—which includes charity care charges—to Blue Cross of Mississippi.

The significance of charity care in these four states' formulas varies. In Florida and Michigan, charity care is a variable used to determine both a hospital's disproportionate share status and its payment amount. Florida's payment formula combines Medicaid and charity care days with charity care days receiving greater weight. Indigent volume is a significant factor in Michigan's disproportionate share status and payment formula, with uncompensated care being one of several variables used to determine indigent volume.

In Louisiana and Virginia, hospitals may qualify for the disproportionate share program by using the Medicaid or low-income utilization criteria. For Louisiana hospitals qualifying based on low-income utilization criteria, charity care is a variable in determining disproportionate share status and the payment amount. In Virginia, charity care is generally not a factor in determining disproportionate share status. Only 8 of 72 disproportionate share hospitals qualified for the program under the low-income utilization criteria. However, these 8 hospitals also qualified for the program under the Medicaid utilization criteria. Once hospitals qualify for the program, charity care is not a factor in determining the amount of disproportionate

share payments. Virginia uses a formula that only considers Medicaid inpatient utilization and type of hospital for this purpose.

Officials in all four states said that hospital data measuring charity care provided to low-income patients is audited. In Florida and Louisiana, information used to determine the amount of care provided is audited annually by insurance companies under contract with the state. In Virginia, each hospital's audit firm is required to review annually the charity care data reported to the state by the hospital. In Michigan, the state audits charity care data, but not on a systematic basis.

We discussed a draft of this report with HCFA officials in the Medicaid Bureau in Baltimore and the regional office in Dallas. We also discussed the draft report with TDHS officials. We have incorporated their comments where appropriate. We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Director of the Office of Management and Budget, the Commissioner of the Texas Department of Human Services, and other interested parties. We will also make copies available to others upon request. Please call me on (202) 512-7104 if you or your staff have any questions about this report. Other major contributors are listed in appendix VI.

Sincerely yours,

Leslie G. Aronovitz
Associate Director, Health
Financing Issues

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Abbreviations

DRG	diagnosis related group
DSH	disproportionate share hospital program
HCFA	Health Care Financing Administration
NHIC	National Heritage Insurance Company
OBRA	Omnibus Budget Reconciliation Act
SFY	state fiscal year
TDHS	Texas Department of Human Services

Texas Medicaid Disproportionate Share Payments by County (State Fiscal Year 1992)

Texas' four disproportionate share programs made payments amounting to over $1.4 billion to 155 hospitals for SFY 1992, making Texas' overall program one of the largest in the country. This appendix shows the payment amounts that each hospital received from each of the four programs.

Dispro I funding has grown significantly over the years as Texas made greater use of intergovernmental transfers to obtain increased federal matching funds. For SFY 1992, funds were transferred from hospital districts, and state teaching and psychiatric hospitals, and added to $7 million in general revenue funds contributed by the state. Dispro I made payments to 118 hospitals in SFY 1992 based on the formula developed in 1986.

The Dispro II program started in SFY 1991 and covers three state-owned and operated teaching hospitals. Dispro II is financed by funds transferred to the state from the three hospitals, along with federal matching funds.

The Dispro III and Dispro IV programs first distributed funds in SFY 1992. The two programs are financed by state taxes levied on the 24 largest Medicaid hospitals based on 1989 data. After the state receives federal matching funds, Dispro III pays 95 percent of the total to the 24 hospitals. Dispro IV pays the remaining 5 percent to qualifying hospitals in federally designated rural areas based on the same formula used for Dispro I. Fifty percent of the rural hospitals participating in the Medicaid program receive Dispro IV funds.

Table I.1: Texas Medicaid Disproportionate Share Payments by County (State Fiscal Year 1992)

Hospital	County	Dispro I	Dispro II	Dispro III	Dispro IV	Total payments
Trinity Valley Medical Center	Anderson	•	•	•	$829,914	$829,914
Permian General Hospital	Andrews	$236,830	•	•	699,869	936,699
Tri-City Community Hospital	Atascosa	180,579	•	•	561,781	742,360
Muleshoe Hospital District	Bailey	96,953	•	•	219,332	316,285
Smithville Hospital	Bastrop	93,334	•	•	177,428	270,762
Bee County Medical Center	Bee	253,057	•	•	773,929	1,026,986
Scott & White Hospital	Bell	•	•	$18,146,409	•	18,146,409
San Antonio State Hospital	Bexar	15,738,568	•	•	•	15,738,568
San Antonio Chest Hospital	Bexar	2,055,455	•	•	•	2,055,455
Santa Rosa Children's	Bexar	2,052,530	•	18,652,773	•	20,705,303
Bexar County Hospital District	Bexar	6,759,110	•	61,504,510	•	68,263,620
Southwest General Hospital	Bexar	1,032,886	•	•	•	1,032,886

(continued)

Hospital	County	Dispro I	Dispro II	Dispro III	Dispro IV	Total payments
Humana Women's Hospital	Bexar	637,932	•	•	•	637,932
Santa Rosa Medical Center	Bexar	•	•	26,175,547	•	26,175,547
Baptist Medical Center	Bexar	•	•	34,520,538	•	34,520,538
Angleton Danbury Hospital District	Brazoria	285,015	•	•	•	285,015
Brewster County Hospital District	Brewster	137,900	•	•	291,827	429,727
Brooks County Hospital	Brooks	169,339	•	•	381,861	551,200
Edgar Davis Memorial Hospital	Caldwell	61,037	•	•	167,529	228,566
Memorial Medical Center	Calhoun	209,684	•	•	557,354	767,038
South Texas Hospital	Cameron	1,491,199	•	•	•	1,491,199
Valley Regional Medical Center	Cameron	1,251,853	•	•	•	1,251,853
Brownsville Medical Center	Cameron	1,683,130	•	19,572,749	•	21,255,879
Valley Baptist Medical Center	Cameron	2,982,488	•	31,560,059	•	34,542,547
Atlanta Memorial Hospital	Cass	•	•	•	480,465	480,465
Plains Hospital District	Castro	177,110	•	•	403,286	580,396
Rusk State Hospital	Cherokee	12,167,335	•	•	•	12,167,335
Cherokee Medical Center	Cherokee	•	•	•	275,722	275,722
Childress General Hospital	Childress	•	•	•	284,773	284,773
Cochran Memorial Hospital District	Cochran	59,477	•	•	44,251	103,728
Eagle Lake Community Hospital	Colorado	•	•	•	216,472	216,472
Commanche Hospital District	Comanche	71,093	•	•	235,656	306,749
Concho County Hospital	Concho	•	•	•	151,737	151,737
Culberson County Hospital District	Culberson	31,468	•	•	142,351	173,819
Dallas Co. Hospital D. (Parkland)	Dallas	11,099,870	•	75,652,640	•	86,752,510
Children's Medical Center	Dallas	1,537,290	•	•	•	1,537,290
Medical Arts Hospital	Dawson	110,503	•	•	310,279	420,782
Deaf Smith Hospital District	Deaf Smith	198,679	•	•	610,788	809,467
Cuero Hospital District	Dewitt	349,703	•	•	721,680	1,071,383
Dimmit County Hospital	Dimmitt	75,123	•	•	384,738	459,861
Odessa W&C Hospital	Ector	507,337	•	•	•	507,337
Med. Center Hospital District	Ector	2,110,530	•	18,160,194	•	20,270,724
El Paso Hospital District (Thomason)	El Paso	4,200,494	•	42,332,843	•	46,533,337
Southwestern General Hospital	El Paso	337,089	•	•	•	337,089
Providence Hospital	El Paso	•	•	21,002,854	•	21,002,854
Falls Community Hospital	Falls	99,512	•	•	217,562	317,074

(continued)

Hospital	County	Dispro I	Dispro II	Dispro III	Dispro IV	Total payments
Fisher County Hospital District	Fisher	211,741	•	•	•	211,741
Lockney Hospital District	Floyd	149,672	•	•	355,464	505,136
Franklin County Hospital	Franklin	•	•	•	190,699	190,699
Frio Hospital	Frio	164,998	•	•	344,650	509,648
Memorial Hospital District	Gaines	190,190	•	•	183,421	373,611
U.T. Medical Branch	Galveston	9,972,889	194,329,412	•	•	204,302,301
Garza Hospital District	Garza	70,563	•	•	100,497	171,060
Gonzales Hospital District	Gonzales	113,458	•	•	280,008	393,466
Guadalupe Valley Hospital	Guadalupe	451,155	•	•	•	451,155
Chillicothe Hospital District	Hardeman	46,064	•	•	99,678	145,742
Quanah Hospital District	Hardeman	65,737	•	•	•	65,737
Harris Co. Psychiatric Hospital	Harris	6,912,715	•	•	•	6,912,715
Riverside General Hospital	Harris	522,192	•	•	•	522,192
Harris County Hospital District	Harris	15,349,074	•	98,699,755	•	114,048,829
Parkway Hospital	Harris	1,280,642	•	•	•	1,280,642
Doctor's Hospital Airline	Harris	971,561	•	•	•	971,561
Texas Children's Hospital	Harris	3,324,719	•	27,392,577	•	30,717,296
Hermann Hospital	Harris	5,070,318	•	40,944,100	•	46,014,418
Sun Belt Medical Center	Harris	594,930	•	•	•	594,930
M.D. Anderson Hospital	Harris	•	121,106,310	•	•	121,106,310
Hemphill County Hospital District	Hemphill	97,947	•	•	266,173	364,120
East Texas Medical Center	Henderson	•	•	•	1,143,010	1,143,010
Knapp Medical Center	Hidalgo	1,931,014	•	23,512,116	•	25,443,130
Mission Hospital	Hidalgo	779,195	•	•	•	779,195
Edinburg General Hospital	Hidalgo	750,368	•	•	•	750,368
McAllen Medical Center	Hidalgo	3,121,235	•	33,697,066	•	36,818,301
Hill Regional Hospital	Hill	•	•	•	376,005	376,005
Methodist Hospital	Hockley	195,092	•	•	487,485	682,577
Hopkins County Hospital	Hopkins	•	•	•	1,111,134	1,111,134
Houston County Hospital	Houston	245,469	•	•	652,817	898,286
Big Spring State Hospital	Howard	9,029,572	•	•	•	9,029,572
Citizens General Hospital	Hunt	•	•	•	1,379,419	1,379,419
Jack County Hospital District	Jack	80,852	•	•	240,193	321,045
Edna Hospital District	Jackson	162,403	•	•	357,809	520,212
Jasper Hospital District	Jasper	184,533	•	•	404,378	588,911
Mary Dickerson Hospital	Jasper	171,098	•	•	375,172	546,270
Alice Physicians & Surgeons	Jim Wells	1,010,483	•	•	2,011,807	3,022,290
Stamford Memorial Hospital	Jones	•	•	•	385,654	385,654

(continued)

Hospital	County	Dispro I	Dispro II	Dispro III	Dispro IV	Total payments
Otto Kaiser Memorial Hospital	Karnes	•	•	•	464,809	464,809
Terrell State Hospital	Kaufman	13,437,762	•	•	•	13,437,762
Terrell Community Hospital	Kaufman	306,079	•	•	•	306,079
Kerrville State Hospital	Kerr	10,149,825	•	•	•	10,149,825
Kimble Hospital	Kimble	•	•	•	194,189	194,189
Spohn Kleberg Hospital	Kleberg	621,374	•	•	1,629,092	2,250,466
Knox County Hospital District	Knox	55,193	•	•	242,194	297,387
Lamb Healthcare Center	Lamb	116,013	•	•	•	116,013
Lavaca Hospital District	Lavaca	122,583	•	•	349,231	471,814
Yoakum Community Hospital	Lavaca	•	•	•	297,511	297,511
Lee Memorial Hospital	Lee	•	•	•	94,612	94,612
Harris Methodist	Limestone	114,539	•	•	334,984	449,523
South Limestone District	Limestone	•	•	•	281,853	281,853
Lubbock County Hospital District	Lubbock	2,722,305	•	37,646,460	•	40,368,765
Lynn County Hospital District	Lynn	91,144	•	•	247,941	339,085
Martin County Hospital District	Martin	66,561	•	•	253,094	319,655
Matagorda Hospital District	Matagorda	444,009	•	•	865,911	1,309,920
Maverick County Hospital District	Maverick	1,093,938	•	•	2,302,352	3,396,290
Heart of Texas Hospital	McCulloch	•	•	•	163,302	163,302
Hillcrest Baptist Medical Center	McLennan	•	•	15,535,622	•	15,535,622
Medina Community Hospital	Medina	94,128	•	•	281,544	375,672
Mitchell County Hospital District	Mitchell	197,908	•	•	615,912	813,820
Nocona General Hospital	Montague	•	•	•	315,303	315,303
Memorial Hospital	Moore	•	•	•	264,990	264,990
Driscoll Children's Hospital	Nueces	2,285,393	•	19,156,627	•	21,442,020
Nueces County H.D. (Memorial)	Nueces	2,683,915	•	22,253,724	•	24,937,639
Riverside Hospital	Nueces	389,261	•	•	•	389,261
Ochiltree General Hospital	Ochiltree	•	•	•	264,042	264,042
Palo Pinto General Hospital	Palo Pinto	•	•	•	734,622	734,622
Panola General Hospital	Panola	•	•	•	267,554	267,554
Parmer County Hospital District	Parmer	44,842	•	•	•	44,842
General Hospital	Pecos	39,871	•	•	•	39,871
Pecos County Hospital	Pecos	145,496	•	•	318,775	464,271
Lake Livingston Medical Center	Polk	•	•	•	377,094	377,094
Amarillo H.D. (Northwest Texas)	Potter/ Randall	2,372,843	•	27,484,074	•	29,856,917
Red River Hospital	Red River	•	•	•	226,189	226,189

(continued)

Hospital	County	Dispro I	Dispro II	Dispro III	Dispro IV	Total payments
Memorial Hospital District	Refugio	131,195	•	•	364,768	495,963
North Runnels Hospital District	Runnels	55,396	•	•	167,492	222,888
Henderson Memorial Hospital	Rusk	•	•	•	954,172	954,172
Schleicher County Hospital District	Schleicher	168,709	•	•	331,792	500,501
D.M. Cogdell Memorial Hospital	Scurry	161,485	•	•	410,035	571,520
Shackelford County Hospital District	Shackelford	30,539	•	•	134,503	165,042
Memorial Hospital	Shelby	174,526	•	•	517,636	692,162
Doctors Memorial Hospital	Smith	325,227	•	•	•	325,227
U.T. Health Center	Smith	1,229,291	21,043,665	•	•	22,272,956
Starr County Hospital District	Starr	455,936	•	•	1,165,407	1,621,343
Stephens Memorial Hospital	Stephens	•	•	•	152,581	152,581
Stonewall Hospital District	Stonewall	48,603	•	•	259,053	307,656
Lillian Hudspeth Hospital District	Sutton	81,903	•	•	•	81,903
Swisher Memorial Hospital	Swisher	•	•	•	282,720	282,720
Tarrant Co. H.D. (J.P. Smith)	Tarrant	6,336,258	•	40,074,253	•	46,410,511
Tarrant Co. Psychiatric Hospital	Tarrant	1,122,779	•	•	•	1,122,779
Cook-Ft. Worth Children's	Tarrant	1,683,233	•	•	•	1,683,233
Brownfield Hospital District	Terry	191,051	•	•	518,276	709,327
Titus County Hospital District	Titus	787,135	•	•	2,016,820	2,803,955
Austin State Hospital	Travis	13,470,383	•	•	•	13,470,383
Brackenridge Hospital	Travis	3,820,832	•	41,254,934	•	45,075,766
Rankin County Hospital District	Upton	58,241	•	•	145,185	203,426
Uvalde Hospital	Uvalde	285,967	•	•	608,383	894,350
Val Verde Hospital District	Val Verde	591,714	•	•	1,770,459	2,362,173
Ward Memorial Hospital	Ward	154,433	•	•	322,845	477,278
Trinity Community Med.	Washington	•	•	•	689,089	689,089
Doctor's Hospital	Webb	874,204	•	•	•	874,204
Mercy Medical Center	Webb	2,941,742	•	35,594,682	•	38,536,424
Shamrock Hospital District	Wheeler	40,840	•	•	133,897	174,737
Wichita Falls State Hospital	Wichita	14,263,597	•	•	•	14,263,597
Electra Hospital District	Wichita	44,162	•	•	•	44,162
Wilbarger General Hospital	Wilbarger	268,335	•	•	720,992	989,327
Winkler County Hospital	Winkler	•	•	•	168,631	168,631
Wood County General Hospital	Wood	•	•	•	213,853	213,853
Yoakum County Hospital	Yoakum	120,339	•	•	390,218	510,557
Total DSH payment		**$221,276,407**	**$336,479,387**	**$830,527,106**	**$43,711,964**	**$1,431,994,864**

Source: Texas Department of Human Services.

Scope and Methodology

We assessed the formula used in Texas' Dispro I program. All hospitals participating in Texas' Medicaid program can apply for Dispro I funds.

To assess the formula, we visited Austin, Texas, and interviewed officials of the Texas Department of Human Services (TDHS), which administers Texas' four disproportionate share programs; Texas Hospital Association; Texas Association of Public and Nonprofit Hospitals; and Center for Rural Health Initiatives. By telephone, we interviewed a Texas Legislative Budget Board representative. We obtained and reviewed various state reports and other documents pertaining to the four Texas disproportionate share programs.

We also obtained and analyzed the TDHS database for the state fiscal year 1992 Dispro I program. We analyzed the significance of Texas' additional indigent day calculation by eliminating it from the Dispro I formula and determining hospital eligibility based on each hospital's days of care provided to Medicaid and Medicare/Medicaid dual eligible patients. Our analysis does not include a measure of the care provided to non-Medicaid low-income patients as provided for in federal law, and we are not advocating this analysis as a substitute for a formula that does.

We visited R.E. Thomason General Hospital (El Paso Hospital District) in El Paso, Texas; Lavaca Medical Center (Lavaca Hospital District) in Halletsville, Texas; and Harris County Hospital District in Houston, Texas. At these locations, we interviewed hospital and hospital district officials and collected and later reviewed related documents. We also interviewed officials from Brackenridge Hospital in Austin, Texas; Driscoll Children's Hospital in Corpus Christi, Texas; Maverick County Hospital in Eagle Pass, Texas; Harris County Hospital District in Houston, Texas; and Mercy Regional Medical Center in Laredo, Texas.

To obtain information on measures of charity care used in other state disproportionate share formulas, we contacted state Medicaid officials in Florida, Louisiana, Michigan, and Virginia. Each of these states uses a formula they developed as an alternative to the specified federal formulas and includes a measure of charity care in their formulas. We determined that these states have such formulas by reviewing a 1990 National Association of Public Hospitals survey of state Medicaid agencies. We interviewed Medicaid officials in the four states by telephone and obtained and reviewed relevant documents. We did not assess the reliability of the states' charity care data and we did not assess the effect of the states'

formulas in determining which hospitals qualify for disproportionate share funds and in calculating the amount of each hospital's payment.

We contacted officials of the Health Care Financing Administration headquarters office in Baltimore and the HCFA Dallas Regional Office. We interviewed the officials and obtained and reviewed pertinent HCFA documents. We also reviewed federal law pertaining to the Medicaid disproportionate share program.

Our work was performed from January through March 1993 in accordance with generally accepted government auditing standards. We discussed this report with HCFA and Texas officials and incorporated their comments where appropriate. However, in accordance with the requester's wishes, we did not obtain written comments on a draft of this report.

SFY 1992 Texas Medicaid DSH I Data for Three Hospital Districts

To demonstrate how the Dispro I formula works, this appendix shows the SFY 1992 data elements and computation for three hospital districts we visited. The Texas Department of Human Services collects the data from the hospitals, Texas Department of Health, and National Heritage Insurance Company, and then performs the computation.

SFY '92 TEXAS MEDICAID DSH I DATA

for R. E. Thomason - El Paso

The following data were used in the computation of the SFY'92 Dispro I program.

DATA ELEMENT	DATA SOURCE	VALUE
Medicaid Days	Medicaid Payment File/NHIC	42,346
Dual Medicare/Medicaid Days	Medicare Intermediary/NHIC	1,752
Additional Indigent Days*	TDHS calc. using data from hospital	6,892.7
Disproportionate Share Days	Sum of the three types of days above	50,990.7
Patient Census Days	Hospital as reported toTx. Dept. of Health	82,539
State/Local Dollars	Hospital as reported to TDHS	$18,059,398
Gross Inpatient Revenue	Hospital 's cost report as reported to TDHS	$100,717,847

Hospitals qualify based on the ratio of disproportionate share days to patient census days. For R. E. Thomason this ratio is 50,990.7 divided by 82,539 or 0.6178.

Payment is calculated by multiplying the per diem value of a disproportionate share day by each hospital's number of disproportionate share days. (This per diem value is the allocated fund divided by the total disproportionate share days of all qualifying hospitals.) For Thomason the DSH I payment in SFY '92 was $4,200,494.

* Additional Indigent Days are calculated using the following formula.:

The ratio of State/ Local $ to Gross Inpatient Revenue times Patient Census Days after Title 19 and Medicare/Medicaid Dual Eligible Days have been removed. For Thomason the figures are:

($18,059,398/$100,717,847) x (82,539 - 42,346 - 1,752) = 6,892.7

Source: Texas Department of Human Services.

SFY '92 TEXAS MEDICAID DSH I DATA

for Lavaca Medical Center - Halletsville

The following data were used in the computation of the SFY'92 Dispro I program.

DATA ELEMENT	DATA SOURCE	VALUE
Medicaid Days	Medicaid Payment File/NHIC	164
Dual Medicare/Medicaid Days	Medicare Intermediary/NHIC	996
Additional Indigent Days*	TDHS calc. using data from hospital	328.1
Disproportionate Share Days	Sum of the three types of days above	1,488.1
Patient Census Days	Hospital as reported toTx. Dept. of Health	3,834
State/Local Dollars	Hospital as reported to TDHS	$415,625
Gross Inpatient Revenue	Hospital 's cost report as reported to TDHS	$3,387,730

Hospitals qualify based on the ratio of disproportionate share days to patient census days. For the Lavaca Medical Center this ratio is 1,488.1 divided by 3,834 or 0.3881.

Payment is calculated by multiplying the per diem value of a disproportionate share day by each hospital's number of disproportionate share days. (This per diem value is the allocated fund divided by the total disproportionate share days of all qualifying hospitals.) For Lavaca Med. Ctr. the DSH I payment in SFY '92 was $122,583.

* Additional Indigent Days are calculated using the following formula.:

The ratio of State/ Local $ to Gross Inpatient Revenue times Patient Census Days after Title 19 and Medicare/Medicaid Dual Eligible Days have been removed. For Lavaca Med. Ctr. the figures are:

($415,625/$3,387,730) x (3,834 - 164 - 996) = 328.1

Source: Texas Department of Human Services.

SFY '92 TEXAS MEDICAID DSH I DATA

for the Harris County Hospital District - Houston

The following data were used in the computation of the SFY'92 Dispro I program.

DATA ELEMENT	DATA SOURCE	VALUE
Medicaid Days	Medicaid Payment File/NHIC	96,598
Dual Medicare/Medicaid Days	Medicare Intermediary/NHIC	4,401
Additional Indigent Days*	TDHS calc. using data from hospital	85,326.8
Disproportionate Share Days	Sum of the three types of days above	186,325.8
Patient Census Days	Hospital as reported toTx. Dept. of Health	303,276
State/Local Dollars	Hospital as reported to TDHS	$139,888,560
Gross Inpatient Revenue	Hospital 's cost report as reported to TDHS	$331,621,744

Hospitals qualify based on the ratio of disproportionate share days to patient census days. For the Harris County Hospital District this ratio is 186,325.8 divided by 303,276 or 0.6143.

Payment is calculated by multiplying the per diem value of a disproportionate share day by each hospital's number of disproportionate share days. (This per diem value is the allocated fund divided by the total disproportionate share days of all qualifying hospitals.) For the Harris County Hospital District the DSH I payment in SFY '92 was $15,349,074.

* Additional Indigent Days are calculated using the following formula.:

The ratio of State/ Local $ to Gross Inpatient Revenue times Patient Census Days after Title 19 and Medicare/Medicaid Dual Eligible Days have been removed. For Harris County the figures are:

($139,888,560/$331,621,744) x (303,276 - 96,598 - 4,401) = 85,326.8

Source: Texas Department of Human Services.

Formula Options for Medicaid's Disproportionate Share Program

States may choose one or more of three basic payment adjustment formulas to calculate the amount of reimbursements to hospitals with disproportionate share status: (1) the Medicare formula, (2) proportionally increasing payments based on the hospital's Medicaid or low-income utilization rate, and (3) alternative payment adjustments. Several states have pursued each option, and a few have adopted more than one option. As previously discussed, Texas is exempt from disproportionate share eligibility and payment requirements and uses an entirely different formula that it developed in 1986.

Medicare Formula

States are permitted to calculate their Medicaid payment adjustment for disproportionate share hospitals according to the Medicare disproportionate share formula. Since May 1986, the Medicare payment system has included an adjustment for hospitals that serve a disproportionately large number of low-income patients.

A hospital's Medicare disproportionate share adjustment depends on the number of patient days that are Medicaid days and joint Medicare/Supplemental Security Income days. The adjustment is based on an index that is the sum of two ratios. The first ratio is the proportion of all Medicare patient days that are attributable to beneficiaries of Supplemental Security Income—a means-tested cash benefit program for aged and disabled people. The second ratio is the proportion of all patient days for which Medicaid is the primary payer. The index is used to determine the hospital's eligibility status and the size of the payment adjustment.

The hospital is classified according to several variables, including bed size, whether urban or rural, and whether it is a sole community provider or rural referral center. This classification is used to calculate the Medicaid payment adjustment. The Medicare formula is:

Operating costs generated under Medicaid	X	Medicare disproportionate percentage

The Medicare disproportionate percentage varies with the type of hospital.

Proportionally Increasing Payment Adjustment Formula

Under this formula, the state provides for an additional payment, and for an increase in this payment

"in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or the hospital's low-income utilization rate."[1]

For example, if a state's average Medicaid utilization rate is 10 percent and one standard deviation above that rate is 15 percent, a hospital with a Medicaid utilization rate of 15 percent or above would qualify for a payment adjustment.

Alternative Payment Adjustment Formula

States may use an alternative formula as long as it applies equally to all hospitals of each type and results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or portion of services provided to patients eligible for medical assistance or to low-income patients. Most of the alternative formulas developed resemble the proportionally increasing payment adjustment formula.

[1]Standard deviation is a statistical term that allows a numerical measurement of dispersion of a group of values about their mean. One standard deviation from the mean includes 68 percent of all values, two standard deviations include 95 percent of all values, and three standard deviations include 99.7 percent of all values.

Description of Aspects of Other Selected State Disproportionate Share Programs

Florida

The primary goal of Florida's disproportionate share program is to provide payments to hospitals serving a disproportionate share of Medicaid and charity care patients. Florida began distributing disproportionate share funds in 1988. The state now has four programs: the Regular program, the Mental Health program, the Regional Perinatal Intensive Care Center program, and the Teaching Hospitals program. In SFY 1992, Florida made disproportionate share payments of approximately $191.4 million to 64 of 252 hospitals that served Medicaid patients.

To qualify for disproportionate share payments under each program a hospital must meet various criteria. Total Medicaid days and charity care days[1] must equal or exceed 7 percent of total adjusted patient days.[2] The total of charity care days, weighted by 4.5, and Medicaid days must be equal to or greater than 10 percent of total adjusted patient days. In addition, each qualifying hospital must meet federal minimum eligibility criteria. To receive payment in the Mental Health program, the perinatal intensive care program, and Teaching Hospitals program, each hospital must meet additional specific requirements.

Florida's payment adjustment formula focuses on Medicaid and charity care, with charity care receiving the greater weight. The payment formula for the Regular program calculates a disproportionate share rate for each hospital by adding charity care days, weighted by 4.5, and Medicaid days and dividing that sum by adjusted patient days. Once the rate is determined, a disproportionate share percentage[3] is assigned which corresponds with the rate. For example, in SFY 1992, a rate of 15 percent was assigned a percentage of 2.1544347. This percentage is multiplied by the number of Medicaid days and the base Medicaid per diem to determine the total payment earned by each hospital. As necessary, the payments may be adjusted on a pro rata basis so that the total payments to hospitals equal total funds available for the program.

[1]Charity care days are determined by subtracting 50 percent of local and tax district revenues provided to a hospital from total charity care charges for a net charity care amount, which is then divided by gross revenue per adjusted patient day.

[2]Total adjusted patient days is the total of acute and intensive care patient days divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

[3]The disproportionate share percentages used are pre-set percentages assigned to hospitals according to their disproportionate share rate. The percentage assigned to a hospital is higher for every increase of 10 percentage points in the disproportionate share rate up to 60 percent, beginning with the minimum required 10 percent.

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Louisiana began its disproportionate share program in 1988. In federal fiscal year 1992, Louisiana expects to distribute $1.2 billion in disproportionate share funds to 51 of 171 hospitals that serve Medicaid patients.

Louisiana uses the federal minimum criteria to identify hospitals eligible for disproportionate payments. Qualifying hospitals may select a payment methodology based on either a Medicaid inpatient utilization rate formula, low-income utilization rate formula, or Medicare formula for the calculation of their disproportionate share payments.

If the Medicaid inpatient utilization formula is selected, a payment is applied to the target rate limits to determine allowable inpatient costs. This payment is $1 plus a proportional adjustment equal to the percentage, or portion thereof, in excess of the qualifying threshold of the mean plus one standard deviation of the Medicaid utilization rates for all hospitals in the state participating in the Medicaid program. The same percentage adjustment is then applied to the allowable inpatient cost to calculate the disproportionate share payment amount.

For hospitals selecting the low-income utilization rate payment formula, a payment of $1 plus a proportional adjustment factor of three times the percentage above the low-income utilization qualifying threshold of 25 percent is applied to the target rate limits to determine allowable inpatient costs. The same percentage adjustment is then applied to the allowable inpatient cost to calculate the disproportionate share payment amount.

If the Medicare payment formula is chosen, the hospital's disproportionate share factor for Medicare reimbursement is applied to the target rate limits to determine total Medicaid allowable inpatient costs. The same percentage adjustments is applied to allowable inpatient costs to calculate the disproportionate share payment amount.

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Michigan began its Medicaid disproportionate share program in 1985 and now has four separate programs.[4] Michigan expects to distribute about $543.4 million in disproportionate share payments to 80 of 188 hospitals that served Medicaid patients in SFY 1992.

[4]A fifth program, which was based on voluntary contributions that hospitals made to the state, was terminated last year because of new federal laws affecting provider taxes and donations.

Michigan allocated approximately $38 million to diagnosis related group (DRG)[5] hospitals for SFY 1992. About $400,000 of that amount was allocated to distinct part rehabilitation units[6] of DRG hospitals in a separate disproportionate share program.

In addition, Michigan allocated $489.2 million to hospitals that made voluntary contributions to the state to obtain federal matching funds, about $9.2 million to state-owned mental hospitals, and $7 million to psychiatric and freestanding rehabilitative hospitals.

Michigan's disproportionate share formulas are based on indigent volume.[7] For DRG reimbursed hospitals to qualify for disproportionate share funds, they must have an indigent volume of at least 130 percent of the average indigent volume for all DRG hospitals in the state that report indigent data. For SFY 1992, the average indigent volume was 14.24 percent. Therefore, to qualify for disproportionate share funds, DRG hospitals had to have an indigent volume of a least 18.51 percent (130 percent of 14.24 percent). This is referred to as the eligibility threshold. A special adjustor is added to the formula for hospitals with indigent volumes greater than 50 percent.

Michigan has several payment formulas. Michigan's formula, used to determine payments to DRG hospitals with an indigent volume between 18.51 percent and 50 percent, is: 1 + (IV - DRG eligibility threshold x IV factor 1). IV represents the hospital's indigent volume and DRG represents the diagnostic related group hospital. IV factor 1 is a prospectively set number generated by the state to make sure all of the $38 million allocated to DRG hospitals is expended.[8] The result of the formula is multiplied by the hospital's Medicaid DRG cost or per diem rate to determine the disproportionate share payment to the hospital.

[5]A DRG hospital, basically a regular medical/surgical hospital, is one that receives reimbursement for services provided to Medicaid beneficiaries based on patient diagnosis or the nature of services furnished where those diagnosis are classified into one or a set of DRGs.

[6]A distinct part unit of a hospital is a part of a hospital that is specifically designated to provide certain rehabilitative or psychiatric services to patients.

[7]A hospital's indigent volume is measured as the percentage of inpatient indigent charges to total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for Medicaid, Children's Special Health Care Services (Title V), the Resident County Hospitalization Program, the Wayne County Care Program, and uncompensated care.

[8]IV factors were set to allocate portions of the $38 million to DRG hospitals with an eligibility threshold of at least 50 percent (IV factor 2), to distinct part rehabilitative units of DRG hospitals (rehab unit IV factor), and factor 1 is set to distribute the remainder of the DRG share of the $38 million.

For DRG hospitals with indigent volumes of at least 50 percent, the following formula was used: 1 + ((IV - DRG eligibility threshold) x IV factor 1 + ((IV - 0.5) x IV factor 2))). Michigan uses a different formula for allocating funds to distinct part rehabilitation units of DRG hospitals: 1 + (IV - rehab. unit eligibility threshold) x rehab. unit IV factor. The result of these formulas is multiplied by the hospital's Medicaid DRG cost or per diem rate to determine the disproportionate share payment.

Michigan uses different payment formulas for hospitals and distinct part units of hospitals reimbursed on a per diem basis, state mental hospitals, and certain freestanding rehabilitation hospitals.

Virginia

Virginia has been making disproportionate share payments to hospitals since 1988. Virginia officials estimate that disproportionate share payments to 72 of 115 hospitals serving Medicaid patients will be $147 million in federal fiscal year 1992.

Virginia qualifies hospitals for disproportionate share payments using modified federal Medicaid inpatient utilization criteria or the low-income criteria. Hospitals qualify for payments if their Medicaid inpatient utilization rate exceeds 8 percent or their low-income utilization rate exceeds 25 percent. Virginia uses an 8 percent Medicaid rate to allow more hospitals to qualify for disproportionate share payments than would qualify if the state used the federal Medicaid utilization criteria. As in the federal criteria, the amount of a hospital's charity care is a factor in calculating the low-income utilization rate.

Hospitals that qualify for disproportionate share payments receive those payments based on their type of hospital and their Medicaid inpatient utilization. The amount by which a hospital's Medicaid inpatient utilization rate exceeds 8 percent is called the disproportionate share payment adjustment. For state-owned teaching hospitals, the disproportionate share payment is determined by multiplying the disproportionate share payment adjustment by 11, then multiplying that amount by the lower of the prospective operating cost rate or ceiling. For all other hospitals, the disproportionate share payment adjustment multiplied by the prospective operating cost rate or ceiling determines the disproportionate share payment amount.

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