



## Medicaid Disproportionate Share Hospital Payments and Health Care Reform

## FORUM SESSION ANNOUNCEMENT

### A PRESENTATION BY:

**Jim Frizzera**

*Principal*

Health Management Associates

### WITH DISCUSSION FEATURING:

**John Curless**

*Director*

Bureau of Coverage and Reimbursement Policy for Medicaid  
State of Utah

**Peg Burnette**

*Chief Financial Officer*

Denver Health and Hospital Authority

**Thomas P. Traylor**

*Vice President, Federal, State and Local Programs*

Boston Medical Center

FRIDAY, JUNE 19, 2009

11:45AM–12:15PM—Lunch

12:15PM–2:00PM—Discussion

### LOCATION

Reserve Officers Association  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor  
*(Across from the Dirksen  
Senate Office Building)*

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**OVERVIEW**

*Medicaid disproportionate share hospital (DSH) payments provide financial assistance to hospitals that serve a large number of low-income patients, such as people with Medicaid and the uninsured. It is expected that \$11.3 billion of the projected \$216 billion that the federal government will spend on Medicaid in fiscal year 2009 will be for DSH payments. Over the years policymakers have grappled with a variety of issues regarding Medicaid DSH, including rapid growth in state programs and federal expenditures, questionable methods of raising state matching funds, and inappropriate targeting and use of DSH funds. As state and federal policymakers consider health care reform options, the Medicaid DSH program and use of DSH payments face renewed scrutiny. Some advocate redirecting DSH funds to cover the costs of expanded insurance coverage; others call for changing how DSH payments are made. An option under consideration by the Senate Committee on Finance involves federalizing Medicaid DSH payments with payments to hospitals being determined and paid directly by the federal government instead of the states. This Forum session will examine the current Medicaid DSH program, the role DSH funding plays for states and safety net hospitals, and the potential implications for the program under health care reform.*

**SESSION**

Safety net hospitals serve predominantly low-income communities and have substantial caseloads of Medicaid patients whose costs frequently are not covered by Medicaid reimbursement rates. These hospitals also are often the principal source of care for uninsured patients in their communities. Since its inception in 1981, Medicaid DSH has been a major source of funding for safety net hospitals and the largest source of federal funding for uncompensated hospital care. According to the National Association of Public Hospitals, Medicaid DSH payments fund 25 percent of unreimbursed costs for their member hospitals.

While few question that safety net facilities rely on Medicaid DSH payments for financial viability, there are perceived flaws in the current DSH program. Limited state reporting requirements in the past have led to questions regarding the program's impact on care of low-income populations. For example, federal officials do not know what

proportion of state-reported DSH payments actually finance care for low-income patients since they aren't told how much of the funds are re-channeled to states through provider taxes and intergovernmental transfers. In addition, the absence of reliable data also has led to questions regarding the appropriate targeting of DSH funds and their actual use. New state and hospital reporting requirements have been issued to address these concerns; however, some questions remain. Are DSH funds going to critical safety net, as opposed to non-safety net, hospitals? Are DSH funds proportional to hospitals' uncompensated care and unreimbursed Medicaid costs? Lastly, the current Medicaid DSH program is seen by many as inequitable across states, because the federal allotments to states are capped based on historical program spending levels and not current need, leading to per-capita DSH allotments favoring a handful of states.

As the health care reform debate moves forward, these long-term Medicaid DSH concerns, coupled with the need to assure that health care dollars are spent appropriately as part of reining in health care spending in general (and federal spending in particular), may lead to proposed changes to DSH policies. In addition, health insurance coverage expansions would alter the volume and distribution of uncompensated care raising new issues about the role of safety net providers, the DSH program, and the targeting of its payments. This Forum session will examine the potential impact changes under health care reform may have on state Medicaid DSH programs and their funding of safety net hospitals.

## KEY QUESTIONS

- How are federal Medicaid DSH funding levels determined? How are these federal funds distributed to states and qualifying hospitals?
- Why do state Medicaid DSH programs vary in size and payments to hospitals? How do different objectives affect the way states structure their programs?
- What is the importance of federal Medicaid DSH funds to states and safety net hospitals? How do states and hospitals use DSH funds? Are there other sources of uncompensated care funding available?
- What are alternative approaches to distributing federal DSH funds to states? What are the challenges in implementing them? Should the federal government play a greater role in determining Medicaid DSH hospital payments?

- What effect will expanded health insurance coverage likely have on uncompensated care and the role of safety net hospitals? What has been the experience of public hospitals in Massachusetts under state health care reform, where a portion of the states' uncompensated care funds, including Medicaid DSH funds, have been redirected to expand health insurance coverage?

### SPEAKERS

**Jim Frizzera**, a principal with Health Management Associates, will begin the session with an overview presentation of the Medicaid DSH program. A national expert in the area of Medicaid financing, including health care-related taxes, provider-related donations, intergovernmental transfers, and certified public expenditures, Mr. Frizzera worked at the Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Administration, or HCFA) overseeing the development and application of national policy regarding federal Medicaid grant outlays. A facilitated discussion will follow the overview presentation. Participating in this discussion will be **John Curless**, director of the Bureau of Coverage and Reimbursement Policy for Medicaid in the state of Utah, a "low" DSH state with 21 of its 58 hospitals located in rural areas; **Peg Burnette**, chief financial officer for Denver Health and Hospital Authority, Colorado's primary safety net institution and largest Medicaid provider; and **Thomas P. Traylor**, vice president for federal, state and local programs at Boston Medical Center, a large urban, safety net hospital in Massachusetts that is adjusting to a reformed state health system where coverage expansions have reduced the uninsured rate to 2 percent. The facilitated discussion will explore state and hospital use of Medicaid DSH funding, how the need for such funding is affected under insurance coverage expansions, and the implications of possible changes to the current Medicaid DSH program under health care reform.