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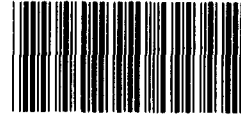
United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-249657

December 22, 1992

The Honorable Ronald D. Coleman
House of Representatives



148391

The Honorable J.J. Pickle
House of Representatives

Hospitals that serve large numbers of Medicaid patients can face significant financial burdens because Medicaid generally reimburses providers at a lower rate than other insurers. To reduce the burden, the Congress established the Medicaid disproportionate share program in 1981.¹ The program allows states to designate hospitals treating large numbers of low-income patients as "disproportionate share hospitals" and to give these hospitals additional Medicaid reimbursement. In recent years, the number of such hospitals has grown significantly.

Each state chooses the formulas that are used to qualify hospitals for disproportionate share status and to determine the amount of funds these hospitals receive. States have used provider taxes and voluntary contributions as a primary funding source for disproportionate share programs. Moreover, recent legislation limits the total amount that can be paid as disproportionate share payments to 12 percent of the amount of medical assistance expenditures paid nationally.² It is too soon to tell how individual states will change their disproportionate share programs in response to these limitations, and the information in this report reflects the situation before these changes.³ Enclosure I is a summary of federal legislation pertaining to the Medicaid disproportionate share program.

¹Omnibus Budget Reconciliation Act of 1981, P.L. 97-35.

²Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, provisions effective October 1, 1992.

³Implementing regulations for the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 were issued November 24, 1992.

GAO/HRD-93-3R, Medicaid: Disproportionate Share Policy

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This letter responds to your request that we review the Medicaid disproportionate share program. You specifically asked us to (1) identify how states designate disproportionate share hospitals and the formulas they use to reimburse these hospitals, (2) describe the role of charity care in state disproportionate share formulas, and (3) describe Texas' experience with this program.⁴

RESULTS IN BRIEF

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) gives states minimum criteria and formulas for identifying hospitals that qualify for disproportionate share status. Even so, states have maintained significant control over the number of hospitals that receive disproportionate share status. In some states, no hospitals qualify for this designation, while in other states, the vast majority of hospitals qualify.

States also have considerable control over the amount of reimbursement disproportionate share hospitals receive. States choose one or more formulas, which are prescribed in OBRA-87, to calculate the amount of disproportionate share payments. As a result, reimbursements may range from an average of a few thousand dollars per hospital in one state, to over \$2 million per hospital in another.

Federal legislation requires states to consider the amount of charity care provided by the hospitals when deciding if they qualify as disproportionate share hospitals and in calculating their reimbursements. However, there is limited federal guidance on and no widely accepted definition of charity care. As a result, states--and even individual hospitals within a state--use a variety of approaches to measure charity care. These approaches can affect the amount of reimbursements hospitals receive.

Concerning Texas' program, we found that as of October 1992, 37 percent of hospitals in the state qualified for disproportionate share status. The qualification criteria and the amount of reimbursement for Texas hospitals are based on a formula that incorporates the various sources of hospital revenue--expressed in "patient days." An

⁴Charity care generally is free care provided to patients who are not expected to pay. This differs from the related concept of bad debt, which is the cost of unpaid care for which the hospital expected to be paid.

exemption in federal law allows Texas to use this formula.⁵ One aspect of this formula is Texas' calculation of charity care. Because charity care is so difficult to define, the state has developed a proxy measure called "indigent care." Texas officials believe that using their indigent care measure leads to disproportionate share reimbursements that more accurately reflect hospitals' charity care load.

BACKGROUND

Established in 1965 as title XIX of the Social Security Act,⁶ Medicaid is a federally aided, state-administered medical assistance program serving about 30 million low-income people in fiscal year 1992, with expenditures estimated at \$127 billion. Federal support averages 57 percent of payments for services, but ranges from 50 to nearly 80 percent depending on the state's Medicaid matching rate. The matching rate is based on the state's per capita income relative to the national per capita income.

Medicaid programs vary considerably from state to state. 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 (HHS). Within the broad legal framework, each state designs and administers its own Medicaid program and sets eligibility standards and coverage policies. Participating states must provide eligible clients with certain basic benefits, such as inpatient and outpatient hospital and physician services and health examinations for children. States may also choose to provide additional services, such as dental care and prescription drugs.

In the past few years, the disproportionate share program has grown significantly. A 1990 National Association of Public Hospitals (NAPH) survey found that the percentage of disproportionate share general hospitals, of all hospitals in the 44 states responding, was expected to increase from

⁵The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) allows states that operate their Medicaid program through a health insuring organization to continue using their approved disproportionate share formulas, thereby exempting them from the formula requirements in OBRA-87. A health insuring organization is a fiscal entity that assumes financial risk for the cost of services.

⁶42 U.S.C. 1396-1396s.

B-249657

21 to 29 percent after July 1988. The survey also found that expenditures on disproportionate share payments to hospitals were expected to increase as well. Forty-one states reported actual costs of \$569 million in fiscal year 1988-89, and 38 states estimated their costs at \$1.08 billion in fiscal year 1990-91.

To determine how state formulas are developed and how charity care is defined and used in these formulas, we interviewed representatives of national and state hospital associations; state Medicaid officials in Florida, Pennsylvania and Texas; and HCFA officials. To examine the Texas experience with the Medicaid disproportionate share program, we interviewed Texas state officials. Finally, to identify the variation in state disproportionate share formulas, we reviewed the results of the 1990 NAPH study of state Medicaid policies for disproportionate share hospitals. We used this survey because it was the most comprehensive and detailed information available on a state-by-state basis at the time of our study.⁷

Recently, states have been relying increasingly on the use of provider taxes and donations in their disproportionate share programs. This is a complex and contentious issue, and although interim final rules were published by HCFA on November 24, 1992, the impact of these rules on the state disproportionate share programs is still unclear. We therefore did not include the subject of provider taxes and donations in the scope of our work.

DISPROPORTIONATE SHARE DESIGNATION AND REIMBURSEMENT POLICIES VARY BY STATE

Disproportionate share designation was intended for hospitals that serve a large share of poor patients. The NAPH survey showed that states vary widely in both the number of hospitals they designate and the amount of additional reimbursement these hospitals receive. The variation results from states' creativity in developing their programs within the broad discretion provided by federal legislation.

Designation and Reimbursement Formulas

The percentage of hospitals in each state with disproportionate share designation varies significantly;

⁷We did not attempt to verify the accuracy of NAPH's findings.

however, there is a trend toward an increasing number of hospitals qualifying for this designation. Once a hospital receives disproportionate share status, the amount of additional Medicaid reimbursement it receives also varies considerably among states--depending on which of several formulas the state chooses and the funding level for the program.

The NAPH survey reported a considerable disparity in the percentage of hospitals expected to qualify for disproportionate share designation across states. For example, the data showed that 16 states expected fewer than 10 percent of their general hospitals to qualify after July 1988. On the other hand, 5 states expected at least 75 percent of their general hospitals to qualify.

OBRA-87 provided specific formulas for state use in designating disproportionate share hospitals. Although states are required to designate hospitals according to these legislated formulas, states are permitted to expand their programs to be more inclusive. A few states--including Texas--have also received or are seeking exemptions to use alternative formulas.

The general trend among state Medicaid programs has been to provide disproportionate share payments to more hospitals. For example, the NAPH survey asked state officials about the percentage of their general hospitals that were expected to qualify for disproportionate share status after July 1988, compared to the percentage qualifying before that date. Nineteen states reported an expected increase of at least 10 percentage points.

Once states designate their qualifying hospitals, they have wide latitude in calculating the disproportionate share reimbursement amount these hospitals will receive. This has resulted in a wide disparity of reimbursement amounts to hospitals across states. For example, the NAPH survey reported that in fiscal year 1988-89, the average disproportionate share reimbursement ranged from a few thousand dollars per hospital in one state to over \$2 million per hospital in another.

States may choose one or more of three basic reimbursement formulas: (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. The Medicare formula is calculated using a percentage defined by the hospital's participation in the Medicare disproportionate share program. The second

B-249657

formula incorporates a progressive payment based partly on the amount of Medicaid inpatient services the hospital provides. Finally, the alternative payment adjustment option allows states to develop their own reimbursement formulas as long as they meet minimum criteria. Further information regarding each of these formulas is found in enclosure II.

MEASUREMENT OF CHARITY
CARE IS NOT STANDARDIZED

States use a variety of approaches when incorporating a measure of charity care into their formulas. The definition of charity care used affects the amount of reimbursement a disproportionate share hospital receives. In one state it also posed equity concerns about how these reimbursements were distributed to the hospitals.

OBRA-87 requires states to incorporate a factor for charity care when designating hospitals that qualify for disproportionate share status. It also requires considering charity care if states choose the second reimbursement option--payments based on a measure of the hospitals' Medicaid or low-income patients. Although charity care must be incorporated into state formulas, it is not clearly defined in the legislation or in program regulations, and we found no generally accepted definition.

Across states a variety of definitions of charity care are being used. For example, three states use patient income levels to determine whether the care provided can be classified as charity care. One state specifies what factors cannot be included in charity care, while another requires hospitals to independently make this determination when a patient is admitted.

TEXAS' DISPROPORTIONATE
SHARE PROGRAM

Texas initiated disproportionate share payments to hospitals at the beginning of state fiscal year 1987. After federal disproportionate share formulas were required by legislation, state Medicaid officials applied for and received a special exemption that permitted them to retain their unique formula. (Enclosure III describes Texas' formula in more detail.) At the time, at least 25 percent of all hospitals qualified for these payments.

To designate qualified facilities, the state applied its formula to measure the relative amount of care that each

hospital provided to low-income patients. The number of days of care provided to Medicaid, Medicaid/Medicare dual eligible, and low income patients as a percentage of the number of days of care provided to all patients was used to generate a score for each hospital. Currently, Texas has 4 approved disproportionate share programs, with 37 percent of Texas hospitals qualifying for disproportionate share payments.

In recent years, Texas has also instituted several other disproportionate share programs, as well as an intergovernmental transfer program. These new programs have greatly affected the amount of federal funds the state has been able to qualify for. In fiscal year 1992, Texas' disproportionate share programs are expected to generate approximately \$1 billion in federal funds.

Beginning in 1989, the state legislature established an intergovernmental transfer program whereby local public hospitals were required to transfer to the state an amount equal to 1 percent of their operating budgets, which was then used as state matching funds for the Medicaid disproportionate share program. The state's use of these funds increased significantly in fiscal year 1991 as a result of an increase in the percentage required for transfer, from 1 to 5 percent.

In December 1990, HCFA approved a Medicaid state plan amendment for another disproportionate share program called Dispro II. Under this program, the amount of inpatient charity care charges incurred by the three state-owned teaching hospitals are counted as state disproportionate share matching funds. The state expected to receive about \$216 million in federal funds from the Dispro II program in fiscal year 1992.

At the beginning of fiscal year 1992, Texas instituted another program, called Dispro III, which imposed a monthly tax on 24 hospitals equal to 1.25 percent of their non-Medicaid inpatient revenue. The state expected to receive \$561 million in federal funds from the Dispro III hospital assessment program during fiscal year 1992. The state also created the Dispro IV program, which allocates 5 percent of the proceeds from the Dispro III assessment to be distributed among rural disproportionate share hospitals.

The Texas disproportionate share programs may be significantly changed in 1993, when the state legislature meets. According to Texas state officials, Texas has until July 1993 to assure that its method of finance for the

B-249657

Dispro III program is in compliance with the new federal statute imposing restrictions on provider taxes. Furthermore, the Texas disproportionate share program will be limited to its fiscal year 1992 payments level by the recent federal legislation that caps expenditures on state disproportionate share programs.

As previously discussed, the number of days of care provided to Medicaid, Medicaid/Medicare dual eligible, and low income patients is used in the Dispro I state formula for designating disproportionate share hospitals. The same measurement is also used to allocate reimbursement amounts to qualified hospitals. However, because of the problems in defining charity care, Texas officials developed the concept of "indigent care". (Enclosure III contains information on how this is defined and calculated.) They incorporated a measure for indigent care in the payment adjustment formula because they believe that a formula based on Medicaid alone does not appropriately reimburse hospitals for the total package of charity care provided. They stated that a Medicaid-driven formula may result in adjustments that do not appropriately compensate hospitals that have a very high charity care burden, but only a moderate Medicaid patient burden.

State officials believe that by incorporating an alternative measure to charity care and having a variety of disproportionate share programs, the Texas Medicaid program meets the financial needs of disproportionate share hospitals in the state.

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We will make copies of this letter available to other interested parties upon request. Please call me at (202) 512-7119 if you have any questions about the information discussed.

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Enclosures - 3

Summary of Federal Legislation on the Medicaid
Disproportionate Share Program

Omnibus Budget Reconciliation Act of 1981 (OBRA-81)	Required states to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs when developing inpatient hospital reimbursement rates.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA-85)	Required HHS to report on each state's methodology for implementing the adjustment required by OBRA-81. Exempted disproportionate share payments to hospitals from annual state Medicaid expenditure caps.
Omnibus Budget Reconciliation Act of 1987 (OBRA-87)	Required states to submit Medicaid state plan amendments that both defined disproportionate share hospitals and established payment adjustments. Specified minimum criteria for the definition of such hospitals.
Omnibus Budget Reconciliation Act of 1990 (OBRA-90)	Allowed states to develop alternative payment adjustment methodologies.
Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991	Disallowed the use of funds from provider donations as part of the state share for Medicaid service expenditures, although some can be used for administrative expenditures. Capped the percentage of the states' share of Medicaid expenditures that can be raised through provider taxes. Also limited the amount of disproportionate share payments a state can make.

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 some states have adopted more than one option.

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 a sole community provider or rural referral center. This classification is important because it is used to calculate the Medicaid payment adjustment.

The Medicare formula is used to calculate the Medicaid payment adjustment as follows:

Operating costs generated under Medicaid	X	Medicare disproportionate percentage
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The Medicare disproportionate percentage varies with the type of hospital.

Proportionally Increasing Payment 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 proportion of services provided to patients eligible for medical assistance or to low-income patients. Most of the alternative formulas developed resemble proportionally increasing payment rate methodologies.

¹Standard 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.

Texas Disproportionate Share
Payment Adjustment

In Texas, a hospital's disproportionate share payment adjustment depends on the percentage of total patient census days that are either Medicaid, dual Medicare and Medicaid, or indigent care days. The Texas formula is as follows:

$$\frac{\text{Medicare days} + \text{Medicaid days} + \text{Additional indigent days}}{\text{Total patient census days}}$$

Data on the number of days attributable to Medicaid and patients who are dually eligible for Medicare and Medicaid are readily available. However, because there is no reliable data source to directly measure indigent days, Texas developed a formula to serve as a proxy measure for indigent days. Indigent days are calculated using the following formula:

$$\frac{\text{State and local revenue}}{\text{Gross inpatient revenue}} \times (\text{Total patient census days} - \text{Medicare days} + \text{Medicaid days})$$

State and local revenue includes total annual revenue for inpatient care received by a hospital from cities, county hospital districts, and units of state government, excluding Medicaid funds for inpatient services.

The use of state and local revenue as an indicator of charity care may be advantageous for public hospitals relative to other hospitals because public hospitals are more likely to receive such revenue.

The use of gross inpatient revenues, rather than net patient revenue, in the formula that is used to determine charity days is an issue in Texas.¹ It has been argued that the use of gross inpatient charges underestimates the amount of charity care provided by hospitals that have a large charity care burden. The Texas Medicaid program, however, takes the position that net patient revenue is an inappropriate measure because it includes both inpatient and outpatient revenue available to the hospital. Disproportionate share by definition is an inpatient hospital payment adjustment program, according to the state. Further, net inpatient revenue data cannot be used because they do not appear on the HCFA Medicare/Medicaid Hospital Cost Report. While those data are reflected in hospitals' financial statements, not all

¹Gross patient revenues are the total charges generated by hospital patients in a given period. Net patient revenue is the payment actually received by the hospital for charges generated in a given period.

ENCLOSURE III

ENCLOSURE III

hospitals submit those statements to the Medicaid program with their cost reports.

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13

GAO/HRD-93-3R, Medicaid: Disproportionate Share Policy