

REPORT ON THE RESULTS OF THE WORKGROUP'S EFFORTS TO DERIVE A NEW DSH FORMULA

(FY2012 Appropriation Bill - Public Act 63 of 2011)

March 1, 2012

Section 1699: (1) The department may make separate payments in the amount of \$45,000,000.00 directly to qualifying hospitals serving a disproportionate share of indigent patients and to hospitals GME training programs. If direct payment for GME and DSH is made to qualifying hospitals for services to Medicaid clients, hospitals shall not include GME costs or DSH payments in their contracts with HMOs. (2) The department shall allocate \$45,000,000.00 in DSH funding using the distribution methodology used in fiscal year 2003-2004. (3) By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the new distribution of funding to each eligible hospital from the GME and DSH pools. (4) The department shall form a workgroup on DSH funding consisting of representatives from hospitals and hospital systems receiving DSH funding and the Michigan health and hospital association. The workgroup shall work to derive a new DSH formula or formulas designed to provide equitable payments to qualifying hospitals. The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the results of the workgroup's efforts by March 1 of the current fiscal year.

*Michigan Department
of Community Health*



Rick Snyder, Governor
Olga Dazzo, Director

Disproportionate Share Hospital (DSH) Report to the Legislature

In response to and in accordance with Section 1699(4) of Public Act 63 of 2011, the Department of Community Health (DCH) convened a workgroup to discuss the objectives outlined in the boilerplate language. The following report describes the conclusions of the workgroup.

The DSH workgroup began discussions on November 28, 2011 and met for two subsequent meetings. The workgroup was chaired by DCH and consisted of representatives of DSH hospitals and the Michigan Health and Hospital Association. Over the course of the three meetings, the following conclusions were reached:

- 1) The workgroup was not able to reach a unanimous agreement on the definition of “equitable payments to qualifying hospitals”, and was therefore unable to propose a new funding formula that all represented hospitals could agree upon. Several safety net hospitals (Detroit Medical Center, Hurley Medical Center, and McLaren Health Care) with a historically high proportion of Medicaid and uninsured care have a large vested interest in retaining the current funding formula for the \$45 Million Regular DSH Pool. Other hospital systems which have seen significant increases in their Medicaid and uninsured business have an interest in revising the current funding formula for the \$45 Million Regular DSH Pool so that the Pool allocation will reflect this growth. The revised formula put forth by the latter group of hospitals is described in item #2 below.
- 2) The hospital systems which have seen significant increases in their Medicaid and uninsured business recommended a new formula to distribute DSH funds. The formula retains the basic logic of the current formula for the \$45 Million Regular DSH Pool with one significant exception: the new formula would distribute funds

amongst hospitals that have at least a 1% share of the statewide cost incurred by hospitals to provide inpatient hospital care to indigent patients, including uninsured patients and patients covered by public programs (including Medicaid but not Medicare). This can be contrasted with the current formula which requires hospitals to have a minimum facility-specific indigent payer mix of 20% (or 50% for one subcomponent of the pool) to qualify for any funding from the \$45 Million Regular DSH Pool. The Detroit Medical Center, Hurley Medical Center and McLaren Health Care opposed modifying the current \$45 Million Regular DSH Pool formulas in this manner. These hospitals stressed that funding from this pool should continue to recognize hospitals that serve a disproportionate share of indigent patients. All remaining hospitals represented on the workgroup advocated for the modified formula.

- 3) There was unanimous support on the work group that, if the Legislature does not support modification to the \$45 Million Regular DSH Pool formulas in isolation, (1) the current \$45 Million Regular DSH Pool formulas and amounts should be continued in FY 2013, **AND** (2) a new DSH pool should be developed based on the modified formulas that were advanced during the workgroup discussion. Though there was not a detailed discussion on the amount of funding recommended for this new pool, there was a general understanding among the workgroup members that this pool would become a regular part of the DCH budget as opposed to a one-time funding item.
- 4) The Department of Community Health would like to acknowledge two key points that emerged during the discussions and interactions with the DSH workgroup.

First, hospitals and hospital systems across the State have seen the Michigan Medicaid caseload nearly double over the last decade, and, as a result, have experienced significant growth in their Medicaid volumes, especially during the last several years. This has created additional pressure on the hospital industry as a whole and also enhanced the visibility and scope of Medicaid reimbursement including, but not limited to, DSH payments. Second, and related to the first point, the hospital reimbursement landscape is changing and becoming more reliant on public payers such as the Medicaid program. These factors increase the visibility of the Medicaid reimbursement system, including DSH, and explain why the industry is very interested in exploring new options for distributing limited pools of funding.

Attachments:

1. List of DSH work group members and their affiliations
2. Summary of current policy on and distribution of the \$45M DSH pool
3. Summary of current vs. alternative DSH distribution methodology
4. DMC White Paper distributed to the workgroup

MDCH would like to acknowledge the following comments that were received from workgroup members.

- Some workgroup members expressed a strong concern that this report does not reflect the thinking of the workgroup. Specifically, they felt the report does not reflect the position of hospital systems that have seen indigent care grow significantly in recent years, nor did they feel

that the recommendation of the majority of the workgroup to switch to an alternative formula for FY 2013 was reflected.

- Several members of the workgroup requested that other, non-DSH Medicaid reimbursement be considered as part of this process.
- One workgroup member recommended increasing the threshold for the new DSH formula to a number greater than 1%.

Attachment 1

Disproportionate Share Workgroup Members

Ed Bruff – Covenant Health System
Dave Buckley – St. John Ascension
Craig Clarady – Sparrow Health System
Brian Connolly – Oakwood Healthcare
Doug Darland – Beaumont Hospital
Chip Falahee – Bronson Health System
Marilyn Litka-Klein – Michigan Health and Hospital Association
Conrad Mallett- Detroit Medical Center
Kevin Murphy – Hurley Health System
Clarence Sevillian – McLaren Health System
Cathy Sinning – Spectrum Health Services
Mike Tomkovich – Trinity Health System
Mary Whitbread – Henry Ford Health System
Mary Whitbread – Kingswood Psychiatric Hospital

Attachment 2

Summary -- Regular \$45 Million Pool MSA Actuarial Division -- 2/7/2012

All DSH Payments

In order to qualify for any DSH payment, hospitals must meet both of the following federal criteria:

1. Medicaid inpatient days must be no less than 1% of the hospital's total number of inpatient days.
2. The hospital must fall into one of the following categories:
 - * Have two obstetricians on staff;
 - * If in a rural area, have two physicians on staff that can perform obstetrics;
 - * Be classified as a Children's hospital; or
 - * Have existed in 1987 and not offered obstetrics at that time.

Regular \$45 Million DSH Pool

Hospitals that meet the criteria above may qualify for the Regular DSH pool. To qualify, hospitals must have a minimum 20% Indigent Volume (IV).

Indigent Volume is a State requirement. It is a proxy for the proportion of the hospital's business that is devoted to public programs (including Medicaid but not Medicare) and the uninsured. The IV formula is as follows:

$IV = \text{indigent inpatient charges} / \text{total inpatient charges}$.

Hospitals with at least 20% IV can qualify for one or more of the following four components of the Regular DSH pool based on their designation specified below:

1. Hospitals reimbursed via DRG payments with at least 50% IV share proportionally in \$7,300,000.
2. Hospitals reimbursed via DRG payments with at least 20% IV share proportionally in \$30,200,000.
3. Hospitals reimbursed via per diem payments with at least 20% IV share proportionally in \$7,000,000.
4. Hospitals with distinct part rehabilitation units with at least 20% IV share proportionally in \$500,000.

Again, only hospitals that meet or exceed the IV thresholds listed above qualify for any Regular DSH payments. Additionally, payments increase significantly to the extent that qualifying hospitals' IV ratios exceed the minimum qualifying threshold.

Attachment 3 -- Current vs. Alternative DSH Methodology

Current DSH Methodology:

I. \$45M in DSH payments for Med\Surg, Psychiatric and Rehab hospitals are split into four pools. They are:

A Hospitals with at least 50 percent MedSurg Indigent Volume (IV) (\$7,300,000). The share of the DSH payment for hospitals with at least 50 percent IV is based on a DSH share computed as follows:

- 1 Title XIX Med\Surg Charges x Operating Ratio x (IV - 0.5)
- 2 Each hospital's share will be reduced proportionately if computation exceeds \$7.3M.

NOTE: Only 2 DMC hospitals are typically eligible for the \$7.3M DSH pool. (Children's & Detroit Receiving)

B Hospitals with at least 20 percent MedSurg IV (\$30,200,000). The share of the DSH payment for hospitals with at least 20 percent IV is based on a DSH share computed as follows:

- 1 Title XIX Med\Surg Charges x Operating Ratio x (IV - 0.2)
- 2 Each hospital's share will be reduced proportionately if computation exceeds \$30.2M.

NOTE: Both Childrens & Detroit Receiving are also eligible to receive DSH payments from the \$30.2M pool

C Hospitals with at least 20 percent Psychiatric IV (\$7,000,000). The share of the DSH payment for hospitals with at least 20 percent IV is based on a DSH share computed as follows:

- 1 Title XIX Psych Charges x Operating Ratio x (IV - 0.2)
- 2 Each hospital's share will be reduced proportionately if computation exceeds \$7M.

D Hospitals with at least 20 percent Rehab IV (\$500,000). The share of the DSH payment for hospitals with at least 20 percent IV is based on a DSH share computed as follows:

- 1 Title XIX Rehab Charges x Operating Ratio x (IV - 0.2)
- 2 Each hospital's share will be reduced proportionately if computation exceeds \$500,000.

II. Proposed Methodology:

A Consolidate the current two Med\ Surg DSH Pools into one Med\ Surg DSH Pool totaling \$37.5M

B Retain the current Psych DSH Pool at \$7M

C Retain the current Rehab DSH Pool at \$500,000

D Change the minimum IV% threshold requirements to 1% for the Med Surg Pool and 0% for the Psych and Rehab Pools to allow all higher volume Michigan hospitals to receive DSH payments

E The share of a DSH Pool payment for hospitals would be computed separately for each of the three DSH pools as follows:

- 1 Indigent Charges x Medicaid Cost Ratio = Indigent Care Cost
- 2 Calculate each hospital's percentage of Statewide Indigent Care services provided
- 3 Eliminate hospitals from the cost pool whose Statewide Indigent Care percentage is less than 1% for the Med Surg Pool
- 4 Recalculate an Indigent Care percentage based on the Indigent Care Cost related to hospitals with greater than 1%
- 5 Each hospital's percentage of recalculated Indigent Cost percentage x Pool Dollars = Each Hospital's DSH Pool Payment

Talking Points:

The existing methodology is outdated and should be reviewed to determine if it is still achieving its intent. The current calculation of using a 50% threshold and 20% threshold excludes many Michigan hospitals who provide a significant amount of indigent care services. All higher volume **eligible** Michigan hospitals who provide indigent care services should receive their fair share of Medicaid DSH Pool payments.

The existing Medicaid DSH payment policy causes employers in areas with a higher commercial mix to subsidize the Medicaid shortfalls in their local communities by paying higher health care premiums due to the inequitable distribution of limited Medicaid funds. In the current economy and as healthcare reform becomes a reality, this "employer tax" is not sustainable.

The proposed methodology reimburses each hospital according to their share of indigent cost as a percentage of the Statewide Indigent Care cost distributing Medicaid DSH dollars equitably to all higher volume eligible hospitals providing indigent care. It is simple and uses the existing data collected by the State.

This proposed methodology recognizes the importance of the current smaller DSH pool which would continue to distribute DSH dollars to hospitals with less than 1% Statewide Indigent Care Cost.

Disproportionate Share

White Paper

Disproportionate Share Hospital (DSH) pool is
NOT A "PRO RATA" PROGRAM.

DSH is a program to help offset losses hospitals incur due to high Medicaid and Uncompensated Care patients.

- **ONE SYSTEM** – DMC – having 24.43% of the statewide Medicaid case load is **extraordinary**.
- DMC has provided **\$2.1 BILLION** in uncompensated care over eight years.
- Value Health Partners (VHP) is proposing a **\$21 MILLION CUT to ONE SYSTEM** so the remaining 133 hospitals can receive an average of \$270 thousand per hospital.
- VHP hospitals **CAN** receive more of the DSH pool – **NOW** – *by seeing more Medicaid patients!*

→ **IS THIS SOUND PUBLIC POLICY?!**

Disproportionate Share Hospital (DSH) Program

Background:

Please see **Exhibit A** page 10

Today, approximately 50 million Americans lack health insurance coverage. An estimated 1.4 million Michigan citizens have no health insurance whatsoever. The number of uninsured individuals in Wayne County is nearly 300,000 and about two thirds of those individuals live in Detroit. The number of uninsured and under-insured people in Michigan continues to grow.

The uninsured gain access to health care services through a “safety net,” which includes hospitals, community health centers, and some private physicians – all of whom help shoulder the burden of uncompensated care. Although a broad range of providers serve the uninsured, the largest share of uncompensated care is delivered by urban hospitals.

Medicaid enrollment in Michigan is now approaching 2 million. Approximately 500,000 Medicaid beneficiaries reside in Wayne County. Nearly 300,000 of these Medicaid beneficiaries reside in the City of Detroit.

History of the Medicaid DSH program

Prior to 1981, Medicaid based its payments to hospitals on reasonable costs for services provided to program beneficiaries. Congress was concerned that this “cost-based” reimbursement was inherently inflationary. To address this concern, Congress passed the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981), which contained provisions allowing states to experiment with prospective hospital payment systems, as long as reimbursement was “reasonable and necessary to the efficient and economical delivery of services” (often referred to as the “Boren Amendment”). However, Congress wanted to protect facilities that treat a large volume of Medicaid patients and patients who are not covered by other third party payers. Therefore, the law also mandated that states consider the special payment needs of hospitals that serve a large volume of Medicaid and uninsured patients. OBRA 1981 established the Disproportionate Share Hospital (DSH) program to address this issue by providing additional special Medicaid payments to this group of hospitals.

The rationale behind these special payments was that hospitals rendering high volumes of care to low-income patients often lose money as a result of low Medicaid reimbursement rates. They also lose money because they generally provide high volumes of care to the uninsured and to indigent patients, thus have high uncompensated care burdens. Since these hospitals have low private case loads, they are not able to shift this burden to other payers. **Many safety net hospitals rely on these special DSH payments in order to maintain their charitable missions.**

continued...

History of the Medicaid DSH program continued...

The original language was broad and states were given wide latitude to adopt optional benefits, expand coverage, and establish payment methods and levels. The provision did not define which hospitals were to be assisted, nor did it specify how states should provide the assistance. To help remedy this situation, Congress included an amendment in the Omnibus Budget Reconciliation Act of 1987 which established a federal definition of DSH hospitals and required states to make payments to certain hospitals. The new federal DSH definition required states to include, at a minimum:

- Any hospital with a Medicaid utilization rate (Medicaid days divided by total days) of one standard deviation or more over the mean Medicaid utilization rate in the state, or ✓ DMC
- Any hospital with a low-income utilization rate of 25% or more (the low-income utilization rate is the sum of the ratio of Medicaid revenues divided by total revenues and the ratio of inpatient charity care charges divided by total charges). ✓ DMC

In addition to the above, **to be eligible to receive DSH funds, a hospital must meet at least one of the following federal criteria:**

- At least two obstetricians with staff privileges at the hospital must have agreed to provide obstetric services to individuals who are eligible for Medicaid. ✓ DMC
- The hospital is located in a rural area and at least two physicians with staff privileges at the hospital must have agreed to provide obstetric services to individuals who are eligible for Medicaid.
- The hospital serves an inpatient population that is predominately comprised of individuals under 18 years of age. ✓ DMC
- On December 22, 1987, the hospital did not offer obstetric services to the general population except in emergencies. ✓ DMC

In addition to the above, each hospital must have a Medicaid utilization rate of at least 1%. ✓ DMC

The DSH program is not a block-grant program. Like the regular Medicaid program, the state must provide matching funds in order to obtain federal DSH funds. However, unlike the regular Medicaid program, the federal government “caps” state DSH payments by establishing annual allotments for each state. In addition, DSH payments to any specific hospital cannot exceed a hospital-specific cap based on the un-reimbursed cost of providing hospital services to Medicaid and uninsured patients.

Michigan's Regular Medicaid DSH Pool

When the Medicaid DSH program was first initiated in Michigan, Medicaid DSH was paid as a percentage add-on based on hospital specific factors. In the early 1990's, these payments were converted to a regular-fixed pool set at \$45 M to facilitate budgeting for both the state and hospitals. Eligibility for the regular Medicaid DSH pool distribution is based upon charges for all indigent patients including Medicaid as well as uncompensated care as a percentage of the total hospital charges. This is known as the Indigent Volume (IV) percentage. **To qualify for Medicaid regular \$45 M DSH pool payments, the hospital's IV percentage needs to exceed 20%. If a hospital's IV percentage is less than 20%, it does not qualify for Medicaid regular DSH pool payments.**

The \$45 M regular Medicaid DSH pool is comprised of three smaller pools. A pool of \$37.5 M for DRG-reimbursed hospitals, with \$30.2 M distributed to hospitals having an IV of greater than 20%, and \$7.3 M distributed to hospitals having an IV of greater than 50%. A second pool of \$7 M distributed to psychiatric and rehabilitation hospitals that are reimbursed on a per-diem basis and their IV exceeds 20% and a third pool of \$500,000 distributed to Distinct Part Rehabilitation Units where the IV exceeds 20%.

continued...

DMC Uncompensated Care (in thousands)



DMC PROVIDED MORE UNCOMPENSATED CARE AS A PRIVATE COMPANY THAN IT DID AS A NON-PROFIT!

2.1 BILLION IN UNCOMPENSATED CARE OVER EIGHT YEARS!

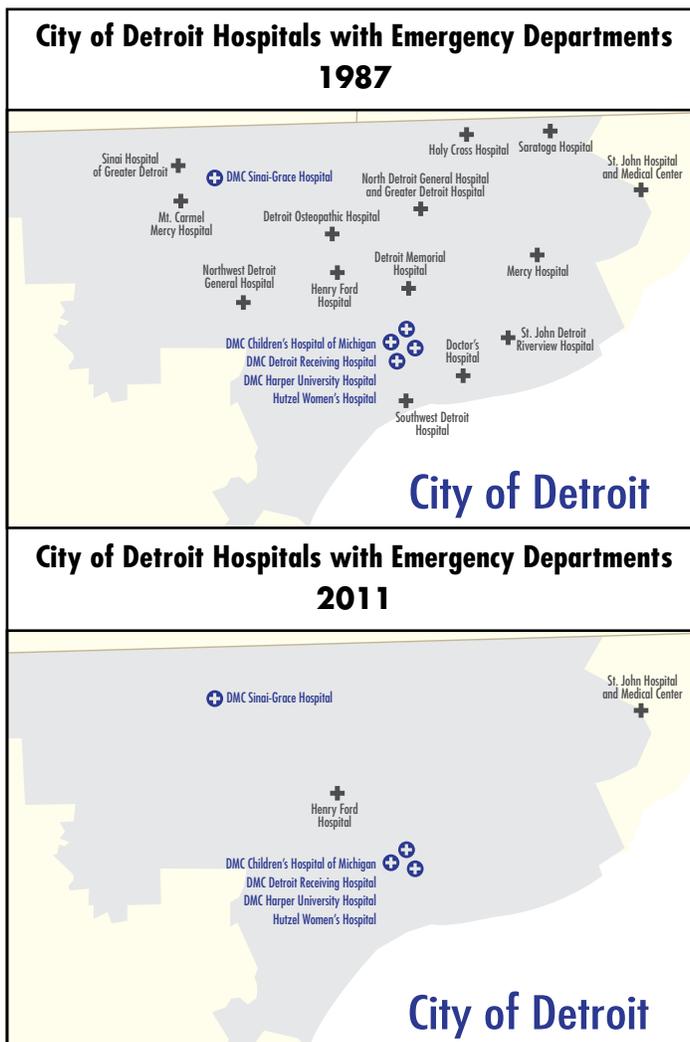
Michigan's Regular Medicaid DSH Pool continued...

The size of the regular DSH pool has not increased since its inception. Meanwhile, uncompensated care costs have skyrocketed. The Michigan Health and Hospital Association estimates that Michigan hospitals provided more than \$1.9 B in uncompensated direct patient care in FY 2009.

In Michigan, the \$45 M regular DSH pool represents only a portion of total state DSH-related funding. Although the size of the regular DSH pool has not increased, overall DSH funding both nationally and in Michigan has grown substantially over the past ten years. During that time, state Medicaid budgets have come under increasing pressure and states began to explore and implement special financing techniques that have made it easier to collect increased DSH payments from the federal government, such as intergovernmental transfers, provider donations, provider taxes, etc. Current DSH-related funding in Michigan totals about \$400 M annually. This funding is used to help support a variety of health care programs, such as:

- Hospitals with indigent care agreements
- Public hospitals
- Special FFS and HMO payments
- A special pool for hospitals that don't receive significant funding from the regular DSH pool
- A special pool that is supported by provider taxes that addresses the cost of uninsured in the outpatient setting. This pool focuses on small and rural hospitals.

Many of these payments go to providers and help support various health care programs outside of Wayne County.



DMC is the largest **safety net provider** in the state. In 1987, the City of Detroit was home to 19 hospitals. In 2010 it is home to six — **four are DMC Hospitals**

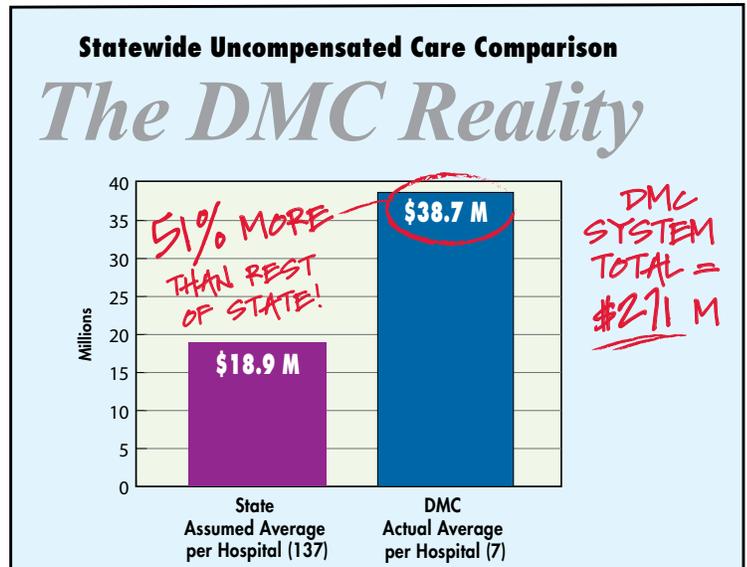
Why the current regular DSH pool distribution formula should be maintained

Please see **Exhibit B** page 18

The history of the DSH payment program reflects a long-standing and continuing commitment to protect hospitals treating large volumes of Medicaid patients and those who do not have access to health insurance coverage.

In the FY 2011 MDCH appropriation bill, language was included asking the MDCH to review the current distribution formula for the regular DSH pool and submit their recommendations to the legislature.

Since 1983 (nearly 30 years) Governors Blanchard, Engler, Granholm and Snyder; 162 Senators and 584 Representatives have reviewed the DSH policy. Each administration and each session of the legislature have concluded that the current DSH policy and formula are sound public policy and have continued it. Today, facts are even more compelling that the current DSH formula is fair, and a case can be made that DMC's allotment should be increased.



EVERYBODY benefits from DMC Children's Hospital of Michigan

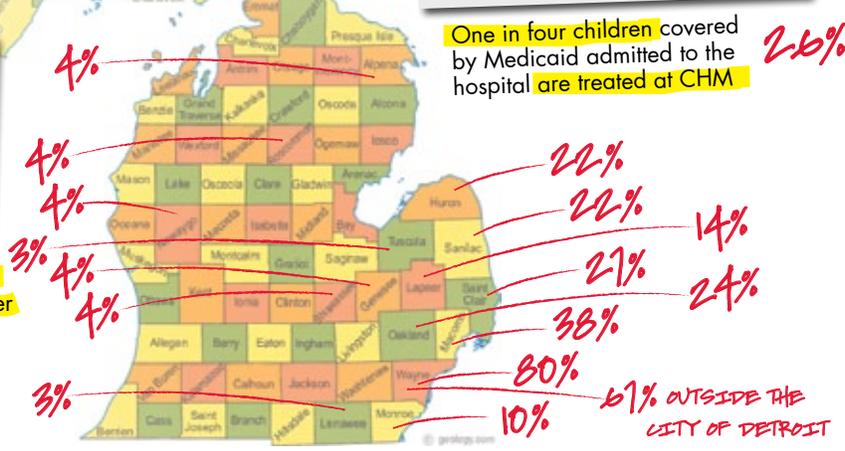
Medicaid Inpatient Discharges by County FY 2010



CHM treats more kids than any other provider in the State overall



One in four children covered by Medicaid admitted to the hospital are treated at CHM



The most seriously ill and injured children are transferred to Children's Hospital of Michigan from hospitals across the state because they are unable to provide the same level of acute, specialized pediatric care

Cuts to DMC's DSH payment hurts kids the most

Why the current regular DSH pool distribution formula should be maintained continued...

Statewide DSH Coalition's

"Fairness" Proposal

Cut one system (DMC) ~~\$21 million~~ 70% cut

\$14 million from Children's Hospital ALONE

To give the remaining hospitals
an average of **\$270 thousand**

IS THIS SOUND
PUBLIC POLICY?!

Source: Statewide Disproportionate Share Hospital (DSH) Coalition

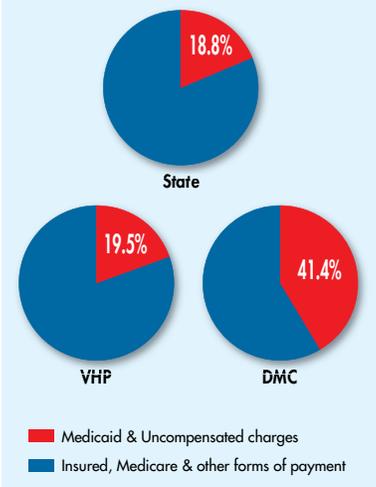
IT SHOULD ALSO BE NOTED that under the recently passed national health reform law [Patient Protection and Affordable Care Act (PPACA)] federal Medicaid DSH allotments to states will be reduced by \$14.1 B over 10 years, beginning with a \$500 M cut in FY 2014. The Secretary of HHS is required to develop a methodology for reducing federal DSH allotments to each state. The largest DSH reductions would be imposed on states that have the lowest uninsured percentages and on states that do not target their DSH payments based on high Medicaid inpatient volumes and have high levels of uncompensated care (excluding bad debt). Therefore, one might interpret this as congressional intent to protect DSH funding in states like Michigan and more importantly to protect the DSH pools that are targeted to safety net providers. **Changing the current distribution of the regular \$45M DSH to spread payments among more hospitals might be considered contrary to this language and could place our federal DSH payments in jeopardy** when it comes time to impose the reductions across the nation.

Detroit Medical Center and DSH Dollars

The Detroit Medical Center is the state's largest provider of hospital services for Medicaid and the uninsured. The DMC system alone provides about 24.43% of all Medicaid hospital-related services delivered annually in Michigan. The Medicaid program represents about 34% of the DMC's overall payer mix. The estimated uncompensated care burden for the DMC in 2010 is estimated to be approximately \$260 M, an increase of nearly \$80 M over the past 10 years. Meanwhile, the size of the regular Medicaid DSH pool has remained the same.

Medicaid DSH payments to the DMC cover only a small portion of the costs related to serving these populations. The disproportionate burden borne by the DMC is significant. For example, indigent volume is significantly higher at some DMC hospitals, such as Hutzel Women's Hospital (80%), Children's Hospital of Michigan (70%), and Detroit Receiving Hospital (53%).

Systemwide Percentage of Medicaid & Uncompensated Charges



DMC-Vanguard Partnership

The DMC and Vanguard Health System closed on a final purchase agreement in December 2010. As a part of that agreement, Vanguard has committed to invest \$850 M in facility improvements, new equipment, and other related capital projects. Vanguard has also committed to:

- Continue to operate the DMC as a Detroit-based health care system.
- Keep all DMC hospitals open for at least 10 years.
- Maintain current DMC charity care policies for at least 10 years.

• DMC Vanguard will provide an estimated **\$274 M** of uncompensated care in 2011 – more than DMC provided as a non-profit company – and more than any other system in the state.

• DMC Vanguard will pay **\$21 M** in taxes in 2011, non-profit hospitals in Michigan will pay **\$0** in taxes.

Since the DMC will continue its charity care mission and will continue serving essentially the same population, it is critical that DSH funding levels remain at current levels during this transitional period. Failure to do so could jeopardize this agreement and the proposed \$850 M investment in the DMC and the City of Detroit.

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL
MIKE COX
ATTORNEY GENERAL

security than the Warrant Certificate.

2. Maintenance of Hospital Core Services

A key provision in the Purchase and Sale Agreement requires that for at least ten years after the Closing Date, Vanguard will maintain each of the hospitals as a general acute care hospital, or as a rehabilitation hospital in the case of the Rehabilitation Hospital of Michigan.³³

Additionally, each hospital must provide certain core services. These core services are shown in

³³ An exception to the requirement to maintain Hospitals allows for closure if reductions in state or federal funding and reimbursements discriminate against for-profits and cause the Hospital to suffer material declines in EBITDA. Purchase and Sale Agreement Section 12.3(a).

Report on the Proposed Sale of the Detroit Medical Center Hospital Businesses to Vanguard Health Systems, Inc. November 13, 2010

Conclusion:

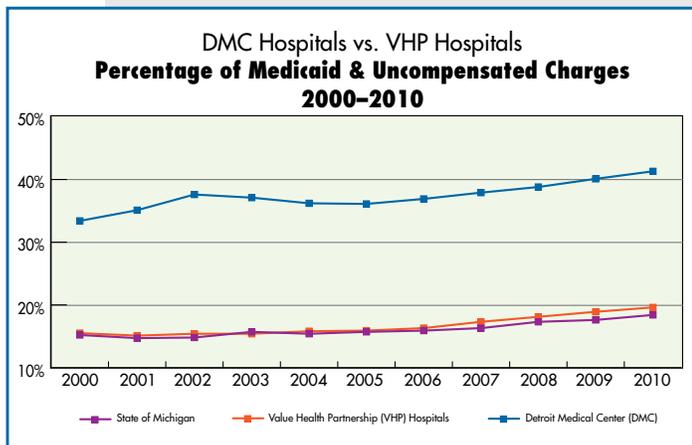
The distribution formula for the regular DSH pool was created in the early 1990's to identify and provide financial assistance to those Michigan hospitals that serve a "disproportionate share" of Medicaid and uninsured individuals. This current formula appropriately accomplishes that purpose and should be maintained.

The solution to Medicaid under funding and the increasing uncompensated care burden being placed on other hospitals is to find innovative ways to expand our Medicaid funding base and draw down additional federal matching funds -- not taking critical funding away from those safety net providers which have and will continue to shoulder a disproportionate share of the burden of providing services to this vulnerable population.

Disproportionate Share Hospital Program Reality vs. Fiction

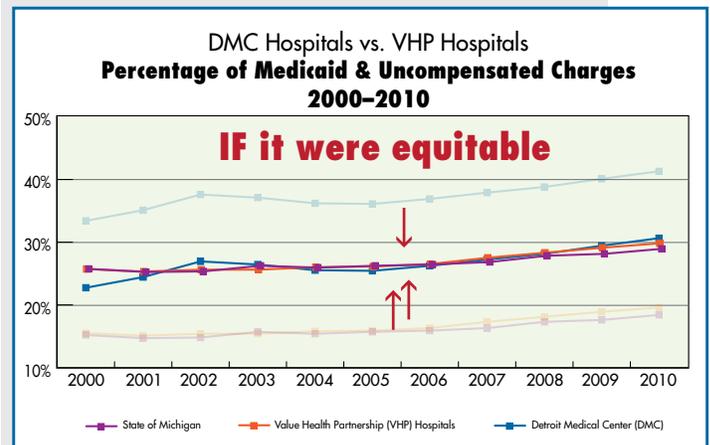
dis-pro-portion-ate — adj
1. out of proportion; unequal

EXAMPLE:



equi-ta-ble — adj
1. characterized by equity or fairness; just and right; fair

EXAMPLE:



DSH is thoughtfully named...

Disproportionate Share Hospital (DSH) payments: Special payments made to hospitals that have disproportionately large volumes of Medicaid and uninsured patients.

STATE OF MICHIGAN



MAY 03 2001

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR., Director

May 1, 2001

TO: Senator Joel Gougeon, Chairperson
Senate Appropriations Subcommittee on Community Health

Representative Mickey Mortimer, Chairperson
House Appropriations Subcommittee on Community Health

FROM: James K. Haveman, Jr.

SUBJECT: FY01 Boilerplate Report

In compliance with Section 1710 of Public Act 296 of 2000, the Department of Community Health is submitting the plan for the allocation of the Medicaid Disproportionate Share (DSH) payment for FY-01. The Medicaid Disproportionate Share payment was created to increase reimbursement to hospitals who have served a disproportionate share of Medicaid eligible persons. Section 1710 states that it is the sense of the legislature that the DSH payment should be equitably distributed on a statewide basis. Unfortunately, persons enrolled in Medicaid are not distributed equitably throughout the state. The department has reviewed the formula used to distribute the DSH payments and has decided to maintain the same formula that was used in FY-00. This formula creates a 20% indigent volume level of care as a minimum threshold a hospital must meet to participate in the DSH funding. This 20% indigent volume is then used as one factor in the funding calculations.

Enclosed for your review is the FY-00 Medicaid bulletin, a one page summary document of the requirements to receive DSH funding, and a listing of the FY-00 DSH payments by region. Using the same formula as was used in FY-00 should result in FY-01 payment levels similar to those made in FY-00. The actual FY-01 payments will be calculated in the next 60 days.

JKH/sc

Enclosure

cc: Senate Appropriations Subcommittee on Community Health
House Appropriations Subcommittee on Community Health
Senate Fiscal Agency
House Fiscal Agency
Department of Management and Budget
Mary Jane Russell





MANUAL TITLE	HOSPITAL		CHAPTER VIII	SECTION 6	PAGE 1
CHAPTER TITLE	REIMBURSEMENT	SECTION TITLE	DISPROPORTIONATE SHARE		DATE 04-01-00 Hospital 00-05

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

Indigent volume data is taken from each hospital's cost report and from supplemental forms that each hospital must file with its cost report. Data from the most recent available filed cost report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and separate adjustors are applied to distinct part psychiatric units and distinct part rehabilitation units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for payments under the Medicaid, CSHCS and State Medical Program plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

Uncompensated care, bad debt recovery, and/or Hill-Burton offset may be apportioned, using the ratio of total inpatient medical-surgical charges to total charges, the ratio of total distinct part rehabilitation unit charges to total charges, the ratio of total distinct part psychiatric unit charges to total charges, and the total of outpatient charges to total charges.

Each hospital must complete the Indigent Volume (IV) Report and Disproportionate Share Eligibility Form as a requirement for complete filing of its annual Medicaid cost report.

The cost report will not be accepted without the IV Report and the Disproportionate Share Eligibility Form.

In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the 4 criteria on the Disproportionate Share Eligibility Form.

The Indigent Volume Report

The IV Report is sent to the hospital by the MSA as part of the annual cost report package to be completed by the hospital and returned to the MSA.

In addition to completion of the indigent volume report, hospitals must complete the following form in order to be eligible to receive DSH payments.



MANUAL TITLE HOSPITAL	CHAPTER VIII	SECTION 6	PAGE 2
CHAPTER TITLE REIMBURSEMENT	SECTION TITLE DISPROPORTIONATE SHARE		DATE 04-01-00 Hospital 00-05

EXAMPLE FORMAT

Disproportionate Share Hospital (DSH) Eligibility Form

Hospital: _____
 City: _____
 Date: _____ FYE: _____

In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the eligibility criteria (Items 1 - 4). Please indicate which of the following applies to your hospital as of the end of your current fiscal year.

- 1 _____ At least two (2) obstetricians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.
- 2 _____ This hospital is located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and at least two (2) physicians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.
- 3 _____ This hospital serves as inpatients a population predominantly comprised of individuals under 18 years of age.
- 4 _____ On December 22, 1987, this hospital did not offer obstetric services to the general population, except in emergencies.

_____ None of the above apply. The hospital is not eligible for a disproportionate share adjustor.

Each year, this form must submitted to the MSA along with your cost report.



MANUAL TITLE	HOSPITAL	CHAPTER VIII	SECTION 6	PAGE 3
CHAPTER TITLE	REIMBURSEMENT	SECTION TITLE	DISPROPORTIONATE SHARE	
		DATE	04-01-00 Hospital 00-05	

In addition to the minimum requirements specified in the form above, each hospital must have a Medicaid utilization rate of at least 1%. Medicaid utilization is measured as:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital, including Subproviders)}}{\text{Total Hospital Days (Whole Hospital, including Subproviders)}}$$

Days are taken from filed hospital cost reports for fiscal years ending during the second previous state fiscal year. All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year (i.e. DSH payments for state FY 1998 are calculated using data collected in state FY 1996).

Regular DSH Payments

Medicaid inpatient DSH payments are made annually in a single distribution, based on charges converted to cost, using the hospital's cost to charge ratio. The payment will normally be made during the first half of the state fiscal year.

Each hospital's indigent volume is taken from hospital cost reporting periods ending during the second previous state fiscal year.

Title XIX charges used for computing DSH payments are the sum of Title XIX charges and Title XIX Qualified Health Plan (QHP) charges from hospital IV Reports for cost periods ending during the second previous state fiscal year. Data for cost periods of more or less that one-year is proportionately adjusted to one year.

Hospital total cost ratios are taken from hospital cost reporting periods ending during the second previous state fiscal year. If a hospital has more than one cost reporting period ending within this range, data from the two periods are added together and a single ratio is computed. If the ratio is greater than 1.00, a ratio of 1.00 is used.

1. DRG Reimbursed Hospitals (\$37,500,000 allocated)

The DSH payments for DRG reimbursed hospitals are split into two pools.



MANUAL TITLE	HOSPITAL	CHAPTER VIII	SECTION 6	PAGE 4
CHAPTER TITLE	REIMBURSEMENT	SECTION TITLE	DISPROPORTIONATE SHARE	
		DATE	04-01-00 Hospital 00-05	

- a) Hospitals with at least 50% IV (\$7,300,000)

The share of the DSH payment for hospitals with at least 50% IV is based on a DSH share computed as follows:

Title XIX Charges x Operating Ratio x (IV-0.5)

- b) Hospitals with at least 20% IV (\$30,200,000)

The share of the DSH payment paid to hospitals with at least 20% IV is based on the following DSH share amount. This is in addition to the amount from a) above.

Title XIX Charges x Operating Ratio x (IV-0.2)

2. Per Diem Reimbursed Hospitals and Units (\$7,000,000 allocated)

The share of the DSH payment paid to hospitals with IV of at least 20% is based on a DSH share based on the following:

Title XIX Charges x Operating Ratio x (IV-0.2)

3. Distinct-Part Rehabilitation Units (\$500,000 allocated)

The share of the DSH payment paid to hospitals with IV of at least 20% is based on a DSH share of the following:

Title XIX Charges x Operating Ratio x (IV-0.2)

4. For groups 1. through 3. Above, the determination of the share of the allocated DSH pool is made using the DSH share of the following:

$$\frac{\text{Hospital's DSH Share}}{\sum \text{DSH Shares for the Group}} \times \text{Allocated DSH Pool}$$

5. The payment amount for each hospital is determined by comparing the results of 4. above to the individual hospital payment limit. Any amount not paid to a hospital because of the OBRA 1993 limits is returned to the pool and redistributed using the same formula as the initial distribution with hospitals over the ceiling removed from the calculation. This process will continue until the entire pool is distributed. DSH amounts that cannot be paid because of the ceiling are withheld from hospitals in the following order:



MANUAL TITLE	HOSPITAL	CHAPTER VIII	SECTION 6	PAGE 5
CHAPTER TITLE	REIMBURSEMENT	SECTION TITLE	DISPROPORTIONATE SHARE	
		DATE	04-01-00 Hospital 00-05	

a) Distinct-Part Rehabilitation Unit DSH Payment

Any hospital that is above the DSH ceiling that is eligible for payment from the distinct-part rehabilitation unit DSH pool will forfeit DSH payments from the distinct-part rehabilitation unit pool in an amount necessary to get to the limit.

b) DRG Reimbursed Hospital

If a hospital is not eligible for a distinct-part rehabilitation unit DSH payment, or if forfeiting that unit's DSH payment is not sufficient to put the hospital below the DSH ceiling, the hospital will forfeit DSH payments from the DRG hospital pool in an amount necessary to get to the limit.

c) Per Diem Reimbursed Hospitals and Units

If steps a) and b) above are not sufficient to get the hospital below the DSH ceiling, the hospital will forfeit DSH payments from the per diem reimbursed hospital and unit pool in an amount necessary to get to the DSH limit.

**Special DSH Payments
for Public Hospitals**

Determination of annual special DSH payments for public hospitals is based on 100% of Medicaid and uninsured costs. Each public hospital's maximum payment is calculated as follows:

$[(\text{Title XIX Costs} + \text{Uninsured Care Costs}) - (\text{Title XIX Payments} + \text{Uninsured Care Payments})] - \text{Regular DSH payment}$

The maximum payment amount may be reduced if funds are not available to finance the payment.

**DSH Payments for
Geographic Areas with
Indigent Care
Agreements**

Annual DSH payments will be made to hospitals for geographic areas covered by an Indigent Care Agreement (ICA) approved by the Deputy Director for MSA. Separate pools will be established based upon local funds transferred to the state by one or more counties specifically for this purpose, a proportionate share of state dollars appropriated for the

Distribution of Regular Disproportionate Share Hospital (DSH) Pools

Federal Requirements:

In order to receive DSH funds, a hospital must meet at least one of the following federal criteria:

- At least 2 obstetricians with staff privileges at the hospital must have agreed to provide obstetric services to individuals who are eligible for Medicaid.
- The hospital is located in a rural area and at least 2 physicians with staff privileges at the hospital must have agreed to provide obstetric services to individuals who are eligible for Medicaid.
- The hospital services as inpatients a population predominantly comprised of individuals under 18 years of age
- On December 22, 1987, the hospital did not offer obstetric services to the general population except in emergencies.

In addition to the above requirements, each hospital must have a Medicaid utilization rate of at least 1 %.

In addition, a hospital's Medicaid inpatient utilization rate must exceed by one or more standard deviations the mean inpatient utilization rate of hospital's receiving Medicaid payments in Michigan or its low-income revenues exceed 25% of a hospital's total revenues. The Medicaid inpatient utilization rate is defined as the hospital's Medicaid inpatient hospital days divided by its total hospital days.

State Requirements:

\$45 million in regular DSH is distributed annually in the following pools:

- I. DRG Reimbursed Hospitals (\$37.5 Million)
The DSH payments for DRG reimbursed hospitals are split into 2 pools:
 - a. Hospitals with at least 50% Indigent Volume (IV) (\$7.3 Million)
 - b. Hospitals with at least 20% IV (\$30.2 Million)
- II. Per Diem Reimbursed (Psychiatric and Rehab) Hospitals and Units (\$7.0 Million)
- III. Distinct Part Rehab Units (\$½ Million)

Each hospital's Indigent Volume (IV) charges are computed as follows:

Medicaid Charges + Medicaid Managed Care Charges + Children's Special Health Care Services Charges + State Medical Plan Charges + Total Uncompensated Charges - Recoveries & Offset Charges

IV Factor = Hospital's IV Charges/Net Hospital Charges

An example of a hospital's distribution from a single pool:

Hospital's Costs = Hospital's Medicaid (Fee for Service & Health Plan) Charges x Hospital's Cost to Charge Ratio x (IV Factor - 0.X*)

$$\text{Hospital's Distribution} = \frac{\text{Hospital Costs}}{\Sigma \text{Hospital Costs}}$$

* Eligibility Percentage 20% or 50%

2000 Regular DSH Payments

5/1/2001 3:28 PM

Facility Name	2000 Regular DSH Payments
NORTHERN REGION	
ALPENA GENERAL HOSPITAL	\$ 12,181
MEMORIAL MEDICAL CENTER OF WEST MICHIGAN	\$ 38,330
MUNSON MEDICAL CENTER	\$ 680
SOUTHEAST REGION	
AURORA HOSPITAL	\$ 1,131,092
CHILDREN'S HOSPITAL OF MICHIGAN	\$ 13,151,423
COTTAGE HOSPITAL OF GROSSE POINTE	\$ 158,692
DETROIT RECEIVING HOSPITAL	\$ 6,480,315
DETROIT RIVERVIEW HOSPITAL	\$ 3,652,218
GRACE HOSPITAL DIVISION	\$ 2,010,221
HARPER HOSPITAL	\$ 365,494
HENRY FORD WYANDOTTE HOSPITAL	\$ 76,866
HOLY CROSS HOSPITAL	\$ 1,010,586
HUTZEL HOSPITAL, DETROIT	\$ 10,164,061
MADISON COMMUNITY HOSPITAL	\$ 9,804
NORTH OAKLAND MEDICAL CENTERS	\$ 39,507
OAKWOOD HOSPITAL ANNAPOLIS CENTER	\$ 369,751
OAKWOOD HOSPITAL HERITAGE CENTER	\$ 157,227
PONTIAC OSTEOPATHIC HOSPITAL	\$ 48,357
REHABILITATION INSTITUTE	\$ 265,196
RIVERSIDE OSTEOPATHIC HOSPITAL	\$ 322,425
SINAI HOSPITAL	\$ 303,433
ST. JOHN HEALTH SYSTEM OAKLAND HOSPITAL	\$ 134,679
ST. JOSEPH HOSPITAL - EAST	\$ 45,256
THUMB & EASTERN REGION	
BAY MEDICAL CENTER	\$ 27,400
CHELSEA COMMUNITY HOSPITAL	\$ 12,760
EDWARD W. SPARROW HOSPITAL	\$ 125,143
EMMA L. BIXBY MEDICAL CENTER	\$ 64,294
HEALTHSOURCE SAGINAW	\$ 95,698
HERRICK MEMORIAL HOSPITAL, INC.	\$ 43,383
HURLEY MEDICAL CENTER	\$ 3,210,403
LAPEER REGIONAL HOSPITAL	\$ 15,535
PORT HURON HOSPITAL	\$ 26,928
UNIVERSITY HEALTH SYSTEM	\$ 20,734
W. A. FOOTE MEMORIAL HOSPITAL	\$ 8,817
UPPER PENINSULA REGION	
MARQUETTE GENERAL HOSPITAL	\$ 120,709
WEST & SOUTHWEST REGION	
BORGESS MEDICAL CENTER	\$ 42,285
BRONSON METHODIST HOSPITAL	\$ 183,374
CARSON CITY OSTEOPATHIC HOSPITAL	\$ 57,594
GERBER MEMORIAL HOSPITAL	\$ 92,293
HAYES-GREEN-BEACH MEMORIAL HOSPITAL	\$ 22,282
LAKELAND MEDICAL CENTER, ST. JOSEPH	\$ 74,630
LAKESHORE COMMUNITY HOSPITAL	\$ 6,480
METROPOLITAN HOSPITAL	\$ 318,377
SOUTH HAVEN COMMUNITY HOSPITAL	\$ 28,558
SPECTRUM HEALTH - DOWNTOWN CAMPUS	\$ 202,269
ST MARY'S HEALTH SERVICES	\$ 196,945
THREE RIVERS HOSPITAL	\$ 66,276
TRILLIUM HOSPITAL	\$ 9,039
	<u>\$ 45,000,000</u>

**Statewide Disproportionate Share Hospital (DSH) Coalition
DSH Comparison Current v. Proposed by Highest Percentage to Least of Indigent Care**

(Note: Providers with at least 1% of state percentage)

Hospital	State Percentage of Indigent Care (Based on Medicaid and Uninsured Volume)	Current DSH Distribution	Fair DSH Distribution
University of Michigan Health System	9.06%	0	\$ 3,397,533.00
Vanguard@DMC - Harper U. Hospital	7.95%	\$ 4,788,350.00	\$ 2,979,757.00
Henry Ford Hospital	7.52%	\$ 670,220.00	\$ 2,818,221.00
Spectrum Health	6.86%	\$ 361,016.00	\$ 2,571,364.00
Vanguard@DMC Children's Hospital of M	6.50%	\$ 16,879,104.00	\$ 2,438,323.00
St. John Hospital and Medical Center	5.71%	\$ 1,319,516.00	\$ 2,142,642.00
Vanguard@DMC - Detroit Receiving	5.23%	\$ 6,029,345.00	\$ 1,960,933.00
Vanguard@DMC - Sinai-Grace Hospital	4.75%	\$ 2,366,490.00	\$ 1,780,198.00
Hurley Medical Center	4.32%	\$ 3,154,080.00	\$ 1,619,810.00
Edward W. Sparrow Hospital	3.87%	\$ 425,175.00	\$ 1,452,087.00
Bronson Methodist Hospital	3.74%	\$ 658,230.00	\$ 1,401,427.00
Oakwood Hospital and Medical Center	3.49%	0	\$ 1,309,155.00
William Beaumont Hospital - Royal Oak	2.90%	0	\$ 1,086,275.00
Covenant Medical Center, Inc.	2.69%	\$ 39,795.00	\$ 1,008,267.00
Borgess Hospital	2.43%	0	\$ 911,059.00
Allegiance	2.31%	0	\$ 865,281.00
St. John Macomb Hospital	2.15%	0	\$ 808,086.00
Genesys Regional Medical Center	2.13%	0	\$ 798,672.00
Providence Hospital	2.05%	0	\$ 769,815.00
St. Joseph Mercy Hospital - Ann Arbor	2.02%	0	\$ 756,659.00
Munson Medical Center	1.85%	0	\$ 693,411.00
St. Joseph Mercy Oakland	1.83%	0	\$ 686,116.00
St. Mary's Medical Center - Saginaw	1.63%	\$ 6,168.00	\$ 612,895.00
Lakeland Hospital - St. Joseph	1.46%	0	\$ 548,082.00
Ingham Regional Medical Center	1.45%	0	\$ 545,076.00
Botsford General Hospital	1.38%	0	\$ 518,016.00
Mt. Clemens General Hospital	1.36%	0	\$ 511,680.00
St. Mary's Health Care (Grand Rapids)	1.36%	0	\$ 509,162.00

Statewide Disproportionate Share Hospital (DSH) Coalition
 DSH Comparison Current v. Proposed by Highest Percentage to Least of Indigent Care

(Note: Providers with at least 1% of state percentage)

**PART of
 ONE SYSTEM
 PROVIDES
 24%
 OF THE CARE**

Hospital	State Percentage of Indigent Care (Based on Medicaid and Uninsured Volume)	Current DSH Distribution	Fair DSH Distribution	
University of Michigan Health System	9.06%	0	\$ 3,397,533.00	
Vanguard@DMC - Harper U. Hospital	7.95%	\$ 4,788,350.00	\$ 2,979,757.00	(\$1,808,593.00) ↓
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Spectrum Health	6.86%	\$ 361,016.00	\$ 2,571,364.00	
Vanguard@DMC Children's Hospital of M	6.50%	\$16,879,104.00	\$ 2,438,323.00	(\$14,440,781.00) ↓
St. John Hospital and Medical Center	5.71%	\$ 1,319,516.00	\$ 2,142,642.00	
Vanguard@DMC - Detroit Receiving	5.23%	\$ 6,029,345.00	\$ 1,960,933.00	(\$4,068,421.00) ↓
Vanguard@DMC - Sinai-Grace Hospital	4.75%	\$ 2,366,490.00	\$ 1,780,198.00	(\$ 586,292.00) ↓
Hurley Medical Center	4.32%	\$ 3,154,080.00	\$ 1,619,810.00	
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**AND GETS
 HIT WITH A
 10% CUT**

Cut one system (DMC) ~~\$21 million~~

To give the remaining hospitals
 an average of **\$270 thousand**

IS THIS SOUND PUBLIC POLICY?!