The Florida Senate

Interim Project Report 2000-44 *September 1999*

Committee on Fiscal Policy Senator Roberto Casas, Chairman

MEDICAID DISPROPORTIONATE SHARE FUNDING REPLACEMENT

SUMMARY

Federal law requires state Medicaid programs to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. Expenditures for DSH programs have increased significantly and were a major reason for the rapid growth nationally in Medicaid expenditures in the early 1990s. The federal government has been critical of some states "abuse" of the program, arguing that these states have used DSH payments to decrease the state's Medicaid fiscal responsibilities at the expense of the federal government. Florida is not one of the states that abused the DSH program.

The Balanced Budget Act of 1997 (BBA of 1997) represents a significant cutback in federal Medicaid (Title XIX) dollars that were targeted to provide financial relief to safety net providers. This report describes the changes in federal funding policies and their impact on the DSH program, which includes a major reduction in funding for the Mental Health DSH program. A description and summary of the funding structure for each of Florida's seven DSH programs are provided: Regular; Regional Perinatal Intensive Care Centers (RPICC); Teaching Hospitals (GME); Mental Health Hospitals; Rural Hospitals; Primary Care; and Specialty Hospitals. The Legislature will need to make some critical policy decisions about how to handle the DSH reductions. For example, the Legislature may opt to replace the DSH funds lost to cutbacks with state dollars. Alternatively, the legislature may decide to alter how the DSH dollars are distributed to hospitals.

This report recommends that the DSH reductions for FY 2000-01 be handled by eliminating the Primary Care DSH program and reducing the Regular DSH program. For FY 2001-02, it is recommended that a task force convene prior to the 2001 Legislative session to analyze the BBA impact, cost out policy changes, develop alternative funding strategies to reimburse hospitals and review the DSH formula. Additionally, it is recommended that the Department of Children and Family Services develop a state plan to handle the Mental Health DSH reductions.

BACKGROUND

Overview of Federal DSH Legislation

The DSH legislation was enacted under the Omnibus Budget Reconciliation Act (OBRA) 1980 and 1981 to help hospitals that provided large volumes of care to indigent patients and had high levels of uncompensated care. These same hospitals had low private caseloads and were less able to shift the cost of uncompensated care. Although the DSH mandate was legislated in the early 1980s, states were slow to implement. To encourage states to move forward, Congress passed several DSH provisions during the mid-1980s.

OBRA 1986 and 1987

A major provision included in OBRA 1986 allowed states to pay rates above the Medicare "upper payment limit" to hospitals rendering high volumes of care to the poor. OBRA 1987 outlined the minimum criteria that states were to use in identifying disproportionate share hospitals. The bill included two formulas. Hospitals would qualify as disproportionate share providers if they had above average use by Medicaid clients or if more than 25% of their business was from serving Medicaid and other low-income persons. The low-income formula included both Medicaid revenues and charity charges. States could use other formulas if they included at least all the hospitals which qualified under the federal formulas.

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Central to DSH expenditure growth was the development of Medicaid provider tax and donation programs. States were allowed to receive donations from private medical care providers and use this as state match. These

arrangements brought federal dollars to states, with the funds being largely distributed to hospitals providing disproportionate amounts of care to low-income individuals. In some states, federal funds substituted for expenditures states would have otherwise made, leaving total health care expenditures relatively the same. Florida was the first state to establish a provider tax program in 1984. Hospitals are assessed 1.5% of the annual net operating revenues (s. 395.701, F.S.) which are deposited into the Public Medical Assistance Trust Fund (PMATF). The assessment was expanded in 1991 to other health care entities (s. 395.7015, F.S.). The PMATF revenue was used to match the Regular DSH program for four years (FY 1988-89 through FY 1991-92) until the match was eventually replaced with local government funds. The PMATF revenue is currently used as state match for hospital inpatient services.

With the rapid rise in DSH payments, however, federal policy makers became concerned that states were abusing the program. In response, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 which curtailed DSH expenditure growth. The law banned provider donations, capped provider tax revenue, revised provider tax criteria so that taxes were broad based, uniformly imposed and providers were not held harmless. The law also capped DSH payments to 12% of total Medicaid costs. As a result of this legislation, many states had to restructure the financing of their DSH programs and several states turned to *"intergovernmental transfers*" to fund expenditures. These transfers were typically made by state and local governments to the Medicaid agency and used as a funding source for the state share of DSH programs.

OBRA 1993

Another federal concern with the DSH program was that some states were making payments to medical facilities that were not large Medicaid providers and that some providers were receiving DSH payments that exceeded their financial losses in serving the Medicaid and uninsured populations. In response, OBRA 1993 contained provisions that prohibited DSH payments to hospitals with less than 1% Medicaid utilization and required that total DSH payments to a hospital not exceed the hospital's losses on Medicaid and uninsured patients (sometimes referred to as the “hospital-specific cap”). Many states responded to this legislation by making or expanding DSH payments to "institutions for mental diseases (IMDs)". The use of IMDs allowed states to fully spend their DSH allotments while remaining within the facility-specific caps because of the large percentage of uninsured persons in IMDs. Because many IMDs are public institutions owned by state or local governments, the same entities that made the intergovernmental transfers benefitted from the DSH payments. Through DSH payments to IMDs, federal dollars have replaced state dollars. Florida expanded DSH payments to IMDs (state mental health hospitals) in FY 1992-93 and has maximized available federal funding.

Balanced Budget Act (BBA) of 1997

States are currently faced with implementing the BBA of 1997. To achieve the goal of a balanced budget by 2002, Congress targeted the DSH program as a reduction in Medicaid expenditures, because federal policy makers believed that payments have provided fiscal relief for the state's budgets rather than helping safety net providers. The key changes that the BBA made were as follows:

- Allotments - established new state-specific DSH allotments each year for FY 1998 through 2002. For FY 2003 and after, federal DSH expenditures are allowed to increase by the percentage change in the Consumer Price Index, subject to a ceiling of 12% of each state's total annual Medicaid expenditures.
- Limitations on Payments to IMDs - limited a state's federal DSH allotment paid to institutions for mental diseases (IMDs) or long-term mental hospitals to the lesser of the mental health DSH expenditures for 1995 or the amount equal to the "applicable percentage" of the 1995 federal share of DSH spending related to the 1995 DSH allotment. The applicable percentage for fiscal years 1998, 1999 and 2000 is the proportion of 1995 expenditures (44.8% for Florida) and is 50% for 2001, 40% for 2002, and 33% for each succeeding year.
- Targeted Payments - provided targeted payments for hospitals serving high numbers of uninsured and Medicaid patients. States methodologies to identify and make payments to DSH hospitals based on the proportion of low-income and Medicaid patients served had to be submitted to HCFA by October 1, 1998.
- Payments to Hospitals - After October 1, 1997, DSH payments must be made to hospitals and not to managed care entities (i.e., DSH payments are not to be included in capitation rates). This does not affect Florida since payments have always been made directly to hospitals.

Overview of State DSH Legislation

There are currently seven separate DSH programs operated in Florida by the Agency for Health Care Administration (AHCA or Agency) in accordance with chapter 409, F.S. They are the Regular; Regional

Perinatal Intensive Care Centers (RPICC); Teaching Hospitals (GME); Mental Health Hospitals; Rural Hospitals; Primary Care; and Specialty Hospitals DSH programs. Hospital payment amounts are determined according to the formulas specified in law and in the Florida Title XIX Inpatient Hospital Reimbursement Plan. The DSH program has grown substantially from $76.8 million in FY 1988-89 to $348.5 million in FY 1999-00 (Table 1). Although this growth is significant, the DSH program represents only 4.7% of the total FY 1999-00 estimated Medicaid expenditures. Prior to the BBA of 1997, "low-DSH" states such as Florida were allowed to increase DSH payments each year by the percent that the overall Medicaid program increased, not to exceed 12%. Florida is not one of the states that abused the DSH program.

Regular DSH Program

The Regular DSH program, authorized under s. 409.911, F.S., was implemented on July 1, 1988. To qualify for reimbursement, a hospital must have:

- a Medicaid inpatient utilization rate greater than one standard deviation above the statewide mean, or have a low-income utilization rate of 25% or greater;
- Medicaid and charity care days equal or exceed 7 percent of its total adjusted patient days;
- total charity care days weighted by a factor of 4.5 plus total Medicaid days weighted by 1 be equal to or greater than 10% of total adjusted patient days; and
- at least two obstetricians or physicians with staff privileges at the hospital who have agreed to provide services.

DSH payments for qualifying hospitals are calculated in accordance with the formula specified in law. The state law requires the Agency to use the most recent calendar year audited data available for calculation of DSH payments. However, language has been included each year in the Implementing Bill of the General Appropriations Act (GAA) that requires the Agency to use "the 1992-93 disproportionate share formula, the 1989 audited financial data, and the Medicaid per diem rate as of January 1, 1992, for those hospitals that qualify for the hospital disproportionate share program." There were 61 hospitals that participated in the program in FY 1998-99. Ninety-three percent (93%) of these payments were made to three hospitals: Jackson Memorial received 61% of the funds, University Medical Center 21% and Tampa General 11%.

The Regular DSH program has grown from a total of $76.8 million ($34.4 million state and $42.4 million federal) in FY 1988-89 to $153.4 million ($66.7 million state and $86.7 million federal) in FY 1999-00 (reference Specific Appropriation 243 in the FY 1999-00 GAA). The state share of $66.7 million is contingent upon receipt of county contributions. The original source of state matching funds for the Regular DSH program was the Public Medical Assistance Trust Fund (PMATF). Budget reductions in FY 1990-91 reduced the Regular DSH program by a total of $33.7 million (from $44.3 million to $10.6 million). However, through negotiations with local governments, state match was generated by the counties and payments were made for an Extraordinary DSH program that totaled $51 million ($23.2 million state and $27.8 million federal). For the first time, *intergovernmental transfers* of state matching funds were made from three counties (Dade, Duval and Hillsborough). By FY 1992-93, county funds had eventually replaced the PMATF revenues as the source of match for the Regular DSH program.

Regional Perinatal Intensive Care Centers (RPICC) DSH Program

The RPICC DSH program, authorized under s. 409.9112, F.S., was implemented July 1, 1989. This program provides supplemental payments to hospitals that participate in the RPICC program established pursuant to chapter 383, F.S., that qualify for the Regular DSH program and meet the additional requirements imposed by s. 409.9112, F.S. There were eleven hospitals that participated in this program in FY 1998-99 (All Children's Hospital, Bayfront Medical Center, Broward General Medical Center, Jackson Memorial Hospital, Memorial Regional Hospital, Orlando Regional Medical Center, Sacred Heart Hospital, Shands Teaching Hospital and Clinic, St. Mary's Hospital, Tampa General Hospital, and University Medical Center).

The RPICC DSH program was originally funded in FY 1989-90 at a total of $9.7 million ($4.4 million General Revenue and $5.3 million federal). In FY 1991-92, the General Revenue funds were reduced and the match was funded with county funds. The program is currently budgeted in FY 1999-00 at a total of $6.9 million of which $3 million is contingent upon receipt of county contributions and $3.9 million is federal funds (reference Specific Appropriation 271 in the FY 1999-00 GAA).

Teaching Hospital DSH Program

The Teaching Hospital DSH program (Graduate Medical Education), authorized under s. 409.9113, F.S., was implemented July 1, 1991. This program provides supplemental payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. Payments to hospitals

are based on an allocation fraction consisting of three primary factors: 1) the number of nationally accredited graduate medical education programs offered by the hospital; 2) the number of full-time equivalent trainees in the hospital; and 3) a service index. In order to qualify for the program, a hospital must qualify under the Regular DSH program and must be formally affiliated with an accredited medical school which demonstrates activity in the area of medical education as reflected by a minimum of seven different resident specialties and the presence of 100 or more resident physicians (s. 408.07(44), F.S.). There were six teaching hospitals that participated in the program in FY 1998-99 (Jackson Memorial Hospital, Mount Sinai Medical Center, Orlando Regional Medical Center, Shands Teaching Hospital and Clinic, Tampa General Hospital, and University Medical Center).

The Teaching Hospital DSH program was initially funded in FY 1991-92 at $16.8 million ($7.6 million General Revenue and $9.2 million federal). In FY 1991-92, through budget reductions, $2.7 million in General Revenue funds were reduced and replaced with county funds. In FY 1998-99, the Legislature appropriated an additional $10.4 million in nonrecurring funds of which $4.5 million was General Revenue. This brought the program up to a total of $29.8 million; however, the nonrecurring funds were not replaced by the 1999 Legislature. The FY 1999-00 appropriation totals $19.8 million (reference Specific Appropriation 238 in the FY 1999-00 GAA). Of this total, $5.9 million is General Revenue, $2.7 million is contingent upon receipt of county contributions and $11.2 million is federal.

Mental Health Hospital DSH Program

The Mental Health Hospital DSH program, authorized under s. 409.9115, F.S., was implemented October 1, 1992. This program provides supplemental payments to state mental health hospitals. In order to qualify for the program, a hospital must qualify under the Regular DSH program, participate in the Title XIX program, serve all individuals referred by appropriate agencies who require inpatient psychiatric services, be certified or certifiable as a Title XVIII (Medicare) provider, and receive all inpatient claims for admissions governed under the Baker Act as specified in chapter 394, F.S. Florida's four state mental health hospitals participate in the program (Florida State Hospital, G. Pierce Wood Hospital, N. E. Florida State Hospital and S. Florida State Hospital).

The Mental Health Hospital DSH program was originally funded in FY 1992-93 at $64 million ($28.8 million General Revenue and $35.2 million federal). The state share is budgeted in the Department of Children and Family Services (DCF). The program allowed the state to maximize federal earnings by using existing state funds and certifying them as match. The FY 1999-00 appropriation totals $147.8 million ($64.2 million General Revenue funds appropriated in DCF and $83.6 million federal). The federal funds are budgeted in AHCA (reference Specific Appropriation 268 in the FY 1999-00 GAA) and are transferred to DCF to fund the operations of the state mental health hospitals.

Rural Hospital DSH/Financial Assistance Program

Section 409.9116, F.S., authorizes a federally matched DSH program for qualifying rural hospitals and a state-funded Financial Assistance Program (FAP) for rural hospitals that do not qualify for DSH. This program was implemented May 1, 1994 and provides supplemental payments to rural hospitals defined in s. 395.602, F.S. In order to qualify for the program, a hospital must conform to all agency requirements to ensure high quality in the provision of services, agree to accept all patients, regardless of ability to pay, on a functional space-available basis, and agree to provide backup and referral services to county public health units and other providers of services to low-income persons within the hospital's service area.

Twenty-seven (27) rural hospitals participated in the program in FY 1998-99. Of this total, 24 rural hospitals received payments or a combination of payments under the Rural Hospital DSH/ Financial Assistance Program and three hospitals received payments only under the Financial Assistance Program. Beginning with FY 1996-97, the Implementing Bill of the GAA prescribed a formula which establishes a minimum payment level of four percent of the amount appropriated. Chapter 98-14, Laws of Florida, (SB 288) added language to s. 409.9116, F.S., limiting the DSH/Financial Assistance Program for rural hospitals only to hospitals that were defined as statutory rural hospitals prior to July 1, 1998. Additional hospitals defined on or after July 1, 1998 are not eligible for the program unless additional funds are appropriated each fiscal year in an amount necessary to prevent any hospital eligible for the program prior to July 1, 1998 from incurring a reduction in payments.

The Rural Hospital DSH/Financial Assistance program was originally funded in FY 1993-94 at $10.3 million ($9.6 million DSH and $.7 million FAP). The FY 1999-00 appropriation totals $11.1 million of which $9.8 million is DSH ($4.3 million state and $5.5 million federal) and $1.3 million is the state FAP program.

(Reference Specific Appropriation 236 in the FY 1999-00 GAA). The state portion of the DSH/FAP program consists of $.7 million General Revenue, $.5 million Tobacco Settlement funds and $4.3 million in other state cash. The $500,000 of Tobacco Settlement funds replaced the non-recurring General Revenue appropriation in FY 1998-99.

Primary Care DSH Program

The Primary Care DSH program, authorized under s. 409.9117, F.S., was implemented July 1, 1997. This program provides supplemental payments to hospitals that participate in the Regular DSH program and also meet the criteria detailed in s. 409.9117, F.S. The purpose of the program is to provide additional payments to hospitals that have established a network for providing health care to uninsured individuals within a geographic boundary. There were seven hospitals that participated in the program in FY 1998-99 (Broward General Medical Center, Imperial Point Hospital, Jackson Memorial Hospital, Memorial Regional Hospital, Shands Teaching Hospital and Clinic, Tampa General Hospital, and University Medical Center).

The Primary Care DSH program was originally funded in FY 1997-98 at $10 million ($4.4 million county contributions and $5.6 million federal). The FY 1999-00 appropriation totals $10.2 million of which $6.5 million is DSH ($2.8 million county funds and $3.7 million federal) and $3.7 million is a state funded program ($1.6 million county funds and $2.1 million state cash). (Reference Specific Appropriation 270 in the FY 1999-00 GAA). Proviso language states that if the total DSH allotment is reduced, a budget amendment is to be submitted that would reduce the DSH programs to the maximum cap and "shall first reduce the Primary Care Hospital DSH program". In order not to exceed the DSH federal allotment, the 1999 Legislature authorized AHCA (through proviso) to spend up to $2.1 million in state cash to cover the federal shortfall. This allows hospitals to continue to be reimbursed at the $10 million appropriated level.

Specialty Hospital DSH Program

The Specialty Hospital DSH program, authorized under s. 409.9118, F.S., was implemented July 1, 1997. This program provides supplemental payments to hospitals that qualify under the Regular DSH program, participate in the Title XIX program, are certified or certifiable as a Title XVIII (Medicare) provider, require a diagnosis for the control of a communicable disease for all admissions and receive all inpatient clients through referrals or admissions from county public health units. A.G. Holley State Hospital, the state's tuberculosis hospital, participates in the program. The program was originally funded in FY 1997-98 at $4.4 million ($1.9 million General Revenue and $2.5 million federal). Matching funds are appropriated in the Department of Health and certified as state match. The FY 1999-00 appropriation has remained at this level (reference Specific Appropriation 269 in the FY 1999-00 GAA). The federal funds are budgeted in AHCA and transferred to DOH to fund the operations of the hospital.

County Contributions

Beginning in FY 1990-91, local governments transferred cash to AHCA to be used as match for the DSH program. The Agency enters into agreements with local governments each year to transfer funds that match Medicaid program expenditures. Dade, Duval, and Hillsborough County will transfer $88 million in FY 1999-00 to match Regular DSH ($66.7 million), RPICC DSH ($3 million), GME DSH ($2.7 million), the hospital outpatient variable cost ceiling ($5.2 million) and the adult expenditure ceiling ($10.4 million). Of the $88 million, Dade County contributes $59.7 million (68%), Duval County $17.8 million (20%) and Hillsborough County $10.5 million (12%). Additionally, $4.4 million in county funds are to be transferred to the state from the participating local governments to match the Primary Care DSH program. Total county contributions in the Medicaid program for FY 1999-00 total $92.4 million.

METHODOLOGY

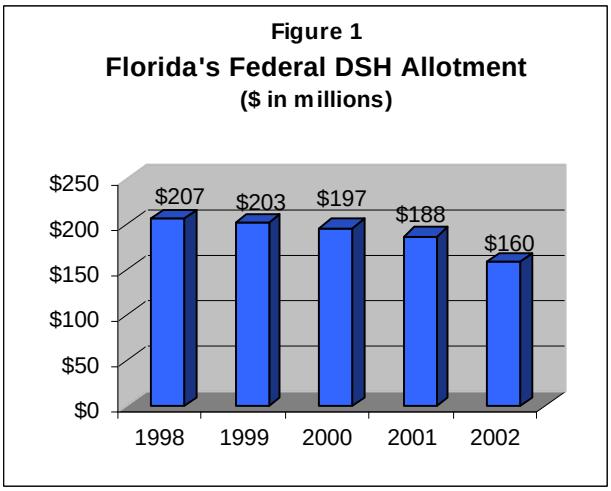
Senate Fiscal Policy Committee staff worked with the Senate Health and Human Services Budget Committee and House Fiscal Responsibility Council to review the DSH funding reductions resulting from the Balanced Budget Act of 1997 and the potential impact of changes in the distribution of payments to hospitals. Staff used the Internet as the primary research tool to collect, review, and analyze federal and state legislation. Staff reviewed existing materials related to the DSH program provided by the Agency for Health Care Administration. The Agency was consulted on numerous aspects of the program and additional specific information was sought regarding estimates of the BBA reductions and potential

changes to the distribution of DSH payments to hospitals using updated financial data.

FINDINGS

Impact of BBA of 1997

Florida's annual federal DSH allotments specified in the BBA of 1997 decrease from $207 million in federal fiscal year 1998 to $160 million in 2002 (Figure 1). Florida will be faced with a reduction of federal DSH payments of $9 million in FY 2000-01 and $28 million in FY 2001-02. The legislature must ensure that DSH payments to IMDs



do not exceed the state specific limitations and that the total DSH allotment is not exceeded. Within these caps, there are various policy alternatives to consider. In FY 1995-96, the DSH reduction was pro rated among all programs and a policy decision was made to hold harmless the Mental Health institutions. Additional nonrecurring state funds were used to fund the lost federal revenue. The Agency projected the BBA changes for FY 2001 through 2003 (Table 2).

FY 2000-01

The reduction needed to remain within the DSH allotment for FY 2000-01 is $15.9 million ($6.9 million state and $9 million federal). The Mental Health DSH cap is estimated at $149 million ($64.8 million state and $84.2 million federal). The FY 1999-00 program is currently budgeted at $147.8 million which is $1.2 million below the cap. If the Mental Health DSH program is maintained at the current funding level, other DSH programs will need to be reduced. If current proviso is followed, the Primary Care DSH program of $6.5 million ($2.8 million state and $3.7 million federal) would be reduced first, leaving $9.4 million ($4.1 million state and $5.3 million federal) to be reduced from other DSH programs.

FY 2001-02

The reduction needed to remain within the DSH allotment for FY 2001-02 is $49.5 million ($21.5 million state and $28 million federal). The major part of the reduction, $37 million ($16.1 million state and $20.9 million federal), must come from the Mental Health Hospital DSH program. The Legislature will be faced with finding state funds to replace the lost federal funds or redesigning the current mental health service delivery system. The remaining $12.5 million reduction ($5.4 million state and $7.1 million federal) would need to come from other DSH programs.

FY 2002-03

The estimate for FY 2002-03 reflects an increase in the DSH allotment of $14.2 million ($6.2 million state and $8 million federal) based on an assumption that the program will grow by 5%. However, the Mental Health DSH program will need to be reduced by $15.3 million ($6.7 million state and $8.6 million federal) so that the other DSH programs can increase by $29.4 million ($12.8 million state and $16.6 million federal).

Regular DSH Reimbursement Formula

During this past legislative session, there was some discussion regarding the Regular DSH formula and the allocation of payments to hospitals using more current data. Current law (Implementing Bill of the GAA) requires that payments be allocated using the FY 1992-93 disproportionate share formula, the 1989 audited financial data, and the Medicaid per diem rate as of January 1, 1992. This language was negotiated with Dade, Duval and Hillsborough counties to ensure that the three hospitals (Jackson Memorial, Tampa General and University Medical Center) received appropriate reimbursement.

The Agency prepared an analysis under the current formula using the 1994 audited data and the January 1999 per diem rates for the Regular and RPICC DSH programs. This analysis reflects that about half of the hospitals would receive less reimbursement and half would receive more when compared to current law. The top two hospitals that would receive less reimbursement are:

- Jackson Memorial Hospital ($25.3 million less or 27.45% decrease)
- All Children's Hospital ($5.2 million less or 93.79% decrease).

The top three hospitals that would receive more reimbursement are:

- Broward General Medical Center ($22.5 million more or 34,478.26% increase)

- University Hospital of Jacksonville ($5.9 million more or 18.15% increase)
- Imperial Point Medical Center ($1 million more or 7,724.67% increase).

The current formula is complex and a simpler more equitable distribution of funds based on charity care and Medicaid utilization could be developed. Any changes to the distribution of DSH payments to hospitals, either through the use of more current data or a formula change, would need to consider voluntary transfers of county funds as appropriate.

RECOMMENDATIONS

- The FY 2000-01 DSH reductions of $15.9 million should be accomplished by eliminating the Primary Care DSH program ($6.5 million) and reducing the Regular DSH program ($9.4 million).

- The Legislature should direct the Department of Children and Families (DCF), appropriate legislators and staff, and other key stakeholders to develop a statewide plan for the Mental Health DSH reductions in FY 2001-02 that will facilitate appropriate community-based care and treatment. Under this plan, the legislature and DCF should consider the Commission on Mental Health and Substance Abuse interim report recommendations due March 1, 2000 (HB 2003).

- The Legislature should convene a task force prior to the 2001 Legislative session that includes representatives of appropriate substantive and fiscal committees of the Senate and House, the Governor's Office, AHCA, DCF and other key stakeholders to make recommendations on policy and funding strategies for the FY 2001-02 DSH reductions.

  1) The task force should consider revisions to the Inpatient Hospital Reimbursement Plan that would increase hospital reimbursement and benefit all hospitals or selected hospitals (i.e., teaching hospitals) to help offset the loss in DSH payments. Options should be explored with local governments to use county funds as match for these expenditures.

  2) The task force should explore having additional local governments contribute funds to match the DSH program, if changes to the DSH formula or distribution of payments to hospitals are adopted.

  3)The task force should evaluate the need for changes to chapter 409, F.S., if it is determined that the DSH program formulas need to be revised.

SUMMARY OF MEDICAID DISPROPORTIONATE SHARE PAYMENTS

Table 1

($ in millions)

Program	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00
DSH Programs												
Regular Program	$ 76.8	$ 44.3	$ 61.6	$ 168.0	$ 152.1	$ 147.6	$ 151.1	$ 139.0	$ 149.6	$ 171.8	$ 151.0	$ 153.4
RPICC Program		$ 9.7	$ 9.6	$ 6.6	$ 6.7	$ 6.6	$ 6.8	$ 6.3	$ 6.7	$ 6.8	$ 6.8	$ 6.9
Teaching Hospital (GME) Prog				$ 16.8	$ 16.9	$ 16.8	$ 17.2	$ 17.9	$ 19.3	$ 19.4	$ 29.8	$ 19.8
Mental Health Hospital Prog					$ 64.0	$ 105.9	$ 149.7	$ 169.1	$ 181.7	$ 149.3	$ 149.7	$ 147.8
Rural Hospital Program						$ 9.6	$ 9.4	$ 7.8	$ 8.5	$ 9.1	$ 9.6	$ 9.8
Primary Care Hospital Prog										$ 10.0	$ 10.0	$ 6.5
Specialty Hospital (TB) Prog										$ 4.4	$ 4.4	$ 4.3
Total DSH Payments	$ 76.8	$ 54.0	$ 71.2	$ 191.4	$ 239.7	$ 286.5	$ 334.2	$ 340.0	$ 365.8	$ 370.8	$ 361.3	$ 348.5
State (General Revenue)		$ 4.4	$ 4.4	$ 4.9	$ 4.9	$ 8.1	$ 7.9	$ 8.0	$ 6.8	$ 8.9	$ 11.4	$ 6.3
State (PMATF)	$ 34.4	$ 20.1	$ 4.8	$ 12.0								
State (State Trust Fund)						$ 1.1	$ 1.1	$ 0.9	$ 2.8	$ 1.0	$ 3.3	$ 3.3
State (Certified State Match)					$ 28.8	$ 47.9	$ 65.5	$ 74.8	$ 80.3	$ 68.2	$ 68.1	$ 66.2
State (County Funds)			$ 23.2	$ 69.8	$ 74.1	$ 72.5	$ 71.7	$ 66.8	$ 71.8	$ 86.4	$ 76.9	$ 75.2
State (Tobacco Trust Fund)												$ 0.5
Federal Share	$ 42.4	$ 29.5	$ 38.8	$ 104.7	$ 131.9	$ 156.9	$ 188.1	$ 189.6	$ 204.1	$ 206.3	$ 201.7	$ 197.0
State Programs												
Rural Financial Assist						$ 0.7	$ 0.9	$ 1.6	$ 1.2	$ 1.0	$ 1.3	$ 1.3
State (General Revenue)						$ 0.5	$ 0.7	$ 1.2	$ 0.3	$ 0.7	$ 0.3	$ 0.3
State (State Trust Fund)						$ 0.2	$ 0.2	$ 0.4	$ 0.9	$ 0.2	$ 1.0	$ 1.0
Primary Care DSH												$ 3.7
State (State Trust Fund)												$ 2.1
State (County Funds)												$ 1.6

Source: Agency for Health Care Administration, June 1999

ESTIMATED IMPACT TO FLORIDA'S DSH PROGRAM
(Balanced Budget Act of 1997)

Table 2

	1997-98	Diff	1998-99	Diff	1999-00	Diff	2000-01	Diff	2001-02	Diff	2002-03*
Total DSH Allotment											
Total Cap	$ 372.0	$ (8.3)	$ 363.7	$ (15.1)	$ 348.5	$ (15.9)	$ 332.6	$ (49.5)	$ 283.1	$ 14.2	$ 297.2
Federal Share	$ 207.0	$ (4.0)	$ 203.0	$ (6.0)	$ 197.0	$ (9.0)	$ 188.0	$ (28.0)	$ 160.0	$ 8.0	$ 168.0
State Share	$ 165.0	$ (4.3)	$ 160.7	$ (9.1)	$ 151.5	$ (6.9)	$ 144.6	$ (21.5)	$ 123.1	$ 6.2	$ 129.2
MH DSH Budget/Cap											
Total Cap	$ 149.7		$ 149.7		$ 149.7		$ 149.0		$ 110.8		$ 95.5
Total Budget	$ 149.3		$ 149.7		$ 147.8		$ 147.8	$ (37.0)	$ 110.8	$ (15.3)	$ 95.5
Federal Share	$ 83.1		$ 83.6		$ 83.5		$ 83.5	$ (20.9)	$ 62.6	$ (8.6)	$ 54.0
State Share	$ 66.2		$ 66.1		$ 64.3		$ 64.3	$ (16.1)	$ 48.2	$ (6.7)	$ 41.5
Other DSH Programs											
Total Cap**					$ 200.7	$ (15.9)	$ 184.8	$ (12.5)	$ 172.3	$ 29.4	$ 201.7
Federal Share					$ 113.5	$ (9.0)	$ 104.5	$ (7.1)	$ 97.4	$ 16.6	$ 114.0
State Share					$ 87.2	$ (6.9)	$ 80.3	$ (5.4)	$ 74.9	$ 12.8	$ 87.7

* Assumes a 5% growth

**Includes funding for the Regular DSH program for Mental Health hospitals.

Source: Agency for Health Care Administration June, 1999

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***

Committee on Fiscal Policy, 404 South Monroe Street, Tallahassee, FL 32399-1100, (850) 487-5140 SunCom 277-5140

Committee on Budget

Committee on Health, Aging and Long-Term Care

Committee on Children and Families

MEMBER OVERSIGHT

Senators Ginny Brown-Waite and Ron Klein