COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor of Virginia

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Disproportionate Share Hospital Workgroup Recommendation

This report is submitted in compliance with 292.GG. of the 2024 Appropriations Act, which states:

The Department of Medical Assistance (DMAS) shall convene a workgroup to evaluate the criteria for hospitals to qualify for disproportionate share hospital (DSH) payments. The workgroup shall evaluate current DSH criteria, including the Medicaid inpatient utilization rate, to determine changes that are necessary to reflect the impact from the Commonwealth's expansion of Medicaid in 2019. The workgroup shall recommend a new Medicaid inpatient utilization threshold to qualify for DSH payments to ensure that those hospitals with the largest uncompensated care costs are receiving appropriate DSH payments. The workgroup shall include representatives from DMAS, the Department of Planning and Budget, and staff from the House Appropriations and Senate Finance and Appropriations Committees. The workgroup shall report its findings to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2024.

Should you have any questions or need additional information, please feel free to contact me at 804-664-2660.

CR/wf
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Disproportionate Share Hospital Workgroup

May 2025

Report Mandate:

Item 292.GG. of the 2024 Appropriation Act states: The Department of Medical Assistance (DMAS) shall convene a workgroup to evaluate the criteria for hospitals to qualify for disproportionate share hospital (DSH) payments. The workgroup shall evaluate current DSH criteria, including the Medicaid inpatient utilization rate, to determine changes that are necessary to reflect the impact from the Commonwealth's expansion of Medicaid in 2019. The workgroup shall recommend a new Medicaid inpatient utilization threshold to qualify for DSH payments to ensure that those hospitals with the largest uncompensated care costs are receiving appropriate DSH payments. The workgroup shall include representatives from DMAS, the Department of Planning and Budget, and staff from the House Appropriations and Senate Finance and Appropriations Committees. The workgroup shall report its findings to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2024.

Background

Disproportionate Share Hospital (DSH) payments are authorized by Section 1923 of the Social Security Act and are designed to offset a hospital's uncompensated care costs. Uncompensated care costs consist of bad debt and charity care. Bad debt occurs when a hospital bills a patient, pursues collection, but then determines it is unlikely to collect payment from patients who are unable or unwilling to pay their bills. [1] Charity care is when hospitals provide free or discounted health services to patients who are determined to be unable to pay based on the hospital's financial assistance policies. [2]

To qualify for DSH payments from DMAS, hospitals must have a Medicaid inpatient utilization rate of at least 14% or a low-income patient utilization rate exceeding 25%, and at least two obstetricians with staff privileges who agree to provide obstetric services to Medicaid-eligible individuals.

An annual DSH allotment for each state is established by federal law on an annual basis, which limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law prohibits FFP for state DSH payments that exceed the hospital's eligible uncompensated care cost.

DSH payments are prospectively made on a quarterly basis, then the hospitals are retrospectively audited to determine if they were paid appropriately for their uncompensated care costs. Any overpayments must be returned to DMAS.

[1] "Hospital Charity Care How it Works and Why it Matters". KFF, March 6, 2025. https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/#:~:text=Medicaid%20and%20Medicare%20both%20provide,the%20costs%20of%20uncompensated%20care.

[2] "Hospital Charity Care How it Works and Why it Matters". KFF, March 6, 2025. https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/#:~:text=Medicaid%20and%20Medicare%20both%20provide,the%20costs%20of%20uncompensated%20care.

Workgroup Analysis

Pursuant to Item 292.GG of the 2024 Appropriation Act, DMAS convened a workgroup to evaluate the criteria for hospitals to qualify for DSH payments. The workgroup met four times and included staff from DMAS, the Department of Planning and Budget, House Appropriations Committee, and the Senate Finance and Appropriations Committee, and representatives from the Virginia Hospital and Healthcare Association and 15 health systems.

The workgroup's analysis identified several findings.

1. For most hospitals, adjusting the allocation method will not result in additional hospitals receiving payment.
2. Across in-state and out-of-state hospitals, 11 could potentially be eligible to accept DSH payments in State Fiscal Year 2025.
3. A portion of DSH funds is going to out-of-state (OOS) hospitals, an arrangement not reciprocated by all neighboring states.
    a. The removal of Virginia hospitals with negative uncompensated care (UCC) from the DSH program significantly increased the amount of remaining funds available to OOS hospitals. This is largely because most OOS hospitals do not report negative UCC.
    b. Negative UCC in Virginia hospitals results from additional directed payments, which these hospitals are required to report on the DSH survey, upon which DMAS relies. OOS hospitals are not required to file DSH surveys, and their cost reports do not include directed payment information.

Recommendations

Based on the findings, the workgroup recommends the following actions to ensure appropriate DSH payments. The department will need authority by the General Assembly to proceed with any of these recommendations.

1. Given the limited number of hospitals eligible for DSH payments, the department could reallocate DSH funds to increase other supplemental payment programs, such as Graduate Medical Education (GME) or Indirect Medical Education (IME). This reallocation could help retain more funds for Virginia hospitals.
2. The department could pursue further evaluation of alternative allocation methods, including reducing the Medicaid inpatient utilization rate threshold, calculating payments based on the percentage of total uncompensated care costs, and eliminating Type 1 and 2 hospital distinctions for DSH allocation purposes.
3. Current regulations, 12VAC30-70-301 (B) and (C), outline the same DSH payment methodology for both instate and OOS hospitals; however, OOS payments are prorated based on Virginia Medicaid days, effectively limiting the calculation to those days. To

address the treatment of OOS hospitals in the DSH calculation, DMAS recommends regulation changes to account for the lack of directed payment information in OOS hospital reporting.

HOSPITAL NAME	MEET OB REQUIREMENT?	MIUR	DSH Limit	ACTUAL PAYMENTS		MODELING SCENARIOS			
				SFY 24 DSH PAYMENTS	SFY25 DSH PAYMENTS	REDUCE 14% to 1%	% TO TOTAL UCC	REDUCE OOS	NO TYPE 1 & 2
Augusta Medical Center	YES	21.78%	$ -	$ 360,122	$ -	$ -	$ -	$ -	$ -
Carilion Medical Center	YES	33.86%	$ -	$ 4,841,836	$ -	$ -	$ -	$ -	$ -
Centra Health	YES	20.32%	$ 144,379,027	$ 718,926	$ 13,373,554	$ 11,266,744	$ 8,321,622	$ 16,703,210	$ 17,098,043
Chesapeake Hospital	YES	20.03%	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Chippenham/Johnston Willis Medical Center	YES	32.30%	$ -	$ 3,763,182	$ -	$ -	$ -	$ -	$ -
CHKD	YES	79.53%	$ 75,914,979	$ -	$ -	$ -	$ -	$ -	$ -
Clinch Valley Medical Center	YES	22.70%	$ -	$ 126,524	$ -	$ -	$ -	$ -	$ -
Danville Regional Medical Center	YES	27.84%	$ -	$ 649,798	$ -	$ -	$ -	$ -	$ -
Halifax Regional Hospital	YES	17.44%	$ -	$ 73,356	$ -	$ -	$ -	$ -	$ -
Henrico Doctors Hospital	YES	20.93%	$ -	$ 1,024,478	$ -	$ -	$ -	$ -	$ -
Inova - Alexandria Hospital	YES	17.91%	$ 3,036,987	$ 469,112	$ 3,954,096	$ 4,707,831	$ 175,044	$ 4,938,560	$ 5,055,299
Inova - Fair Oaks Hospital	YES	17.59%	$ -	$ 64,346	$ -	$ -	$ -	$ -	$ -
Inova - Fairfax Hospital	YES	23.54%	$ -	$ 3,224,760	$ -	$ -	$ -	$ -	$ -
Johnston Memorial Hospital	YES	19.91%	$ -	$ 163,354	$ -	$ -	$ -	$ -	$ -
Lewis-Gale Hospital	YES	24.27%	$ -	$ 1,068,388	$ -	$ -	$ -	$ -	$ -
Lonesome Pine Hospital	YES	24.02%	$ -	$ 102,326	$ -	$ -	$ -	$ -	$ -
Mary Immaculate Hospital	YES	28.77%	$ -	$ 311,714	$ -	$ -	$ -	$ -	$ -
Mary Washington Hospital	YES	23.77%	$ -	$ 608,676	$ -	$ -	$ -	$ -	$ -
Marview Hospital	YES	24.44%	$ -	$ 676,962	$ -	$ -	$ -	$ -	$ -
Memorial Regional Medical Center	YES	17.04%	$ -	$ 100,300	$ -	$ -	$ -	$ -	$ -
New River Valley Medical Ctr [Carilion]	YES	22.26%	$ -	$ 362,638	$ -	$ -	$ -	$ -	$ -
Prince William	YES	20.46%	$ 30,469,238	$ -	$ -	$ -	$ -	$ -	$ 4,384,296
Richmond Community Hospital	YES	52.25%	$ -	$ 732,346	$ -	$ -	$ -	$ -	$ -
Riverside Regional Medical Center	YES	26.83%	$ -	$ 1,967,758	$ -	$ -	$ -	$ -	$ -
Sentara Leigh Hospital	YES	23.75%	$ -	$ 501,196	$ -	$ -	$ -	$ -	$ -
Sentara Norfolk General Hospital	YES	27.01%	$ -	$ 3,319,872	$ -	$ -	$ -	$ -	$ -
Sentara Northern Virginia Medical Center	YES	23.56%	$ -	$ 318,098	$ -	$ -	$ -	$ -	$ -
Sentara Obici Memorial Hospital	YES	23.65%	$ -	$ 424,004	$ -	$ -	$ -	$ -	$ -
Sentara Princess Anne Hospital	YES	15.48%	$ -	$ 111,844	$ -	$ -	$ -	$ -	$ -
Shore Memorial Hospital	YES	23.81%	$ -	$ 102,520	$ -	$ -	$ -	$ -	$ -
Southside Community Hospital	YES	18.47%	$ -	$ 92,860	$ -	$ -	$ -	$ -	$ -
Southside Regional Medical Center	YES	29.49%	$ -	$ 818,068	$ -	$ -	$ -	$ -	$ -
Spotsylvania Regional Hospital	YES	33.21%	$ -	$ 847,596	$ -	$ -	$ -	$ -	$ -
St Francis Medical Center	YES	19.81%	$ 160,911	$ 242,750	$ 3,826,555	$ 3,411,841	$ 9,724	$ 4,779,265	$ 4,892,238
St Mary's Hospital of Richmond	YES	20.91%	$ -	$ 661,904	$ -	$ -	$ -	$ -	$ -
Twin Co. Regional Hospital	YES	31.54%	$ -	$ 222,098	$ -	$ -	$ -	$ -	$ -
UVA	YES	33.22%	$ 38,996,306	$ -	$ 22,821,066	$ 22,821,066	$ 22,821,066	$ 22,821,066	$ 88,027,052
VCU	YES	32.61%	$ 69,390,991	$ -	$ 21,711,023	$ 21,711,023	$ 21,711,023	$ 21,711,023	$ 111,417,685
Virginia Hospital Center Arlington	YES	14.87%	$ 5,443,601	$ -	$ 1,661,176	$ 7,273,420	$ 313,755	$ 2,074,764	$ 2,123,807
Winchester Medical Center	YES	21.38%	$ -	$ 1,094,026	$ -	$ -	$ -	$ -	$ -
Wythe County Community Hospital	YES	21.65%	$ -	$ 57,772	$ -	$ -	$ -	$ -	$ -
Total In State Hospitals				**$ 30,225,510**	**$ 67,347,470**	**$ 71,191,925**	**$ 53,352,234**	**$ 73,027,888**	**$ 232,998,420**
Children's Hospital NMC	YES	57.99%	$ 21,558,244	$ -	$ -	$ -	$ -	$ -	$ -
Duke University Medical Center	YES	27.03%	$ 16,489,521	$ 41,118	$ 682,048	$ 375,381	$ 950,412	$ 340,744	$ 871,996
Georgetown University Hospital	YES	24.24%	$ -	$ 7,238	$ -	$ -	$ -	$ -	$ -
Indian Path Medical Center	YES	37.19%	$ 7,025,500	$ 38,544	$ 483,632	$ 207,924	$ 404,931	$ 120,809	$ 618,322
Johnson City Medical Center Hospital	YES	32.43%	$ 46,814,683	$ 524,666	$ 3,399,732	$ 1,597,281	$ 2,698,273	$ 1,698,469	$ 4,346,545
North Carolina Baptist Hospital	YES	31.59%	$ 313,936,993	$ -	$ 291,784	$ 139,801	$ 18,094,490	$ 145,772	$ 373,045
Washington Hospital Center	YES	32.25%	$ -	$ 18,318	$ -	$ -	$ -	$ -	$ -
Bristol Regional Medical Center	YES	22.71%	$ 15,192,287	$ -	$ 4,170,858	$ 2,863,228	$ 875,643	$ 1,041,858	$ 5,332,427
Total Out of State Hospitals				**$ 629,884**	**$ 9,028,054**	**$ 5,183,615**	**$ 23,023,749**	**$ 3,347,652**	**$ 11,542,335**
TOTAL DSH PAID				**$ 30,855,394**	**$ 76,375,524**	**$ 76,375,540**	**$ 76,375,983**	**$ 76,375,540**	**$ 244,540,755**

Data Sources:

OB = Base year Medicaid cost report (Hospital cost report year ending during SFY 2023) - hospital's self-reported answer to obstetrics (OB) question.

MIUR (Medicaid inpatient utilization rate) = Base year Medicare cost report as reported in HCRIS

UCC = Unreimbursed Costs per Medicaid cost report Exh H-1 (from base year cost report); less private acute care supplemental payments. If UCC is zero or lower, DSH limit is zero. (Implies that Medicaid and Uninsured costs are already covered by existing Medicaid payments.)

Modeling Scenarios

1) Reduced MIUR Threshold 1%: This scenario reduces the Minimum Inpatient Utilization Rate (MIUR) from 14% to 1%. DSH payments are calculated based on the number of days exceeding this 1% threshold. (DMAS) retains the flexibility to utilize any MIUR percentage above 1%, allowing for adjustments to payment distribution.

2) Percentage-Based Payments on Total UCC: This scenario leaves the 14% MIUR threshold in place. DSH payments are determined as a percentage of the hospital's total Uncompensated Care Costs (UCC). This scenario could incorporate a 1% MIUR threshold in future years, potentially impacting payments for hospitals with MIUR below 14%.

3) Reduce OOS Hospital Payments: This scenario reduces DSH payments to OOS hospitals by 80%. DMAS can employ various methods to achieve this reduction, such as setting a specific payment threshold for OOS.

4) Elimination of Type 1 and Type 2 Hospitals: This scenario eliminates the DSH methodologies for Type 1 and Type 2 hospitals. Virginia's full DSH allotment is then distributed among the remaining eligible hospitals. The 14% MIUR threshold remains in effect for determining eligibility within this scenario.

CHKD and Children's Hospital NMC were excluded from modeling scenarios due to their requests to forego DSH citing concerns about UCC limit.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for almost two million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.