Including Dual Eligible Medicare Payments in the Hospital-Specific DSH Limit is Contrary to the Medicaid Statute and is Bad Policy

The hospital-specific limit on Medicaid disproportionate share hospital (DSH) payments required by Section 1923(g)(1)(A) of the Social Security Act (the Act) limits DSH payments to the uncompensated costs incurred by hospitals in providing hospital services to Medicaid and uninsured patients. In the context of guidance concerning the DSH audit and reporting final rule, which was published on December 19, 2008, the Centers for Medicare and Medicaid Services (CMS) has indicated that costs and payments, ***including Medicare payments***, associated with Medicare/Medicaid dual eligible patients must be included in calculating the hospital-specific DSH limits. The decision to include Medicare payments in the hospital-specific DSH limit calculation is contrary to the plain language of the statute, contrary to the intent of the statute in determining losses attributable to Medicaid and uninsured patients, and is punitive to many hospitals that serve a disproportionate share of low-income elderly patients.

CMS should revise its policy to avoid legal vulnerabilities, policy distortions, and the negative impact on hospitals that serve low-income populations caused by the new policy.

To the extent CMS needs more time to study this issue, CMS should announce this intention to states and explicitly allow states to choose whether or not to include dual eligibles in the hospital-specific DSH limit calculation for state fiscal year 2011.

Background

The hospital-specific DSH limit was inserted into the statute in 1993, and is defined as the cost of "furnishing hospital services (as determined by the Secretary and net of [Medicaid] payments..., other than [DSH payments], and by uninsured patients) by the hospital to individuals who either are eligible for [Medicaid] or have no health insurance ...." CMS historically, per a 1994 letter to state Medicaid directors, allowed states substantial discretion in defining the limit. Prior to the recent CMS guidance, many states, including Texas, did not include the costs or payments associated with Medicare/Medicaid dual eligibles in the hospital-specific DSH limit calculation.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added new DSH audit and reporting requirements to the Act through the addition of Section 1923(j). Through implementing regulations, CMS sought to standardize the reporting of hospital-specific DSH limit components. Although neither the underlying statutory language in Section 1923(g)(1)(A), Section 1923(j), nor the text of the final regulation make any mention of including dual eligible patients, CMS stated in the preamble of the final rule and in a later FAQ that costs and revenues associated with dual eligible patients, including Medicare revenues, should be included. THHSC changed its rules to include dual eligible costs and payments specifically to conform to CMS guidance.

Substantial general concern has been raised regarding the DSH audit and reporting rule. Letters expressing concern about policy changes in the rule were sent by the National Association of State Medicaid Directors, and by the entire hospital industry. In response, CMS allowed states an extra year (i.e. until December 2010) to submit the initial reports, although states are required to come into compliance with the standard requirement in state fiscal year 2011. The hospital industry last

year requested that CMS review the impact of the first audit reports completed in 2010 before requiring compliance.

The Dual Eligibles Policy is Contrary to the Medicaid Statute

The hospital-specific DSH limit statutory provision clearly provides the Secretary with discretion in calculating costs included in the limit by explicitly stating that the "costs incurred during the year of furnishing hospital services" are "as determined by the Secretary."[1] On the other hand, the statute is specific and grants no discretion regarding the payments that should be netted against costs included in the limit calculation, including only "payments under this subchapter [Medicaid], other than under this section [Medicaid DSH], and by uninsured patients." Thus, although CMS could easily exercise its discretion in requiring that states not include the costs of dually eligible Medicaid patients, it violates the Medicaid statute to require offsetting a payment, such as Medicare payments, not listed in the statute.

The Dual Eligibles Policy is Bad Policy

The hospital-specific DSH limit calculation is intended to determine unreimbursed costs for the Medicaid and uninsured patients. The DSH limit does not take into account whether hospitals have losses or profits on any other category of patients, including Medicare. CMS' guidance on dual eligibles is anomalous and distortionary in that it explicitly includes costs and payments associated with patients which are generally not considered to be Medicaid or uninsured patients. Although many dual eligible patients may be technically dually *eligible* for both Medicare and Medicaid, Medicaid has little or no involvement; Medicare is the primary, and in many cases the sole, payer for dual eligible patients. The Texas Border Hospitals estimate that Medicaid makes no payment whatsoever with respect to 75 percent of their dual eligible patients. Just as the hospital-specific DSH limit calculation does not include costs for commercial patients, it should not include Medicare costs and payments in a calculation intended to assess unreimbursed costs for serving Medicaid and uninsured patients.

Including Medicare payments and costs has a distortionary impact. As a pertinent example, Texas Border Hospitals have high Medicare payments in part because of the high proportion of low income Medicaid patients they see, which increases their Medicare DSH reimbursement. Partially including Medicare payments in the hospital-specific DSH limit calculation penalizes these hospitals for their high Medicaid population and in effect creates a perverse incentive to discourage these hospitals from seeing additional low income Medicare patients (since, if Medicaid-eligible, these Medicare payments would count against their hospital-specific DSH limit) as opposed to high income Medicare patients.

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[1] This contrasts with similar language in the Medicare DSH context regarding the inclusion of Medicaid days, which contains no similar grant of discretion and which actually goes on to preclude dual eligible days. Despite the explicit discretion granted in the hospital-specific DSH limit statute, we understand HHS legal counsel may have argued that Medicare DSH precedents require inclusion of dual eligible costs and payments.

June 21, 2010

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services (HHS)
200 Independence Avenue, SW
Washington, DC 20201

Secretary Sebelius:

On behalf of the members of the American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), the Catholic Health Association (CHA), the Federation of American Hospitals (FAH), the National Association of Children's Hospitals (N.A.C.H.) and the National Association of Public Hospitals and Health Systems (NAPH), we write to request a delay in the implementation of the enforcement provisions related to the Medicaid Disproportionate Share Hospital (DSH) program audit and reporting regulation issued in December 2008.

The DSH Audit and Reporting Final Rule was issued in the waning days of the prior Administration and implements reporting requirements from the *Medicare Modernization Act (MMA) of 2003*. The hospital community supports reporting and auditing requirements that help ensure that DSH payments are paid in accordance with federal rules. Such transparency will provide assurances to Congress, the Centers on Medicare & Medicaid Services (CMS), states and the public that DSH funds are being used to fulfill their intended statutory purpose to assist hospitals that serve a disproportionate share of low-income individuals. This objective becomes even more important as you implement the Medicaid DSH provisions in the *Patient Protection and Affordable Care Act (PPACA)*.

The Medicaid DSH reporting rule was developed long before the economic recession and before the passage of the new health care reform law. States and providers raised substantial concerns with policy changes included in the initial proposed rule in 2005, but such changes were incorporated into the final rule. For example, the rule excludes uncompensated costs related to services furnished to patients with insurance, but without insurance for the specific service provided. It also excludes the uncompensated costs of physician services and pharmaceuticals provided and paid for by hospitals. The rule seems to run counter to the health care reform movement toward integrating care delivery by not allowing uncompensated physician costs in the DSH calculation. Hospitals often employ or subsidize physician costs to ensure that Medicaid beneficiaries will have access to needed health care services. On top of these concerns, the final rule's enforcement provisions impose potential liabilities

on states as they face severe budget constraints and before CMS can examine the true impact of the policy changes contained in the rule.

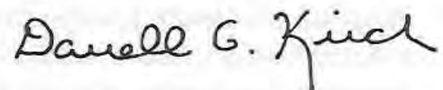
DSH payments are critical to the mission of safety net hospitals which provide essential access to care for the poor and uninsured. Policy changes in this program, particularly changes with significant economic impacts, directly affect their ability to provide this access. Specifically, we request that CMS extend the enforcement transition period so that states are not subject to disallowance risk based on the results of the audits ordered by the regulation and so that CMS can review state audits and consider the impact of the regulation's policy changes. CMS should further request that states specify in their audit reports excluded costs that would previously have been included in the DSH calculations.

As you and your staff work to expand coverage secured by PPACA, the safety net health system is working to continue to ensure access for Medicaid, uninsured, and under-insured patients. The DSH Audit and Reporting Rule needlessly reduces the ability of safety net hospitals to receive DSH payments, impeding the ability of safety net hospitals to ensure access and conflicting with the overall policy goals of the Administration.

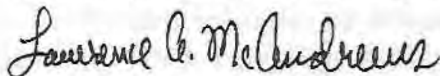
We urge you to hold states and safety net health systems harmless from disallowances based on this rule until state audits can be reviewed and the policy changes assessed. Thank you for your attention to this important issue.

Sincerely,

Larry S. Gage
National Association of Public Hospitals & Health Systems



Darrell G. Kirch, M.D.
Association of American Medical Colleges



Lawrence A. McAndrews
National Association of Children's Hospitals

Richard Umbdenstock
American Hospital Association

Sr. Carol Keehan, DC
Catholic Health Association

Charles N. Kahn III
Federation of American Hospitals

cc: Cindy Mann
Dianne Heffron

Congress of the United States
House of Representatives
Washington, DC 20515

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Berwick:

We are writing you out of concern regarding the impact that guidance issued by the Centers for Medicare and Medicaid Services ("CMS") is having on a number of hospitals in Texas and is resulting in extensive reductions in Medicaid reimbursement to hospitals that serve substantial numbers of Medicaid patients, particularly Medicaid patients dually eligible for Medicare. CMS's guidance on the inclusion of Medicare payments in calculating the hospital-specific limit for purposes of disproportionate share hospital ("DSH") payments will adversely impact safety net hospitals.

According to the Medicaid statute, states may use Medicaid DSH payments to reimburse hospitals for no more than

> the costs incurred … furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided ….[1]

This limit is often called the "hospital-specific DSH limit." The "title" referenced is the Medicaid statute, title XIX of the Social Security Act, and the "section" referenced pertains solely to Medicaid DSH payments. In the Medicare Modernization Act of 2003 ("MMA"), Congress added new auditing and reporting requirements, but did not change the underlying hospital-specific DSH limit. CMS promulgated a final regulation regarding these auditing and reporting requirements on December 19, 2008.

[1] 42 U.S.C. § 1396r-4(g)(1)(A), inserted by Pub. L. No. 103-66, § 13621(b) (1993).

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Although the regulatory language makes no mention of including payments under the Medicare program (title XVIII of the Social Security Act) as an offset to costs incurred for Medicaid-eligible individuals, language in the preamble states CMS's "belief" that the costs attributable to dual eligibles should be included in the calculation and that "it is necessary to take into account both the *Medicare and* Medicaid payment made, since those payments are *contemplated under* Title XIX."[2] In later guidance on this issue, CMS characterized the issue slightly differently, stating that

> There is no exclusion in section 1923(g)(1) for costs for, and payment made, on behalf of individuals dually eligible for Medicare and Medicaid. Hospitals that include dually-eligible days to determine DSH qualification must also include the costs attributable to dual eligibles when calculating the uncompensated costs of serving Medicaid eligible individuals. Hospitals must also take into account payment made on behalf of the individual, including all *Medicare and* Medicaid payments made on behalf of dual eligibles.[3]

The guidance in both the preamble and the later document do not reflect the best interpretation of the statute. The statute specifically states that only payments under title XIX and by uninsured patients should be deducted from the costs incurred by hospitals and says nothing about payments either "contemplated under" title XIX or "on behalf of" Medicaid patients.

The Texas Medicaid program, in its efforts to comply with the CMS regulations, has acted on CMS's guidance. As a result, Texas' recent estimates of the hospital-specific DSH limit have substantially reduced uncompensated care cost estimates for hospitals, including those in our districts, which serve substantial numbers of patients dually eligible for Medicare and Medicaid. This in turn will dramatically reduce Medicaid reimbursement to these hospitals by multiple millions of dollars and threaten patient care at those institutions.

To resolve this concern, we recommend the following solution:

Include Costs for Dual Eligibles Only Where Medicaid Made A Payment

> *Including payments and costs for dual eligible visits where a Medicaid payment was received should address CMS's concern that excluding all dual eligibles would omit Medicaid payments that should be included in the hospital-specific limit calculation. At the same time, excluding payments and costs for dual eligible visits where a Medicaid payment was **not** received appropriately excludes those patients where Medicaid only has a tangential relationship to the patient.* [4]

[2] 73 Fed. Reg. 77904, 77912 (Dec. 19, 2008) (emphasis added).

[3] Additional Information on the DSH Reporting and Audit Requirements, page 18 (response to Question 34) (emphasis added), available at:
http://www.cms.gov/medicaidrf/Downloads/AdditionalInformationontheDSHReportingandAuditRequirements.pdf.

[4] We are open to other solutions for dealing with the dual eligible issue as well. For example, during our meeting we also discussed both excluding all costs and payments related to dual eligibles and the possibility of including all costs and payments

It is significant that CMS's current policy requiring inclusion of all costs and payments related to the dual eligibles (including Medicare payments) was not included in the statute underlying the hospital-specific DSH limit[5], the statute underlying the DSH audit and reporting requirements[6], or the regulatory language implementing the DSH reporting requirements[7]. CMS's current policy has only been issued through preamble language[8] and a subsequent question and answer document[9]. As long as its interpretation is consistent with the statute and the regulations, CMS is free to issue new guidance. Given that this section of the Medicaid statute specifically allows the inclusion of costs "as determined by the Secretary," CMS has sufficient legal discretion (without the necessity even for a new regulation) to adopt the above interpretation to exclude payments and costs for dual eligible visits where a Medicaid payment was not received.

Based in part on the language noted above, we believe CMS has the legal authority to distinguish between "eligible for medical assistance under a state plan," which is used in the Medicaid fraction of the Medicare DSH statute[10], and "eligible for medical assistance under the State plan," which is used in the hospital-specific DSH limit calculation[11]. In addition to the fact that 42 U.S.C. § 1396r-4(g)(1)(A) specifically allows the costs to be "as determined by the Secretary," these statutes have different purposes and, in the context of the hospital-specific DSH limit calculation, different interpretations should be acceptable.

It is worth noting that the Medicaid DSH statute only allows for reductions related to payments under Medicaid and by uninsured patients. Since the statute doesn't allow for reductions based on Medicare payments, it is logical to exclude dual eligible costs from the hospital-specific DSH limit calculation. Even if CMS were required to use the same interpretation in both the Medicare and Medicaid DSH context, the fact that the Medicare DSH statute specifically excludes patients eligible for Medicare Part A ("but who were not entitled to benefits under part A of this subchapter") is significant. CMS could interpret the phrase in the hospital-specific DSH limit calculation to be consistent with the entire phrase used in the Medicare DSH statute, instead of just the first half, and exclude dual eligibles.

Given the harmful implications of the CMS guidance, the undersigned respectfully suggest that CMS reconsider its interpretation by issuing new guidance or by informing Texas and/or the states that Medicare payments should not be included in the hospital-specific DSH limit.

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for dual eligibles, but then reducing those costs and payments by the percentage of payments received from a payer other than Medicaid.

[5] 42 U.S.C. § 1396r-4(g)(1)(A)

[6] 42 U.S.C. § 1396r-4(j)

[7] 42 C.F.R. § 447.299

[8] 73 Fed. Reg. 77904, 77912 (Dec. 19, 2008)

[9] http://www.cms.gov/medicaidrf/Downloads/AdditionalInformationontheDSHReportingandAuditRequirements.pdf

[10] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)

[11] 42 U.S.C. § 1396r-4(g)(1)(A)

Thank you,

Rubén Hinojosa
Member of Congress

Congress of the United States
Washington, DC 20510

June 1, 2010

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

We write to request that you continue through Medicaid state plan rate year 2012 the previously issued guidance that CMS will not implement disallowances resulting from Medicaid State Plan Disproportionate Share Hospital (DSH) audits. This additional time will allow CMS to review the initial DSH audits due this year in order to provide constructive feedback before states are subjected to disallowance risk.

As you know, the DSH Audit and Reporting Rule ("the Rule") was issued to implement new transparency requirements for Medicaid DSH payments mandated by the Medicare Modernization Act of 2003 (MMA). We are concerned that the Rule implements dramatic policy changes that go far beyond the mandate for increased transparency included in the MMA. Specifically, the substantive change in policy with respect to the definition of "DSH-eligible costs," including the definition of what it means to not have insurance, will greatly affect many hospitals in our home states.

In addition to our concerns, providers in various states and a number of state Medicaid agencies have expressed their concerns to you about the enormous consequences of this policy change on safety net hospitals. Further, the American Hospital Association, the National Association of Public Hospitals and Health Systems, and the National Association of State Medicaid Directors have also formally expressed their concerns to your department.

To give states time to adjust their Medicaid DSH methodology, the Centers for Medicare and Medicaid Services (CMS) provided a transition period by not implementing disallowances resulting from audits for years 2005-2010. Instead, states are expected to modify their DSH policies for the 2011 plan year based on the results of the 2005-2010 audits. Under the Rule, initial audits were due in 2009, allowing ample time for CMS to review state DSH policies and request changes based on the DSH methodology mandated by the Rule. CMS delayed this deadline to submit initial audits until the current plan year which starts in June 2010 for many states.

Although our DSH recipients are very grateful for the transition time, the new deadline does not allow CMS time to provide constructive criticism of initial audits so

that states may adjust their programs without fear of punishment. As a result, states have become fearful of potential disallowances for the upcoming state plan year, and are imposing restrictive requirements on DSH payments based on the definitions contained in the Rule. This will have a devastating effect on vulnerable individuals' access to care at critical safety net providers and in some cases, at facilities operated by state agencies.

Given these concerns, we respectfully request that CMS extend the transition period where states are not subject to disallowance risk through Medicaid state plan rate year 2012. This additional time will allow CMS to review the initial audits due this year, before states are subjected to disallowance risk based on policy changes made in the Rule.

Thank you for your consideration of this request. As the deadline rapidly approaches, we look forward to your prompt response.

Sincerely,

Bill Pascrell Jr. [illegible]

Dennis Rehberg Jo Ann Emerson

[illegible] Jerrold Nadler

Gregory W Meeks Carolyn McCarthy

Chris Smith Bill Owens

Gary L. Ackerman [illegible]

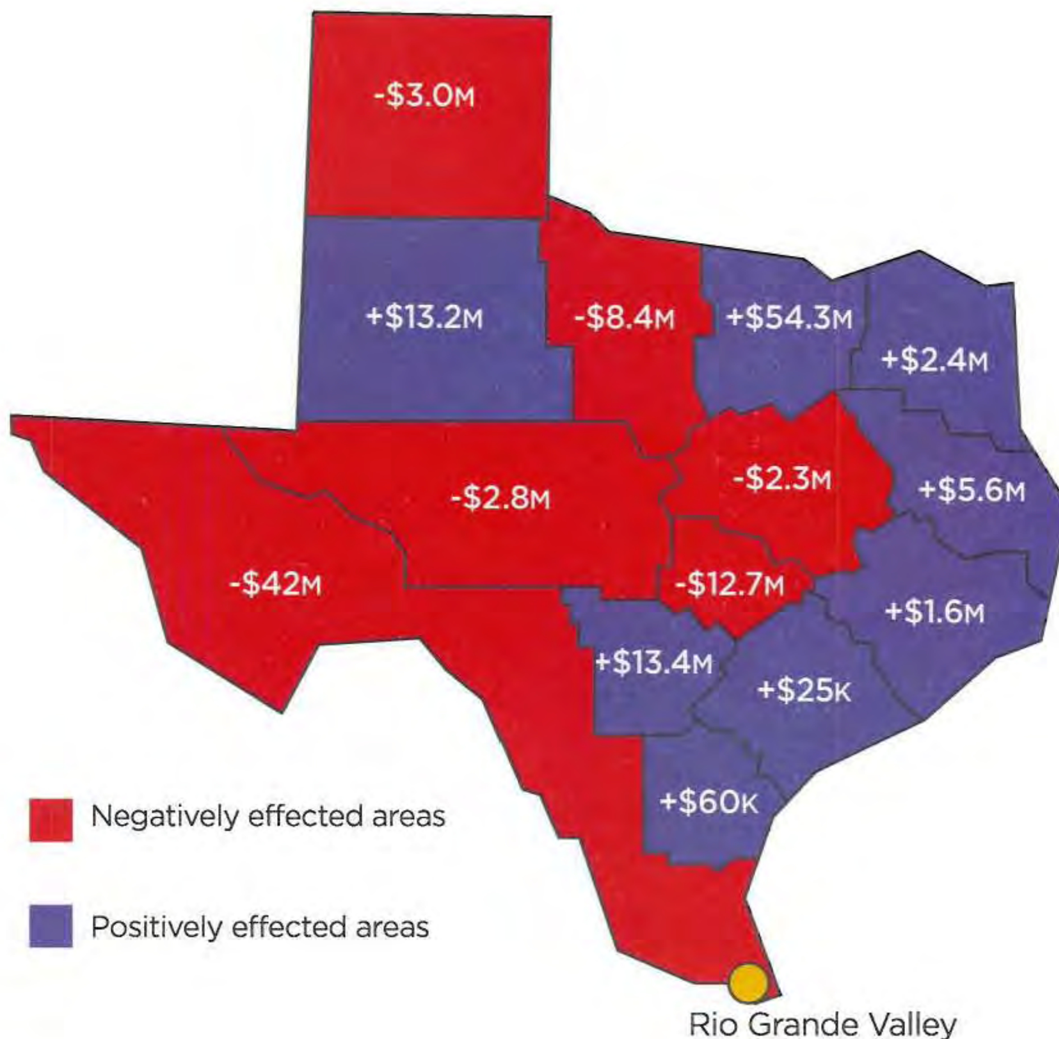
Collin C. Peterson Eliot L. Engel

Joseph Crowley Frank A. LoBiondo

[illegible] [illegible]

Fiscal Impact of Changes to the State Medicaid Disproportionate Share Hospital (DSH) Program Reimbursement Methodology

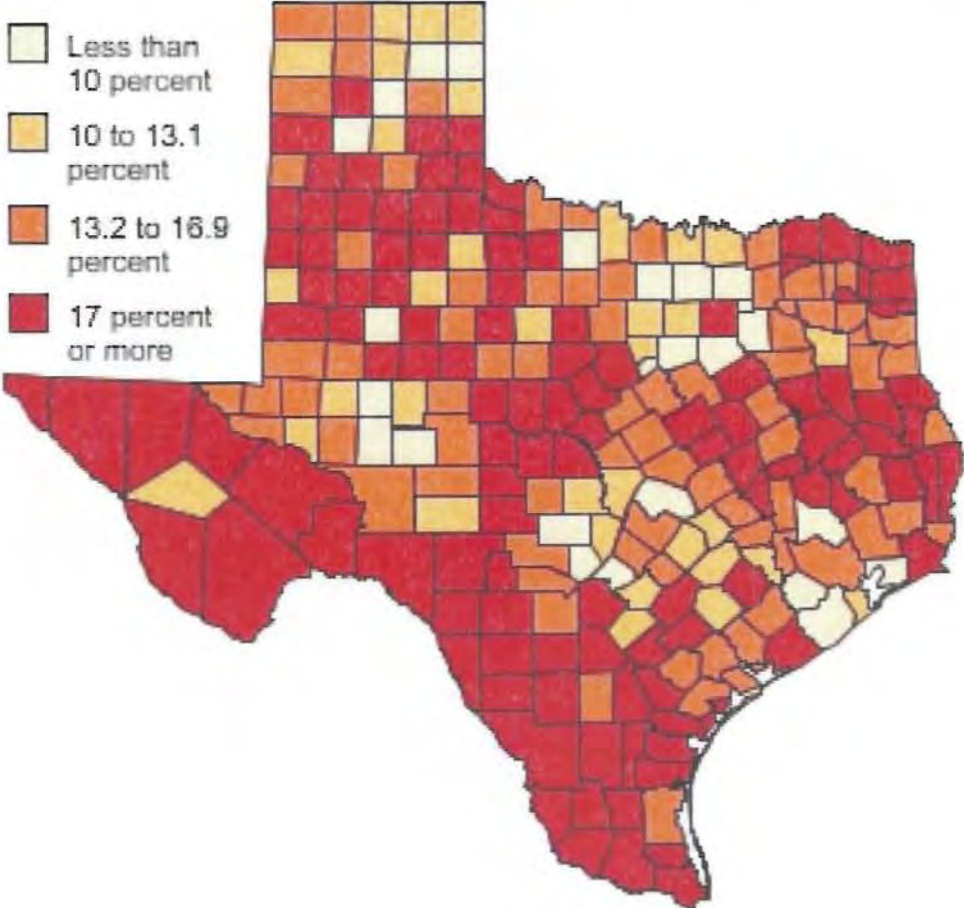
*(Inclusion of all Medicare Funds for Dual Eligibles in Medicaid DSH Calculations, 1 TAC §355.8065)**



* 1 TAC §355.8065 includes all Medicare funding for dual eligibles for all DSH Hospitals, including those that do not need Medicare/Medicaid Dual Eligible inpatient stays to qualify for the Medicaid DSH Program.

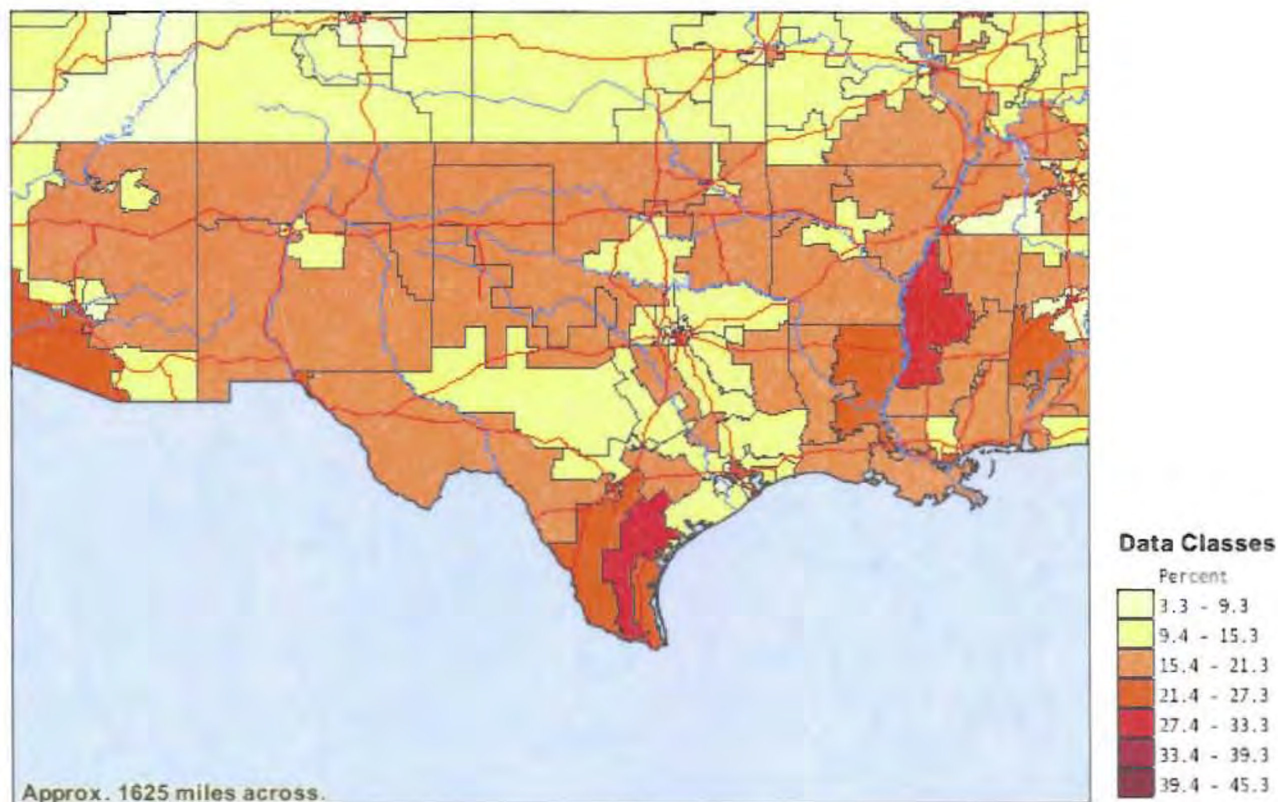
Texas Poverty Rates by County

Percent of total population in poverty, 2008



Source: Bureau of the Census, Small Area Income and Poverty Estimates.

2008 Poverty Rates by Congressional District



M1701. Percent of People Below Poverty Level in the Past 12 Months (For Whom Poverty Status is Determined): 2008
Universe: **Population for whom poverty status is determined**
Data Set: **2006-2008 American Community Survey 3-Year Estimates**
Survey: **American Community Survey, Puerto Rico Community Survey**
United States by 110th Congressional District

United States: Estimate: 13.2 Percent, Margin of Error: +/-0.1 Percent
Source: U.S. Census Bureau, 2006-2008 American Community Survey

Regional Analysis of Texas State Medicaid Disproportionate Share

Impact of HHSC Application of Dual Eligibles 1 TAC § 355.8065

Ranking of All Eligible Hospitals

Total Funding Comparison By Region & Institution for State Fiscal Years 2010 & 2011

Region	County	Fiscal Year 2011	Annual DSH 2011 Pmt	Annual DSH 2010 Pmt	Change
1	**CHILDRESS**	CHILDRESS REGIONAL MEDICAL	656,186	707,209	-51,023
	DALLAM	COON MEMORIAL HOSPITAL	339,432	205,209	134,223
	DEAF SMITH	HEREFORD REGIONAL MEDICAL CENTER	971,149	981,304	-10,155
	GRAY	PAMPA REGIONAL MEDICAL CENTER	607,508	0	607,508
	HUTCHINSON	GOLDEN PLAINS COMMUNITY HOSPITAL	562,604	414,252	148,352
	MOORE	MOORE COUNTY HOSPITAL DISTRICT	637,358	731,198	-93,840
	OCHILTREE	OCHILTREE HOSPITAL DISTRICT	0	473,835	-473,835
	PARMER	PARMER COUNTY COMMUNITY HOSPITAL	97,373	71,091	26,282
	POTTER	BAPTIST ST ANTHONY'S	0	3,307,006	-3,307,006
		NORTHWEST TEXAS HEATHCARE SYSTEM	10,553,334	10,475,863	77,471
	WHEELER	PARKVIEW HOSPITAL	0	156,216	-156,216
1 Total			14,424,944	17,523,183	-3,098,239
2	**ANDREWS**	PERMIAN REGIONAL MEDICAL CENTER	0	962,399	-962,399
	BAILEY	MULESHOE AREA HOSPITAL	230,364	332,378	-102,014
	DAWSON	MEDICAL ARTS HOSPITAL	438,886	555,503	-116,617
	FLOYD	W. J. MANGOLD MEMORIAL HOSP	337,684	313,833	23,851
	GAINES	MEMORIAL HOSPITAL-SEMINOLE	135,767	576,182	-440,415
	HALE	METHODIST HOSPITAL-PLAINVIEW	1,075,078	1,409,045	-333,967
	HOCKLEY	METHODIST HOSPITAL LEVELLAND INC-COVENANT HOSPITAL LEVELLAND	0	476,395	-476,395
	HOWARD	BIG SPRING STATE HOSP	35,010,217	21,663,333	13,346,884
		SCENIC MOUNTAIN MEDICAL CENTER	1,110,223	1,351,194	-240,971
	JONES	HAMLIN MEMORIAL HOSPITAL	117,538	99,511	18,027
	KNOX	UNIVERSITY MEDICAL CENTER-LUBBOCK	23,479,779	22,307,982	1,171,797
	LAMB	LAMB HEALTHCARE CENTER	571,634	503,455	68,179

2	LUBBOCK	COVENANT CHILDREN'S HOSPITAL	3,495,901	1,516,075	1,979,826
		COVENANT HEALTH SYSTEM	7,102,654	7,818,678	-716,024
	MARTIN	MARTIN COUNTY HOSPITAL DIST	178,564	320,775	-142,211
	NOLAN	ROLLING PLAINS MEMORIAL HOSPITAL	838,880	985,302	-146,422
	SCURRY	D M COGDELL MEMORIAL HOSPITAL	1,200,467	1,454,714	-254,247
	TAYLOR	HENDRICK MEDICAL CENTER	5,080,590	4,428,734	651,856
	TERRY	BROWNFIELD REGIONAL MEDICAL CENTER	808,810	955,030	-146,220
	YOAKUM	YOAKUM COUNTY HOSPITAL	424,733	416,432	8,301
2 Total			81,637,769	68,446,950	13,190,819
3	BAYLOR	SEYMOUR HOSPITAL	246,096	232,144	13,952
	COMANCHE	COMANCHE COMMUNITY HOSPITAL	329,013	435,824	-106,811
	ERATH	HARRIS METHODIST (STEPHENVILLE)	846,256	760,550	85,706
	HARDEMAN	Chillicothe Hospital	0	19,094	-19,094
		HARDEMAN COUNTY MEMORIAL	66,818	0	66,818
	JACK	FAITH COMMUNITY HOSPITAL	272,568	281,154	-8,586
	KNOX	KNOX COUNTY HOSPITAL	92,534	111,797	-19,263
	PALO PINTO	PALO PINTO GENERAL HOSPITAL	1,297,772	1,554,929	-257,157
	WICHITA	N TEXAS STATE-WICHITA FALLS	18,328,640	27,032,626	-8,703,986
		UNITED REGIONAL HEALTHCARE SYSTEM	5,673,252	5,148,027	525,225
	YOUNG	GRAHAM GENERAL HOSPITAL	660,031	641,283	18,748
		HAMILTON HOSPITAL	249,636	310,448	-60,812
3 Total			28,062,616	36,527,876	-8,465,260
4	BOWIE	UNIVERSITY MEDICAL CENTER at BRACKENRIDGE	33,656,089	34,997,753	-1,341,664
	DALLAS	BAYLOR UNIVERSITY MEDICAL CENTER	15,922,248	14,146,802	1,775,446
		CHILDREN'S MEDICAL CENTER-DALLAS	25,011,130	22,887,343	2,123,787
		COOK CHILDREN'S MEDICAL CENTER	9,407,073	10,730,494	-1,323,421
		DALLAS COUNTY HOSPITAL DISTRICT	246,595,756	195,625,491	50,970,265

4	**DALLAS**	HICKORY TRAIL HOSPITAL	0		0
		METHODIST DALLAS MEDICAL CENTER	11,524,156	11,827,813	-303,657
		OUR CHILDREN'S HOUSE AT BAYLOR	1,798,084	1,960,476	-162,392
	DENTON	NORTH TEXAS MEDICAL CENTER	1,878,319	1,483,125	395,194
	ELLIS	ENNIS REGIONAL MEDICAL CENTER	785,607	0	785,607
	GRAYSON	TEXOMA MEDICAL CENTER INC	2,790,672	2,844,321	-53,649
	HOOD	LAKE GRANBURY MEDICAL CENTER	0	792,662	-792,662
	Hunt	Hunt Regional Medical Center	0	2,676,217	-2,676,217
	KAUFMAN	TERRELL STATE HOSPITAL	57,764,060	38,724,076	19,039,984
	TARRANT	JPS HEALTH NETWORK	77,742,710	88,714,565	-10,971,855
		MILLWOOD HOSPITAL	0		0
		TEXAS HEALTH FORT WORTH	11,426,871	14,568,610	-3,141,739
4 Total			496,302,775	441,979,748	54,323,027
5	**BOWIE**	CHRISTUS ST MICHAEL HEALTH SYSTEM	4,307,863	5,018,141	-710,278
		WADLEY REGIONAL MEDICAL CENTER	1,413,273	2,890,547	-1,477,274
	CASS	GOOD SHEPHERD M C - LINDEN	124,073	197,044	-72,971
	FRANKLIN	N TEXAS STATE-VERNON	25,977,435	45,370,492	-19,393,057
	GREGG	GOOD SHEPHERD MEDICAL CENTER	7,687,292	7,062,104	625,188
	HARRISON	Good Shepherd Medical Center - Marshall	1,622,896	1,667,042	-44,146
	HOPKINS	HOPKINS COUNTY MEMORIAL HOSP	2,517,646	2,290,009	227,637
	PANOLA	EAST TEXAS MEDICAL CENTER-CARTHAGE	690,074	594,776	95,298
	RED RIVER	EAST TEXAS MED CTR-CLARKSVILLE	384,180	0	384,180
	RUSK	HENDERSON MEMORIAL HOSPITAL	568,986	1,214,176	-645,190
		RUSK STATE HOSPITAL	56,190,979	39,552,961	16,638,018
	SMITH	EAST TEXAS MEDICAL CENTER-TYLER	13,011,855	6,190,276	6,821,579

5	**SMITH**	MOTHER FRANCES HOSP REG HEALTHCARE CTR	5,777,730	5,273,199	504,531
	TITUS	TITUS COUNTY MEMORIAL HOSPITAL	2,380,595	2,890,777	-510,182
5 Total			122,654,877	120,211,544	2,443,333
6	**ANDERSON**	PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP-PALESTINE REGIONAL MEDICAL CENTER	0	2,767,346	-2,767,346
	ANGELINA	MEMORIAL MEDICAL CENTER-PORT LAVACA	563,116	490,084	73,032
	CHEROKEE	EAST TEXAS MEDICAL CENTER-JACKSONVILLE	1,248,636	1,063,029	185,607
		MOTHER FRANCES HOSP - JACKSONVILLE	359,062	0	359,062
	HENDERSON	EAST TEXAS MEDICAL CENTER-ATHENS	2,250,798	0	2,250,798
	HOUSTON	EAST TEXAS MEDICAL CENTER-CROCKETT	1,723,171	827,630	895,541
	JASPER	CHRISTUS JASPER MEMORIAL HOSPITAL	1,542,475	1,118,733	423,742
	NACOGDOCHES	MEMORIAL HOSPITAL-NACOGDOCHES	4,196,127	4,344,027	-147,900
	POLK	POLK COUNTY MEMORIAL HOSP	1,426,521	1,257,115	169,406
	TYLER	UT HEALTH CENTER-TYLER	4,520,664	320,161	4,200,503
6 Total			17,830,570	12,188,125	5,642,445
7	**BELL**	METROPLEX ADVENTIST HOSPITAL	2,291,037	2,352,275	-61,238
		SCOTT AND WHITE MEMORIAL HOSPITAL	11,416,608	11,556,690	-140,082
	BRAZOS	COLLEGE STATION MEDICAL CENTER	1,857,952	0	1,857,952
		ST JOSEPH REGIONAL HEALTH CENTER	3,858,886	4,063,797	-204,911
	FALLS	FALLS COMMUNITY HOSPITAL	284,912	357,300	-72,388
	HILL	HILL REGIONAL HOSPITAL	721,831	802,387	-80,556
	LIMESTONE	LIMESTONE MEDICAL CENTER	0	571,456	-571,456
		PARKVIEW REGIONAL HOSPITAL	0	593,442	-593,442
	McLennan	DePaul Center	0	1,209,805	-1,209,805
	MCLENNAN	HILLCREST BAPTIST MEDICAL CENTER	5,581,081	5,353,789	227,292
	MILAM	CENTRAL TEXAS HOSPITAL	0	1,555,199	-1,555,199
	NAVARRO	NAVARRO REGIONAL HOSPITAL	1,213,580	1,187,894	25,686

7 Total			27,225,887	29,604,034	-2,378,147
8	AUSTIN	BELLVILLE GENERAL HOSPITAL	0	191,781	-191,781
	BRAZORIA	ANGLETON DANBURY MEDICAL CENTER	1,081,997	1,036,965	45,032
	FORT BEND	OAK BEND MED. CTR.	1,638,230	0	1,638,230
	Galveston	UNIV OF TEX MED BRANCH	22,986,484	23,459,628	-473,144
	HARRIS	BAYSHORE MEDICAL CENTER	8,989,875	10,027,872	-1,037,997
		CLEAR LAKE REGIONAL MEDICAL	3,765,110	0	3,765,110
		CYPRESS FAIRBANKS MEDICAL CENTER	0		0
		DEVEREUX-TEXAS TREATMENT	0	9,340	-9,340
		DOCTORS HOSPITAL-TIDWELL	4,097,054	3,958,486	138,568
		HARRIS COUNTY HOSPITAL DISTRICT	189,136,507	182,304,347	6,832,160
		HEALTHBRIDGE CHILDREN'S HOSPITAL	0	609,242	-609,242
		INTRACARE MEDICAL CENTER	0		0
		INTRACARE NORTH HOSPITAL	0		0
		KINGWOOD PINES HOSPITAL	0	882,571	-882,571
		M. D. ANDERSON CANCER CENTER	14,321,894	9,047,847	5,274,047
		MEMORIAL HERMANN HOSPITAL - TMC	29,441,100	34,534,419	-5,093,319
		MEMORIAL HERMANN HOSPITAL SYSTEM	23,323,318	22,801,732	521,586
		RIVERSIDE GENERAL HOSPITAL	3,403,925	2,239,535	1,164,390
		SAN JACINTO METHODIST HOSPITAL	4,046,081	0	4,046,081
		SJ MEDICAL CENTER LLC	13,876,943	10,118,848	3,758,095
		TEXAS CHILDREN'S HOSPITAL	23,461,267	33,789,639	-10,328,372
		WEST OAKS HOSPITAL INC	0	211,397	-211,397
	Jefferson	Memorial Hermann Baptist Orange Hospital	0	1,234,055	-1,234,055
	JEFFERSON	CHRISTUS HOSPITAL	5,558,739	6,866,467	-1,307,728
	LIBERTY	CLEVELAND REGIONAL MEDICAL	0		0

8	WALKER	HUNTSVILLE MEMORIAL HOSPITAL	748,096	0	748,096
	WASHINGTON	TRINITY COMMUNITY MEDICAL CTR of BRENHAM	1,005,352	966,027	39,325
8 Total			350,881,972	344,290,198	6,591,774
9	TRAVIS	AUSTIN STATE HOSP	27,608,059	33,175,766	-5,567,707
		DELL CHILDRENS MEDICAL CENTER	3,714,944	9,499,727	-5,784,783
		ST DAVID'S MEDICAL CENTER	10,423,699	11,350,823	-927,124
	WILLIAMSON	CEDAR CREST HOSPITAL	1,531,586	2,032,851	-501,264
9 Total			43,278,288	56,059,166	-12,780,878
10	COLORADO	COLUMBUS COMMUNITY HOSPITAL	424,263	361,055	63,208
		RICE MEDICAL CENTER	136,347	188,145	-51,798
	DEWITT	CUERO COMMUNITY HOSPITAL	992,877	978,812	14,065
	FAYETTE	ST MARK'S MEDICAL CENTER	324,537	522,339	-197,802
	GONZALES	MEMORIAL HOSPITAL-GONZALES	770,617	775,683	-5,066
	LAVACA	YOAKUM COMMUNITY HOSPITAL	157,187	339,280	-182,093
	MATAGORDA	MATAGORDA REGIONAL MEDICAL CENTER	2,005,958	1,280,830	725,128
	REFUGIO	MEMORIAL HOSPITAL DISTRICT-REFUGIO	106,416	43,094	63,322
	VICTORIA	DETAR HOSPITAL	2,851,790	3,237,632	-385,842
	WHARTON	SIGNATURE GULF COAST HOSPITAL	1,218,071	1,235,534	-17,463
10 Total			8,988,063	8,962,404	25,659
11	BEE	CHRISTUS SPOHN HOSPITAL - BEEVILLE	1,237,282	1,148,574	88,708
	JIM WELLS	CHRISTUS SPOHN HOSPITAL - ALICE	3,754,275	3,008,763	745,512
	KLEBERG	CHRISTUS SPOHN HOSPITAL - KLEBERG	2,376,115	2,378,554	-2,439
	NUECES	CORPUS CHRISTI MEDICAL CENTER	7,801,918	6,926,276	875,642
		DRISCOLL CHILDREN'S HOSPITAL	9,026,522	10,688,699	-1,662,177
		PADRE BEHAVIORAL HOSPITAL	15,033	0	15,033
11 Total			24,211,145	24,150,866	60,279

12	ATASCOSA	SOUTH TEXAS REGIONAL MEDICAL	1,490,669	937,447	553,222
	BEXAR	BAPTIST HEALTH SYSTEM	23,275,064	21,595,157	1,679,907
		BEXAR COUNTY HOSPITAL DISTRICT	79,695,615	76,756,097	2,939,518
		CHRISTUS SANTA ROSA HEALTH CARE	18,083,512	19,431,823	-1,348,311
		CLARITY CHILD GUIDANCE CENTER	944,877	0	944,877
		LAUREL RIDGE TREATMENT CENTER	0		0
		METHODIST HOSPITAL	32,193,572	29,647,777	2,545,795
		SAN ANTONIO STATE HOSP	55,032,979	35,283,352	19,749,628
		SOUTHWEST GENERAL HOSPITAL	6,052,773	7,643,065	-1,590,292
		Southwest Mental Health Center	0	1,756,892	-1,756,892
		TEXAS CENTER FOR INFECTIOUS DISEASE	23,936,680	11,953,936	11,982,744
	FRIO	FRIO HOSPITAL	554,162	460,948	93,214
	GUADALUPE	GUADALUPE VALLEY HOSPITAL	2,078,899	0	2,078,899
	KERR	KERRVILLE STATE HOSPITAL	0	24,243,088	-24,243,088
	MEDINA	MEDINA COMMUNITY HOSPITAL	0	361,446	-361,446
	WILSON	CONNALLY MEMORIAL MEDICAL CENTER	387,009	255,797	131,212
12 Total			243,725,812	230,326,825	13,398,987
13	BROWN	BROWNWOOD REGIONAL MEDICAL CTR	2,225,486	2,026,023	199,463
	COLEMAN	COLEMAN CO. MED. CTR.	220,126	251,683	-31,557
	CONCHO	CONCHO COUNTY HOSPITAL	61,117	103,425	-42,308
	ECTOR	MEDICAL CENTER HOSPITAL	12,284,017	16,010,705	-3,726,688
	LLANO	LLANO MEMORIAL HOSPITAL	521,599	464,865	56,734
	MCCULLOCH	HEART OF TEXAS MEMORIAL HOSPITAL	256,851	156,013	100,838
	MIDLAND	MIDLAND MEMORIAL HOSPITAL	3,983,818	3,612,414	371,404
	Schleicher	Schleicher County Medical Center	0	19,611	-19,611
	SUTTON	LILLIAN M HUDSPETH MEMORIAL HOSP	122,699	225,513	-102,814

13	TOM GREEN	SHANNON MEDICAL CENTER	3,730,436	3,358,088	372,348
	WINKLER	WINKLER COUNTY MEMORIAL HOSPITAL	195,470	232,862	-37,392
13 Total			23,601,619	26,461,202	-2,859,583
14	BREWSTER	BIG BEND REGIONAL MEDICAL CENTER	489,643	364,833	124,810
	CAMERON	HARLINGEN MEDICAL CENTER	0		0
		RIO GRANDE STATE HOSP	14,109,726	9,405,940	4,703,786
		VALLEY BAPTIST MC - BROWNSVILLE	7,246,383	7,275,446	-29,063
		VALLEY BAPTIST MEDICAL CENTER	9,319,814	10,936,899	-1,617,085
		VALLEY REGIONAL MEDICAL CENTER	5,308,540	5,588,970	-280,430
	DIMMIT	DIMMIT COUNTY MEMORIAL HOSPITAL	783,017	915,116	-132,099
	EL PASO	Del Sol Medical Center	0	6,938,943	-6,938,943
		EL PASO PSYCHIATRIC CENTER	0	11,959,102	-11,959,102
		LAS PALMAS MEDICAL CENTER	10,650,646	4,896,400	5,754,246
		PROVIDENCE MEMORIAL HOSPITAL	6,423,317	6,086,498	336,819
		UNIVERSITY MEDICAL CENTER of EL PASO	33,672,538	36,157,233	-2,484,695
	HIDALGO	DOCTORS HOSPITAL AT RENAISSANCE	400,647	15,450,147	-15,049,500
		KNAPP MEDICAL CENTER	6,166,900	5,173,574	993,326
		MISSION REGIONAL MEDICAL CENTER	6,679,097	6,760,523	-81,426
		RIO GRANDE REGIONAL HOSPITAL	8,489,753	8,908,680	-418,927
		SOUTH TEXAS HEALTH SYSTEM	18,179,888	24,873,085	-6,693,197
	MAVERICK	FORT DUNCAN REGIONAL MEDICAL CENTER	3,223,014	2,508,671	714,343
	PECOS	PECOS COUNTY MEMORIAL HOSP	1,103,421	968,519	134,902
	REEVES	REEVES COUNTY HOSPITAL	519,528	555,651	-36,123
	STARR	STARR COUNTY MEMORIAL HOSP	1,421,774	1,191,689	230,085
	UVALDE	UVALDE MEMORIAL HOSPITAL	1,697,490	1,303,947	393,543
	VAL VERDE	VAL VERDE REGIONAL MED CENTER	1,903,271	1,540,581	362,690
	WEBB	DOCTORS HOSPITAL - LAREDO	4,371,560	4,996,599	-625,039
		LAREDO MEDICAL CENTER	0	9,638,507	-9,638,507
14 Total			142,159,967	184,395,553	-42,235,586
Grand Total			1,624,986,305	1,601,127,675	23,858,630

Data Source: Texas Health and Human Services Commission.

Note: Calculations were reached using publically available data. Final DSH allocations could vary when utilizing non-disclosed data or finalization of pending appeals.

Modern Healthcare

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Dual eligibles account for nearly 40% of Medicaid medical outlays, Kaiser brief says

By Jessica Zigmond
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Tags: Kaiser Family Foundation, Medicaid, Medicare

With almost 9 million beneficiaries qualifying as "dual eligibles," this population accounted for 39%, or $121 billion, of Medicaid spending for medical services in 2007, according to a new **issue brief from the Kaiser Family Foundation's Commission on Medicaid and the Uninsured**.

The dual-eligible beneficiary population is composed of low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. In 2007, 24% of Medicaid assistance to dual eligibles went to pay for Medicare premiums, cost-sharing, and other services covered by Medicare, the Kaiser findings showed. And while just 15% of dual eligibles were in an institutional long-term-care setting that year, these enrollees accounted for more than half of all Medicaid spending on dual-eligible beneficiaries.

"Dual eligibles often have multiple chronic conditions and are more likely to be hospitalized, use emergency room and require long-term care than other Medicare beneficiaries," the study said. "Younger duals who are disabled and the oldest duals who rely on long-term care are the most expensive."

The report emphasized that the Patient Protection and Affordable Care Act established the Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation, both of which will be involved in efforts to study and improve care for dual-eligible beneficiaries.