

Disproportionate Share Income (DSH)

Background

In accordance with Legislation signed by the Governor on June 19, 1997, (Bill No. 5550-A), a 1997-98 Budget initiative will replace Office of Mental Health (OMH) and Office of Alcohol and Substance Abuse Services (OASAS) net deficit financing with Disproportionate Share funding (DSH) in some Article 28 voluntary hospitals.

Beginning April 1, 1997 and for annual periods beginning April 1st thereafter, additional Disproportionate Share payments shall be paid to voluntary non-profit general hospitals. Payments shall not exceed such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other Medical Assistance received, including Disproportionate Share payments made to such general hospital and payments from and on behalf of such uninsured patients and shall also not exceed the amount of State aid and local aid grants for which the hospital or its successor would have been eligible pursuant to Articles 25 and 41 of the Mental Hygiene Law for fiscal year 1996-97. Payments beginning April 1, 1998 and thereafter will be related to the hospital's willingness to continue to provide services previously funded by State Aid grants.

The Commissioners of OMH and OASAS, in consultation with county directors of community services, will annually designate to the Department of Health those general hospitals eligible for the additional disproportionate share payment, and the amount thereof.

Maintenance of Effort

Hospitals receiving DSH funds are still subject to all contracting, fiscal and programmatic reporting requirements and guidelines, e.g., for model programs the Full Time Equivalent (FTE) requirements must be maintained. For all programs, gross cost and service levels must be maintained at a level consistent with the program's recent history under state aid funding. Therefore, beginning April 1, 1997 and for annual periods thereafter, if effort is not maintained in both gross expenditures and non-DSH revenues, DSH overpayments shall be calculated and recovered.

Memorandum of Understanding

Chapter 119 of the Laws of 1997 requires the Commissioner of OMH, in consultation with the county director of community services, to annually certify those hospitals which will receive these additional DSH payments.

This annual certification is accomplished through use of a memorandum of understanding (MOU). Annually, the MOU and DSH Appendix A, which details annual amounts of DSH by provider, by program, will be mailed to the county director of community services. This MOU is to be executed by signature of the county director of community services, returned to the OMH, and subsequently signed by Commissioner of OMH or agent thereof.

Payments

DSH payments are to be made on a quarterly basis. The payment process begins and the OMH, by generation of a payment request package. This package contains hospital and program specific detail of amounts to be paid. The payment package is then forwarded to the

New York State Department of Health (NYSDOH). NYSDOH then processes the payments and remits checks for, where applicable, transmits funds through electronic transfer, for the quarterly DSH payment.

Approval of DSH Payments by the NYS Department of Health

As there exist Statewide DSH caps for each hospital that receives DSH, in accordance with the NYS fiscal year (April 1 – March 31), the OMH must provide the NYS Department of Health (NYSDOH) with estimated DSH payment, by hospital, for the upcoming fiscal year. NYSDOH compares the total of all estimated DSH payments (from all agencies) to each hospital's DSH cap.

At times, the OMH may be notified that OMH DSH will cause a hospital to reach or exceed its DSH cap. In such an instance, the OMH may temporarily pay an amount equal to the amount in excess of the hospital's DSH cap to the hospital in State Aid, via a voucher payment. Providers will be notified of such payments, and such notification will include details of the amount of the payment that is attributed to each program.

In some instances, a hospital may perpetually be at its DSH cap. In such instances, the OMH may convert such a hospital's DSH funding back to State Aid.

Fiscal Policy Control Points

Budget Control Points

1. Hospitals must continue to include programs designated to receive DSH funds on schedules DMH-2, DMH-3 and Consolidated Budget Report (CBR)-4 of the CBR.
2. For OMH programs' funding streams with a fiscal model (e.g. Intensive Case Management (ICM), Supportive Case Management (SCM), Assertive Community Treatment (ACT) Teams, Community Residence (CR)), providers continue to be subject to all programmatic and fiscal requirements.
3. If a provider is designated as a DSH provider, the DSH revenue is to be reported on DMH-1, line 30 (Other Revenue – see specific detail line) and DMH-2, line 29 (Other Revenue - see specific detail line). The reported DSH revenue must equal the full annual DSH amount by county, provider and program as maintained by OMH.

Desk Audit Control Points

1. For OMH programs' funding streams with a fiscal model (e.g. ICM, SCM, ACT, CR), providers continue to be subject to all programmatic and fiscal requirements.
2. Actual gross expenditures must be at least the same as budgeted gross expenditures and actual non-DSH "other" income must be at least the same as budgeted non-DSH other income. Actual reported DSH must be the same as budgeted DSH.
3. Providers must report any voucher payments made in lieu of DSH on DMH-1, line 30 (other revenue), and on DMH-2, line 29. In each case, the provider shall report such payments as "OMH Voucher Payment". The DSH payments a provider receives shall be reported in these lines as well, using the specific detail line.

4. A DSH profit exists if claimed expenses are less than reported DSH for that program. If a DSH profit exists, the Closeout process will check for State Aid in the same program. If State Aid exists in that program, recovery will be made against the State Aid. If State Aid does not exist in that program, the DSH profit amount will then be moved to an internal funding code and marked for recovery. Recovery will be made either through reduction in an equal amount to future DSH payments, or through the request of remittance from the hospital should no future DSH payments exist.