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# Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments

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**OVERVIEW —** *This background paper describes the history and political evolution of Medicaid's disproportionate share hospital (DSH) program and examines DSH as it exists today. It highlights the importance of DSH payments for the viability of safety net hospitals and considers the consequences of states' creative financing strategies for maximizing federal Medicaid matching funds. Finally, this paper reviews several options for improving the structure and effectiveness of the DSH program.*

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# Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments

Today, nearly 45 million Americans lack health insurance coverage. In 2004, uninsured persons will incur medical care expenditures approaching $125 billion, with an estimated $40 billion of that in the form of uncompensated care.[1] The uninsured gain access to health care services through a "safety net" that includes public hospitals, private nonprofit hospitals, community health centers, and some private physicians, all of whom help shoulder the burden of uncompensated care. While a broad range of providers serve uninsured patients, the largest share of uncompensated care, in dollar terms, is delivered by hospitals.

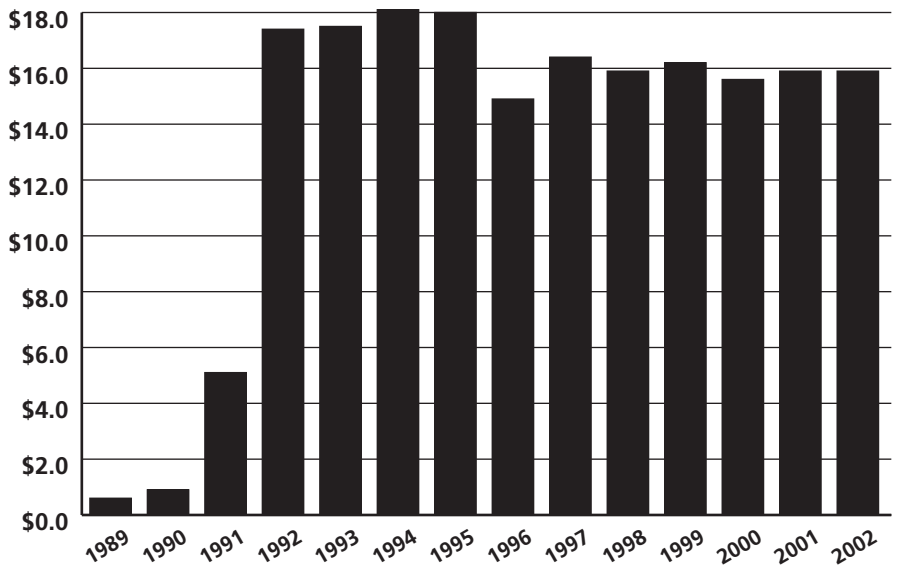
Safety net hospitals serve predominantly low-income communities and have substantial caseloads of Medicaid patients whose costs frequently are not covered by Medicaid reimbursement rates. Often, these hospitals are also the principal source of care for uninsured patients in their communities. They include general inpatient facilities, some of which are teaching hospitals, as well as specialty facilities such as psychiatric hospitals. Although all safety net hospitals provide inpatient care, many also provide outpatient services through hospital-based clinics. Safety net institutions typically have small caseloads of private patients, limiting the extent to which they can "cost shift" by charging higher rates to private insurers. As a result, many safety net hospitals rely on some public financial support to sustain their charitable missions.

Congress established the Medicaid disproportionate share hospital (DSH) program in 1981 to help ensure that states provide adequate financial support to hospitals that serve a significant number of low-income patients with special needs. Recognizing that safety net hospitals typically incur higher uncompensated care costs than other hospitals and rely heavily on Medicaid, which historically has low reimbursement rates, Congress authorized DSH payments to assist states in financing the programs. Congress also established DSH payments for hospitals under Medicare's prospective payment system. Over the past two decades, DSH programs have become a major source of funding for the nation's safety net hospitals. In 2002, the federal government provided $9 billion in matching funds for state Medicaid DSH programs and $6.2 billion in direct DSH payments through Medicare.[2] These payments represent about two-thirds of the $22.3 billion in uncompensated care costs reported by hospitals in 2002.

Although safety net hospitals often receive appropriations from state and local governments to subsidize the costs of serving the uninsured, DSH funding has become a lifeline for many large institutions. Survey data collected by the National Association of Public Hospitals (NAPH) indicate that Medicaid DSH payments fund 25 percent of unreimbursed costs for NAPH members while the Medicare DSH program funds about 6 percent.[3] Medicaid and Medicare DSH dollars are also important funding sources for many rural providers.

However, Medicaid DSH became mired in controversy as states discovered unforeseen opportunities to maximize federal funds and reduce state matching contributions. Medicaid DSH spending skyrocketed from less than $600 million in 1989 to more than $17 billion by 1992 (Figure 1). The Congress and several administrations have taken steps to control the growth of state DSH programs and curtail inappropriate financing schemes, enacting major program changes in 1991, 1993, 1997, and 2000. At the same time, many in Congress view Medicaid DSH as a critical safety net funding source. Congress recently increased state DSH allotments as part of the Medicare Modernization Act of 2003. Experts generally agree that reforms are needed but that they must be undertaken with extreme care to minimize damage to safety net providers that have come to rely on these funds.

**FIGURE 1**
**Federal and State Medicaid DSH Expenditures, 1989–2002** (in billions)




*Source: U.S. Department of Health and Human Services, CMS-64 financial management reports.*

## A BRIEF HISTORY OF MEDICAID DSH

Prior to 1981, Medicaid based its payments to hospitals on reasonable costs for services provided to program beneficiaries. Congress was concerned that this "cost-based reimbursement" was inherently inflationary. The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) enabled states to experiment with prospective hospital payments as long as reimbursement was "reasonable and necessary to the efficient and economical delivery of services." Congress was concerned, however, that this change could harm hospitals serving large numbers of Medicaid and uninsured patients. Therefore, it required states to "take into account the situation of hospitals which serve a disproportionate share of low-income patients with special needs." The Medicaid DSH program was intended to improve the financial stability of these hospitals and preserve access to quality health services for low-income patients. Because the requirement was broad and vague, many states ignored it. By 1985, only 17 states had initiated DSH programs.

**DSH was intended to improve the financial stability of hospitals and preserve access to care for low-income patients.**

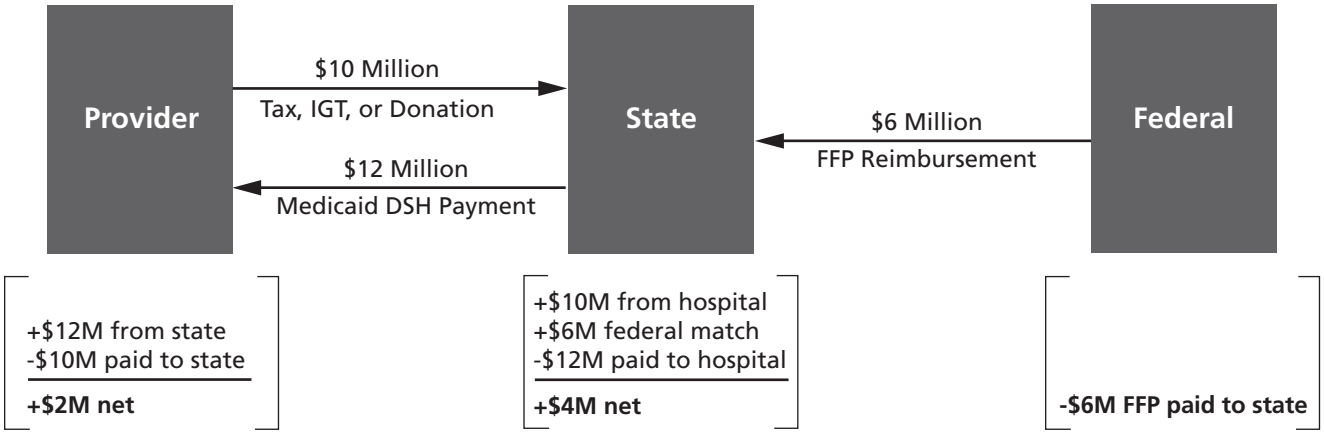
Congress attempted to remedy this problem in the Omnibus Reconciliation Act of 1987 (OBRA 1987) by establishing a federal definition for DSH hospitals and requiring states to make payments to these facilities.[4] The definition included hospitals with (*a*) a Medicaid utilization rate of one standard deviation or more above the mean Medicaid utilization rate in the state or (*b*) a low-income utilization rate of 25 percent or more.[5] OBRA 1987 also established broad parameters for DSH payment adjustments that included (*a*) applying the Medicare DSH formula to Medicaid's base inpatient payments or (*b*) paying a proportional increase based on hospitals' Medicaid or low-income utilization rates. However, OBRA 1987 allowed states to designate additional DSH-eligible hospitals and set reimbursement levels. As a result, DSH payments varied considerably across states.

### State Creative Financing Strategies

In 1985, the Health Care Financing Administration, or HCFA (now the Centers for Medicare and Medicaid Services, or CMS) ruled that states could use hospital taxes and donations to fund the nonfederal share of Medicaid DSH payments. This set the stage for creative financing approaches that could generate new federal funds without matching state contributions. Several factors made this possible. First, Medicaid financing is shared between states and the federal government. Each dollar of allowable state Medicaid spending generates federal matching funds according to a federal medical assistance percentage (FMAP) that ranges from 50 percent to 77 percent based on a state's per capita income.[6] Second, OBRA 1987 maintained state flexibility to designate DSH hospitals and set payment levels, allowing states to direct new Medicaid payments to specific providers. Finally, the federal government did not establish any limits on the amount of state DSH payments eligible for federal matching funds.

In the late 1980s several states, starting with West Virginia, determined that it would be permissible to collect donations from hospitals, use the donations to draw down federal matching funds, and make DSH payments to those same hospitals without actually putting up state dollars.[7] Figure 2 illustrates how the process worked. In this example, a state collects $10 million from a hospital through a provider tax, donation, or transfer. The state then makes a $12 million DSH payment back to the hospital and draws down $6 million in federal funds (assuming a 50 percent federal matching percentage). At the end of the transaction, the hospital has a net gain of $2 million ($12 million DSH payment minus $10 million donation) while the state's net gain is $4 million ($10 million donation plus $6 million federal match minus $12 million DSH payment). As other states began to grasp the implications of West Virginia's approach, they rushed to establish their own programs.

**FIGURE 2**
**Illustrative Example of a DSH Program**




*Source: Urban Institute, 2000.*

IGT=Intergovernmental transfer
FFP= federal financial participation (federal match)

By the early 1990s, alarm bells were going off in Washington as the growth in DSH payments became apparent and stories of inappropriate use of funds began to emerge. Most states did not report how they used funds generated by DSH. In many cases, states used new federal money to enhance payments for safety net providers or expand coverage for low-income populations. Others used the funds to replace state dollars in the budget—often as an alternative to cutting Medicaid eligibility in the face of double-digit spending growth. Federal officials were most concerned by reports that some states had diverted federal Medicaid funds for unrelated

purposes. They were also concerned about reports of "recycling" where states would use excess DSH funds as the state share of new Medicaid expenditures to draw down additional federal payments. Certain states established DSH payments far in excess of what Congress would likely consider reasonable or rational. For example, in 1992, DSH payments were 51 percent of total Medicaid program spending in New Hampshire, 36 percent in Louisiana, and 31 percent in Missouri.[8]

**Certain states established DSH payments far in excess of what Congress would likely consider reasonable or rational.**

## Congressional Restrictions on Medicaid DSH

Congress's first major action to curb state abuses came with the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). The law banned most provider donations and required that provider taxes be (*a*) broad based, (*b*) uniformly imposed, and (*c*) structured so that providers are not held harmless for the cost of the tax. Congress also passed state-specific DSH allotments and limited future growth in these allotments to the annual rate of increase in total Medicaid spending. The new law substantially reduced states' use of provider taxes to fund Medicaid and put the brakes on growth in total DSH payments. However, it also locked in large inequities in states' ability to utilize DSH that persist today. A few states made major program changes to preserve federal funding they expected to lose. The most notable example was Tennessee, which negotiated an exceptionally generous federal Section 1115 Medicaid waiver to implement broad eligibility expansions under a new managed care program called Tenncare. While the new law eliminated the mechanism Tennessee had used to finance a large proportion of its Medicaid program, the waiver preserved the high levels of funding Tennessee received prior to the 1991 reforms.

The 1991 restrictions were the beginning of a continuing conflict over Medicaid financing. Most states found they could not muster political support for allowable provider taxes that required some hospitals to pay new taxes that would not be reimbursed through DSH payments. Instead many states shifted to intergovernmental transfer (IGT) programs. Under IGTs, state or local governments that operate hospitals transfer funds to Medicaid as the state match for DSH payments. Under this arrangement, states directed a large share of DSH payments to a relatively small number of public hospitals. In a 1994 report, the General Accounting Office (now the Government Accountability Office), or GAO, identified IGT programs that allowed Michigan, Tennessee, and Texas to obtain about $800 million in federal Medicaid matching funds without committing state funds.[9]

In the Omnibus Reconciliation Act of 1993, Congress imposed hospital-specific DSH caps, limiting payments to 100 percent of unreimbursed costs of care for Medicaid and uninsured patients. The law provided a transition period for "high-volume" DSH hospitals, capping payments at 200 percent in fiscal year (FY) 1995 and 100 percent in FY 1996. Although the hospital-specific DSH caps reduced states' ability to game

the DSH program, Congress has since created exceptions to the caps for certain states and hospital categories.[10]

The Balanced Budget Act (BBA) of 1997 cut Medicaid DSH payments further, reducing state allotments by 8.6 percent between 1998 and 2002 and limited spending on institutions for mental disease (IMDs). Since its inception, Medicaid has specifically excluded coverage for services delivered to patients between the ages of 21 and 64 in an IMD.[11] Since many IMDs are state-owned, patient care in these facilities has been state-funded. Recognizing that the "IMD exclusion" relates only to reimbursement for services and that DSH payments need not be linked to specific patients or services, many states in the early 1990s substituted Medicaid DSH funding for state IMD funding, in some cases generating large financial windfalls.[12] The BBA limited IMD spending to 33 percent of a state's total DSH payments, reducing windfalls for certain states. Finally, the BBA required states to submit data to HCFA documenting DSH payments to individual hospitals.

In 2000, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA). The law eliminated the BBA's DSH cuts for FY 2001 and FY 2002 and reinstated an annual increase in state allotments based on the consumer price index. But BIPA allowed the full BBA cuts to become effective in FY 2003, creating what has been called the "DSH cliff." The DSH cliff went into effect as scheduled, reducing state allotments by 11.6 percent. However, the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 increased 2004 state allotments by 16 percent. For most states, the allotments in the drug bill will remain level in subsequent years, but low DSH states (those with allotments less than 3 percent of total Medicaid spending) receive a 16 percent annual increase through 2009—doubling their allotments over a five-year period.

The DSH program's history illustrates inherent tensions in Congress between those who want to use Medicaid as a vehicle to finance care for low-income uninsured persons and those who want to control the growth in federal Medicaid payments. Congressional action to limit federal DSH funding has often been followed by new legislation to increase it, as illustrated by passage of the MMA. The BIPA of 2000 simultaneously increased DSH caps for public hospitals and eliminated state loopholes for using Medicaid upper payment limits (see sidebar, page 9—UPL: A New State Approach). Medicaid policymaking has been intensely political and rife with special deals such as the 1997 exemptions to hospital-specific DSH limits for California hospitals. Members of Congress who oppose Medicaid fiscal gamesmanship often support their own governors when state funding is on the line.

**Congressional action to limit federal DSH funding has often been followed by legislation to increase it.**

## The Continuing Federal-State Conflict

The most recent federal action to rein in special Medicaid hospital payments came in a January 2004 CMS proposal to review state plans for

Medicaid spending prospectively. The proposal, which was buried in the January 7 *Federal Register* and had a one-day comment period, caused an outcry. On February 20, Department of Health and Human Services (DHHS) Secretary Tommy Thompson delayed plans to implement these changes and announced a "consultation period" with the National Governors Association. The continuing duel between states and federal regulators has created substantial animosity without much progress towards more rational policies. Efforts are hampered by a lack of reliable data detailing what is actually happening in state programs. States have resisted attempts to develop accurate reporting systems, fearing that this would be an initial step toward reduced funding. States are unlikely to cooperate without a roadmap for reform they perceive as equitable.

## CURRENT STATUS OF MEDICAID DSH

The Medicaid DSH program as it exists today is an amalgam of 50 state programs with different rules, varying resource levels, and few reporting requirements. While federal legislation enacted in the 1990s essentially halted the program's exponential growth, Congress continued to allow state flexibility to structure DSH programs within federal funding constraints. DSH payments declined from 14 percent of total Medicaid spending in 1992 to about 7 percent in 2002. However, the federal DSH allotments locked in funding inequities that arose between states that aggressively maximized DSH payments early on and those that were slow to follow. In 2001, five states reported DSH payments of at least $1,000 per resident below 100 percent of the federal poverty level, while 16 states reported payments of less than $100 per low-income resident (Table 1, see Appendix).

Despite evidence that many major safety net hospitals rely heavily on Medicaid DSH, the program's impact on care to the poor is difficult to

### UPL: A NEW STATE APPROACH

Following the DSH restrictions, states continued to explore new revenue maximization strategies, perhaps most significantly upper payment limit (UPL) programs.[13] Federal law states that Medicaid programs cannot make payments in excess of what "would have been paid under Medicare principles"—the UPL. Originally, this restriction was designed to limit the federal government's liability for Medicaid matching payments. However, states now use the UPL as a rationale for new supplemental payments that help them increase federal Medicaid revenue.

States are required to certify that Medicaid payments do not exceed the Medicare UPL in state plans submitted to the federal government. However, there is no standard methodology for calculating the UPL, which is applied as an aggregate payment limit for broad classes of providers such as hospitals and nursing homes. Medicaid DSH payments are excluded from the UPL calculation.

In the mid-1990s, several states saw an opportunity to use the "room under the upper limit" as a rationale for supplemental payment programs. There were very few federal limits on supplemental payments, so that states could make large UPL payments to individual providers while remaining within aggregate limits. States structured UPL programs much like the original DSH programs—using provider taxes or intergovernmental transfers as the state share to generate federal matching funds, then making supplemental payments back to contributing providers.

A 2001 analysis by the DHHS Office of the Inspector General identified 28 state UPL programs accounting for more than $10 billion in FY 2000 Medicaid payments.[14] Evidence to date suggests that states retain a relatively high percentage of UPL program gains rather than paying them to providers.[15] CMS modified its UPL regulation to establish aggregate caps for three categories of hospitals (private, state, and public nonstate) in 2001 but did not enact limits on provider-specific UPL payments. In contrast, the GAO has a longstanding recommendation that Congress limit UPL payments to provider costs.[16]

document with precision. Federal officials struggle to make informed decisions in the absence of basic program information, including the following:

- How are individual state DSH programs structured?
- What proportion of reported DSH payments are available to finance care for low-income patients after netting out funds returned to states through provider taxes and IGTs?
- What proportion of net DSH payments go to safety net as opposed to non–safety net hospitals?
- How much funding do state and local governments actually contribute to Medicaid DSH?

**While each state DSH program is unique, several general approaches are relatively common.**

## State Medicaid DSH Program Structure

While each state DSH program is unique, several general approaches are relatively common. One is for states to structure programs using the OBRA 1987 guidelines that defined DSH hospitals. For example, in Wisconsin, qualifying hospitals must have a low-income utilization rate (LIUR) of at least 25 percent or a Medicaid utilization rate that is one standard deviation above the statewide mean. Qualifying hospitals are paid using an add-on to the Medicaid DRG rate that ranges from 3.0 percent to 4.5 percent, depending on each hospital's LIUR. Wisconsin's DSH program is relatively modest, with payments of about $50 million in 2002.[17] The state share of DSH is financed predominantly with general revenues, although Wisconsin also uses an IGT from Milwaukee County to help finance the county's General Assistance Medical Program. This OBRA 1987 approach is more common for states with small DSH programs and few public hospitals.

Another general approach is illustrated by states that direct the majority of DSH funds to public hospitals—creating a structure where the state share of DSH payments can be financed through intergovernmental transfers. In California, both public and private hospitals are eligible for DSH if they meet the OBRA 1987 guidelines. However, DSH payments are based on a mathematical formula designed to achieve a predetermined distribution of payments between public and private hospitals. The formula takes into account hospital type and LIUR and rewards Medicaid days more than charity care. Funds not expended in base payments are distributed through supplemental payments to remaining DSH hospitals. In 2002, approximately one-third of California hospitals received DSH payments that totaled approximately $1.4 billion. The state share is financed primarily through IGTs from counties and the University of California.

A third general approach is to make DSH payments to virtually all hospitals in the state. Such programs typically exist in states, such as New York, Massachusetts, and Ohio, that finance DSH payments in part through a provider tax. New York, for example, has an indigent care pool that qualifies for federal matching funds under the DSH program. Hospitals qualify for pool payments if their bad debt and charity care costs are at least 0.5

percent of total hospital costs. As a result, virtually all New York hospitals receive DSH payments. The state pays between 60 and 100 percent of hospitals' uncompensated care costs, depending on their bad debt and charity care percentage. New York also has created supplemental DSH programs for public hospitals. New York's FY 2002 DSH payments were about $2.9 billion. The state's share of indigent care pool payments is financed by a uniform assessment on hospital's private-sector charges and an insurer assessment. The state's share of the public-sector DSH programs is financed primarily by IGTs.

## Net DSH Payments to Hospitals

Despite success limiting aggregate growth in Medicaid DSH payments, federal officials remain concerned about whether states actually use these funds to support hospital uncompensated care. The federal government requires states to report hospital-specific DSH payments to CMS but does not require hospital-specific information about transfers back to states through provider taxes and intergovernmental transfers. As a result, these reports provide little insight into what is really happening to DSH funds.

The Urban Institute, however, has conducted state surveys on the sources and uses of Medicaid DSH funds for FY 1993, FY 1997, and FY 2001.[18] The 2001 survey includes DSH data from 32 states accounting for about two-thirds of that year's total payments. Although the survey data are not a complete or audited accounting of Medicaid DSH programs, they do offer the most comprehensive picture of DSH financing available to date. The surveys also illustrate how state programs have evolved over time in response to federal legislative changes.

States responding to the Urban Institute's DSH survey reported $10.7 billion in total DSH payments. Of this amount, net DSH gains to hospitals or state governments (defined by the Urban Institute as federal matching funds) were $6.2 billion (Table 2, see Appendix). Almost 74 percent of the net DSH gains went to private or nonstate hospitals, 15 percent went to state hospitals, and 11 percent were kept by states as residual funds. In 2002, the federal government made $9 billion in matching payments on total reported DSH payments of $15.9 billion. Extrapolating from the survey percentages suggests that hospitals received $8.1 billion in 2002 net DSH payments (total DSH payments minus provider taxes and IGTs). However, this amount understates net DSH payments to hospitals because the Urban Institute's definition does not include payments financed by state general revenues.

The distribution of DSH gains varies by state (Table 3, see Appendix). For example, New Jersey made $699 million in DSH payments to private hospitals while drawing down $577 million in federal matching funds for DSH, suggesting that the state contributed at least $122 million in state general revenues to fund DSH payments to private hospitals. Nine of the 32 survey states made net state DSH contributions, although these were

relatively modest in all but New Jersey and Connecticut. In contrast, some states captured large DSH gains. For example, Louisiana financed its 2001 DSH program predominantly with state appropriations but made the majority of DSH payments to state hospitals. In 2001, Louisiana's net state gain was almost $540 million. However, Louisiana did not report a transfer of funds from state hospitals back to the general fund, suggesting that the gains finance health services delivered at state hospitals.

**Medicaid DSH is the largest source of federal funding for uncompensated hospital care.**

## DSH Payments to Safety Net Hospitals

Hospitals are the nation's largest providers of uncompensated care, delivering a substantially larger volume of services to low-income patients than community health centers, local clinics, or private physicians. Medicaid DSH is the largest source of federal funding for uncompensated hospital care. However, the burden of uncompensated care is highly variable across hospitals, and policymakers are justifiably interested in understanding how well payments are targeted to safety net providers.

A September 2002 report prepared for the Office of the Assistant Secretary of Planning and Evaluation (ASPE) by RAND and the Urban Institute identifies four major dimensions of safety net hospitals. The hospital must have a legal mandate or mission to serve individuals regardless of their ability to pay, provide service to vulnerable populations (for example, uninsured persons, homeless persons, those with substance abuse problems or mental illness), provide a disproportionate amount of care to low-income populations, and make available specialized services such as trauma care and emergency room services.[19] The structure of the health care safety net varies from community to community. In cities such as Dallas and Los Angeles, the majority of hospital care provided to uninsured and Medicaid patients is concentrated in a small number of public hospitals. In cities such as New York and Detroit, care for the uninsured is shared across a broad range of institutions.[20] Therefore, the health care safety net includes hospitals that vary in size, location, and governance.

The ASPE study analyzed the distribution of DSH payments across hospitals and estimated that 64 percent of net Medicaid DSH payments went to hospitals with at least 30 percent low-income patients while 80 percent of net payments went to hospitals with at least 20 percent low-income patients.[21] Furthermore, it found that 63 percent of net Medicaid DSH payments went to hospitals with Medicaid utilization rates at least one standard deviation above their statewide average. Roughly 75 percent of net Medicaid DSH payments went to hospitals that had negative total margins before receiving these payments. These findings imply that DSH cuts would result in service reductions for uninsured patients. The ASPE study conducted simulations of Medicaid DSH payments using alternative distribution formulas. The authors concluded that the current distribution of net DSH payments targets financially vulnerable safety net hospitals at least as well as alternatives examined in the report.

Taken together, the Urban Institute's DSH survey and the ASPE study suggest that the majority of federal DSH funds accrue to hospitals and that a substantial proportion of these funds flow to safety net institutions. However, the extent to which DSH funds can be considered well-targeted to safety net institutions varies across states. Safety net providers in states with low DSH allotments receive very limited DSH funding. This remains a major gap in the program's ability to target payments to providers with the greatest need.

Although recent research has provided improved insight into the program's financial flows, very little is known about how hospitals use DSH funding to render care to uninsured patients. To assess this issue in greater detail, DHHS sponsored another study by the Urban Institute to examine selected programs that use DSH funds to enhance care for uninsured patients.[22]

The experience of Denver Health (DH) illustrates the role of DSH in supporting a local safety net program. DH, the principal source of care for uninsured patients in the Denver metropolitan area, includes a 350-bed hospital, 11 federally qualified community health centers, the local health department, and 12 school-based clinics. In 1991, DH faced a $40 million operating deficit, but a rapid infusion of Medicaid DSH funding in the 1990s was a critical factor in DH's subsequent financial turnaround. Between 1991 and 2000, DH received nearly $320 million in DSH funding. In 1999, DH provided approximately $75 million in care to the uninsured, $39 million of which was supported by net DSH payments. In addition to supporting direct care, Medicaid DSH has allowed DH eliminate its operating deficit, invest in new infrastructure, and reorganize into a vertically integrated delivery system that can deliver care in a more coordinated and cost-effective manner.

## State and Local Government Contributions to Medicaid DSH

Congressionally mandated restrictions on provider taxes caused a major shift in Medicaid DSH financing. According to the Urban Institute survey, local government funding used to finance the state share of DSH payments increased from 27 percent in 1993 to 47 percent in 2001, while provider taxes declined from almost 50 percent of the state share in 1993 to 11.6 percent in 2001 (Table 4, see Appendix). Local government funds are considered a legitimate source of Medicaid financing. According to federal statute, up to 60 percent of the state share may come from local sources. States have a long history of local government revenue sharing. For example, New York has long required that county governments contribute part of the state share of Medicaid. Similarly, provider-specific taxes are legitimate sources of state funds if they conform to CMS regulations. The critical question is not whether states use local funding to finance the state share, but whether reported DSH payments are valid expenditures for hospital services.

**According to federal statute, up to 60 percent of the state share may come from local sources.**

Congressionally mandated hospital-specific DSH caps can substantially reduce state governments' ability to generate excess federal matching payments through the DSH program. Under caps that limit payments to 100 percent of hospitals' unreimbursed costs, states can still use intergovernmental transfers as the state share of DSH but cannot hold local governments harmless for the cost of these transfers. If a county hospital has $10 million in unreimbursed costs, a state cannot make DSH payments to the hospital in excess of this amount. Figure 3 illustrates that a state with a 75 percent federal matching rate could use a $2.5 million county IGT to draw down $7.5 million in federal matching funds and then make a $10 million DSH payment without appropriating state funds. The county hospital has a net DSH payment of $7.5 million (DSH payment less IGT) but also has unreimbursed costs of $10 million. Therefore, the county has to finance the remaining $2.5 million in unreimbursed costs. This example illustrates that the 100 percent DSH cap requires either state or local government to contribute the full statutory nonfederal share of the Medicaid DSH payment. However, when hospital-specific DSH caps are raised above 100 percent (as is the case under BIPA for public hospitals in 2004 and 2005), states can still generate excess DSH payments that may be used to finance other health care services for low-income patients or diverted for other purposes.

## THE FUTURE OF MEDICAID DSH AND FEDERAL SUPPORT FOR THE HEALTH CARE SAFETY NET

Medicaid DSH provides essential funding to many safety net hospitals. In this capacity, the program helps maintain access to health services for low-income patients. While federal legislation has corrected many of the problems that occurred in the program's early years, Medicaid DSH still has significant flaws:

■ **Lack of transparency and financial controls.** Medicaid DSH lacks oversight mechanisms and financial controls that one would expect in a large government program. Studies by the GAO and others discuss how problems with oversight and management result in questionable federal expenditures.[23] The absence of reliable data protects states that engage in questionable practices and limits the momentum of efforts to change the program in ways that would benefit low-income patients.

■ **Inequity across states.** The Medicaid DSH program is highly inequitable. States with large DSH allotments receive substantially more federal DSH funding than those with smaller allotments. State allotments are not based on need, but rather on historical program spending levels at the time when the federal government established state DSH allotments. States that were most effective in maximizing DSH funding in the early years have continued to benefit for more than a decade.

■ **Lack of incentives for delivery system reform.** The DSH program perpetuates a hospital-centric model of health care delivery. DSH does not fund nonhospital services and accordingly does not provide

incentives for investment in primary care and prevention programs designed to keep patients healthy and out of the hospital.

Enacting change will be difficult. Federal officials are reluctant to invest in a program some view as a raid on the federal treasury. Yet major reform without a new infusion of federal money will create shortfalls for certain states and providers that have come to rely on DSH funds.

## Options for Change

Proposals for structural changes to DSH policies that address the three major issues highlighted above include the following options:

**Establishing New Medicaid DSH Reporting Systems and Financial Controls —** The federal government continues to struggle with the notion of state flexibility in reviewing and approving financing methodologies. In 2002, the GAO added Medicaid to its list of "high-risk" programs, citing lack of financial controls over states claims for federal matching.[24] The Bush administration has proposed establishing Medicaid block grants to reduce federal exposure to future growth in program costs and give states more management flexibility. Yet a recent report for the Kaiser Family Foundation argues that improving financial management within the current program structure is a viable alternative to more radical restructuring of the federal-state Medicaid partnership.[25] The report identifies a variety of specific actions to be considered, including the following:

- Creating a Medicaid financial oversight board.
- Developing a comprehensive plan for Medicaid fiscal integrity.
- Further clarifying allowable Medicaid funding sources.
- Publishing an upper payment limit methodology and applying it consistently across all states.
- Auditing supplemental payment programs.
- Redesigning CMS Medicaid information systems to collect key financial data from states.
- Reporting on effective matching rates.

In addition to controlling costs and reducing Medicaid's exposure to abuse, stronger fiscal controls would limit manipulations that create temporary winners, inequities among states, and financial dislocations when new rules are implemented to eliminate loopholes.

If improved transparency and accountability are considered priority areas for Medicaid DSH reform, the federal government could develop national standards for reporting hospital uncompensated care and a process for collecting consistent data on the volume of care delivered to low-income and uninsured patients. Some states, like Massachusetts, have specific definitions for charity care and require that hospitals document patients' financial status before they can receive uncompensated care funding. However, the only national data source is the American

**The federal government continues to struggle with the notion of state flexibility with respect to Medicaid financing.**

Hospital Association (AHA) annual survey. Hospitals do not use consistent definitions for reporting bad debt and charity care to the AHA, nor is there any way to determine what proportion of this care is provided to uninsured patients. Furthermore, the AHA data are neither audited nor publicly available. National uncompensated care reporting standards would assist both the federal and state governments in targeting DSH payments to more precisely meet policy goals.

**Federalizing Medicaid DSH Payments —** Another way to control federal DSH payments and ensure a more equitable distribution of funds would be to establish a uniform federal Medicaid DSH program. Federal payments would go directly to hospitals, eliminating opportunities for states to engage in financial manipulations. Under this scenario, states could also make DSH payments, but these would not be eligible for federal matching funds.

Medicare already has a uniform federal DSH program. However, Medicare's current qualification criteria and payment formulas are not appropriate for Medicaid DSH. The ASPE analysis found that a smaller proportion of Medicare DSH payments went to hospitals with high ratios of low-income patients than the current state-based Medicaid DSH program. The Medicare Payment Advisory Commission has recommended that Congress require disproportionate share payments be distributed according to each hospital's share of low-income patient costs—defined broadly to include all care to the poor delivered in both inpatient and outpatient settings.[26] However, the ASPE study demonstrates that additional research and better data are needed to ensure payments are effectively targeted to hospitals with the greatest need.

The most difficult issue facing a federal Medicaid DSH program would be determining the level and distribution of funding. Some have suggested increasing the proportion of Medicaid DSH payments directed at hospitals that serve a very high percentage of low-income and uninsured patients.[27] This approach is appealing to those who advocate greater federal support for "true" safety net providers. But such a change would result in large redistributions relative to the current structure.

**Developing New Funding Models to Support Integrated Systems of Charity Care —** A third option would be a new comprehensive institutional financing program for safety net providers designed to replace the existing patchwork of state and federal payments. By establishing stable, predictable, multiyear funding to support a full continuum of services for low-income patients, this option could create a financial structure that encourages integrated, coordinated systems of care. This approach could be structured like a global budget, providing selected safety net providers with the flexibility and financial incentives to treat patients in the most appropriate, cost-effective settings. Such a program would need to incorporate accountability guidelines and require health systems to demonstrate measurable progress in improving patient safety, service quality, and community health status in order to qualify for continued funding.

## CONCLUSION

DSH is a critical source of financing for health care provided to low-income and uninsured patients; however, it continues to be a focal point in the federal-state battle over Medicaid financing. The DSH program is complex and lacks good reporting systems and financial controls. Controversy over states' use of DSH programs to enhance federal Medicaid matching funds sometimes overshadows the importance of directing necessary funding to institutions that serve low-income patients. Furthermore, growth of supplemental payment programs like DSH that are financed by provider taxes and IGTs greatly complicates Medicaid program evaluation and oversight. In the absence of a viable plan to broadly expand health insurance coverage, support for providers that serve low-income patients will become increasingly critical. It is essential that states and the federal government come together to design funding strategies that equitably and effectively strengthen the nation's health care safety net.

## ENDNOTES

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## APPENDIX — TABLE 1
## Medicaid DSH Expenditures per Enrollee and per Uninsured Person, 2001

| | 2001 DSH Payments (in thousands) | Percent of Total Medicaid Payments | DSH Payment per Resident below 100% FPL | DSH per Uninsured Person |
|---|---|---|---|---|
| **U.S. Average** | $15,854,176 | 7.4% | $482 | $385 |
| **Alabama** | $366,738 | 12.8% | $527 | $640 |
| **Alaska** | $13,975 | 2.4% | $259 | $140 |
| **Arizona** | $102,774 | 3.9% | $132 | $108 |
| **Arkansas** | $22,685 | 1.2% | $48 | $53 |
| **California** | $1,926,284 | 8.1% | $446 | $287 |
| **Colorado** | $186,310 | 8.7% | $486 | $271 |
| **Connecticut** | $290,828 | 9.0% | $1,168 | $841 |
| **Delaware** | $4,140 | 0.7% | $78 | $57 |
| **District of Columbia** | $82,381 | 8.4% | $816 | $1,177 |
| **Florida** | $338,809 | 4.0% | $163 | $119 |
| **Georgia** | $425,146 | 8.4% | $398 | $309 |
| **Hawaii** | $0 | 0.0% | $0 | $0 |
| **Idaho** | $10,047 | 1.4% | $67 | $48 |
| **Illinois** | $379,004 | 4.9% | $303 | $226 |
| **Indiana** | $656,157 | 16.4% | $1,284 | $919 |
| **Iowa** | $14,273 | 0.9% | $67 | $66 |
| **Kansas** | $46,991 | 2.8% | $176 | $156 |
| **Kentucky** | $191,149 | 5.8% | $380 | $389 |
| **Louisiana** | $872,308 | 20.8% | $1,230 | $1,032 |
| **Maine** | $49,160 | 3.7% | $372 | $372 |
| **Maryland** | $62,822 | 1.9% | $163 | $96 |
| **Massachusetts** | $485,283 | 7.3% | $865 | $933 |
| **Michigan** | $431,720 | 6.0% | $466 | $420 |
| **Minnesota** | $64,322 | 1.7% | $178 | $164 |
| **Mississippi** | $178,733 | 7.3% | $332 | $389 |
| **Missouri** | $455,068 | 9.6% | $847 | $805 |
| **Montana** | $244 | 0.1% | $2 | $2 |

**(continued on next page)**

**APPENDIX — TABLE 1** (continued)

| | 2001 DSH Payments (in thousands) | Percent of Total Medicaid Payments | DSH Payment per Resident below 100% FPL[a] | DSH per Uninsured Person |
|---|---|---|---|---|
| **Nebraska** | $318 | 0.0% | $2 | $2 |
| **Nevada** | $76,042 | 11.3% | $500 | $221 |
| **New Hampshire** | $158,370 | 18.1% | $1,955 | $1,331 |
| **New Jersey** | $1,117,458 | 15.7% | $1,636 | $1,008 |
| **New Mexico** | $15,265 | 1.0% | $47 | $41 |
| **New York** | $2,455,754 | 7.8% | $922 | $842 |
| **North Carolina** | $415,288 | 6.8% | $410 | $356 |
| **North Dakota** | $1,061 | 0.3% | $12 | $18 |
| **Ohio** | $637,259 | 7.6% | $543 | $511 |
| **Oklahoma** | $22,702 | 1.1% | $45 | $37 |
| **Oregon** | $30,494 | 1.1% | $75 | $69 |
| **Pennsylvania** | $761,019 | 7.0% | $657 | $680 |
| **Rhode Island** | $81,058 | 6.8% | $811 | $1,013 |
| **South Carolina** | $371,948 | 12.3% | $617 | $754 |
| **South Dakota** | $1,075 | 0.2% | $17 | $16 |
| **Tennessee** | $0 | 0.0% | $0 | $0 |
| **Texas** | $1,346,134 | 11.6% | $430 | $271 |
| **Utah** | $724 | 0.1% | $3 | $2 |
| **Vermont** | $26,500 | 4.4% | $449 | $457 |
| **Virginia** | $236,402 | 7.8% | $419 | $305 |
| **Washington** | $327,824 | 7.6% | $517 | $420 |
| **West Virginia** | $102,034 | 6.6% | $351 | $436 |
| **Wisconsin** | $11,855 | 0.3% | $28 | $29 |
| **Wyoming** | $241 | 0.1% | $6 | $3 |

*Source: National Association for Public Hospitals,* Safety Net Financing: A Policy Sourcebook for State Executives, *June 2003.*

*Data from CMS-64 2001 annual reports and March 2002 current population survey.*

[a]*FPL = federal poverty level ($17,650 for a family of four in 2001).*

**APPENDIX — TABLE 2**
**State Sources of Funds, Reported DSH Payments, and Net DSH Payments by Entity in 2000: Summary Results from 32 States**

| Sources of DSH Funds | Amount (in millions) | Percent of Total | Percent of State Share |
|---|---|---|---|
| Provider taxes | $567.2 | 5.0 | 10.9 |
| Local/county IGT and CPE[a] | $2,296.2 | 20.1 | 44.1 |
| State transfers and CPEs | $1,068.9 | 9.3 | 20.5 |
| General appropriations | $1,276.9 | 11.2 | 24.5 |
| Federal Medicaid match | $6,237.6 | 54.5 | N/A |
| Total funds[b] | $11,446.8 | 100.0 | 100.0 |
| **Reported DSH Payments** | | | |
| Private acute hospitals | $3,630.7 | 33.8 | N/A |
| Public (nonstate) acute hospitals | $3,707.3 | 34.5 | N/A |
| State acute hospitals | $1,466.5 | 13.6 | N/A |
| Private IMDs[c] | $6.1 | 0.1 | N/A |
| Public (nonstate) IMDs | $110.8 | 1.0 | N/A |
| State IMDs | $1,823.4 | 17.0 | N/A |
| Total DSH Payments | $10,744.8 | 100.0 | |
| **Net DSH Payments by Entity** | | | |
| Private or nonstate hospitals | $4,592.0 | 73.6 | |
| State hospitals | $944.1 | 15.1 | |
| State residual funds | $701.7 | 11.2 | |
| Total net payments[d] | $6,237.8 | 100.0 | |

*Source: Urban Institute, Survey of UPL and DSH Programs, 2002.*

*[a]CPE = certified public expenditure*

*[b]Sources of funds total exceeds DSH payments total because certain states collect more than they need to cover the state share of DSH payments.*

*[c]IMD = institution for mental disease*

*[d]Total gains is equal to total federal matching funds. A number of states make total DSH payments above the federal matching funds they receive. In the aggregate, states with net payments are combined with states that have net DSH gains.*

## APPENDIX — TABLE 3
## Net DSH Gains by Hospital Ownership and DSH Residual Funds in 32 States, State Fiscal Year 2001
(dollars in millions)

| | Total DSH Gains | Gains to Private or Nonstate Entities[a] | Gains to State Entities[a] | State Residual Funds[b] | Net State Gain | Percent of Gain to State[c] |
|---|---|---|---|---|---|---|
| **Total (32 States)** | $6,237.7 | $4,592.0 | $944.1 | $701.7 | $1,645.8 | 26.0 |
| **Alabama** | $257.0 | $232.0 | $25.0 | - | $25.0 | 10.0 |
| **Alaska** | $4.8 | - | $4.8 | - | $4.8 | 100.0 |
| **California** | $1,020.6 | $1,020.6 | - | - | - | 0.0 |
| **Connecticut** | $160.0 | $232.4 | ($72.4) | - | ($72.4) | -45.0 |
| **District of Columbia** | $32.0 | $36.0 | ($4.0) | - | ($4.0) | -13.0 |
| **Florida** | $203.9 | $128.1 | $75.8 | - | $75.8 | 37.0 |
| **Georgia** | $249.0 | $228.0 | $21.0 | - | $21.0 | 8.0 |
| **Idaho** | $1.0 | $1.4 | ($0.4) | - | ($0.4) | -43.0 |
| **Indiana** | $185.5 | $131.2 | $54.3 | - | $54.3 | 29.0 |
| **Iowa** | $8.6 | $1.8 | $6.8 | - | $6.8 | 79.0 |
| **Kentucky** | $133.8 | $86.6 | $47.2 | - | $47.2 | 35.0 |
| **Louisiana** | $613.8 | $74.2 | $539.6 | - | $539.6 | 88.0 |
| **Maryland** | $40.4 | $40.2 | $0.2 | - | $0.2 | 0.0 |
| **Massachusetts** | $242.7 | $91.2 | ($91.2) | $242.6 | $151.5 | 62.0 |
| **Michigan** | $244.5 | $196.5 | $48.0 | - | $48.0 | 20.0 |
| **Mississippi** | $139.4 | $35.5 | $17.2 | $86.7 | $103.9 | 75.0 |
| **Missouri** | $280.1 | $102.1 | $178.0 | - | $178.0 | 64.0 |
| **Nebraska** | $6.1 | $8.5 | ($2.4) | - | ($2.4) | -39.0 |
| **New Jersey** | $577.0 | $699.0 | ($432.0) | $310.0 | ($122.0) | -21.0 |
| **North Dakota** | $0.7 | $0.3 | $0.4 | - | $0.4 | 52.0 |
| **Ohio** | $363.0 | $290.9 | $72.1 | - | $72.1 | 20.0 |
| **Oklahoma[d]** | $16.6 | $1.0 | $15.6 | - | $15.6 | 94.0 |
| **Oregon[e]** | $8.6 | $11.6 | ($3.0) | - | ($3.0) | -35.0 |
| **South Carolina** | $262.0 | $198.3 | $63.7 | - | $63.7 | 24.0 |
| **Texas** | $830.0 | $548.0 | $282.0 | - | $282.0 | 34.0 |

**(continued on next page)**

**APPENDIX — TABLE 3** (continued)

| | Total DSH Gains | Gains to Private or Nonstate Entities[a] | Gains to State Entities[a] | State Residual Funds[b] | Net State Gain | Percent of Gain to State[c] |
|---|---|---|---|---|---|---|
| **Utah** | $2.7 | $1.4 | $1.3 | - | $1.3 | 49.0 |
| **Vermont** | $15.2 | $24.5 | ($9.3) | - | ($9.3) | -61.0 |
| **Virginia** | $97.2 | $17.8 | $79.4 | - | $79.4 | 82.0 |
| **Washington** | $176.0 | $93.7 | $19.9 | $62.4 | $82.3 | 47.0 |
| **West Virginia** | $58.9 | $50.3 | $8.7 | - | $8.7 | 15.0 |
| **Wisconsin** | $6.6 | $8.7 | ($2.1) | - | ($2.1) | -32.0 |
| **Wyoming** | $0.1 | $0.1 | ($0.1) | - | ($0.1) | -56.0 |

*Source: Urban Institute, Survey of UPL and DSH Programs, 2002*

*Notes:*
*[a]DSH payments to both acute care and mental hospitals are combined for each ownership type shown.*
*[b]Residual funds are state revenues received in excess of the amount needed to draw down the maximum amount of federal funds available based on each state's reported total DSH payments. In states taking in excess funding, the [Urban Institute] authors cut back the level of funding reported from each source (for example, private, local or state) proportionate to the levels reported to estimate the amounts used to draw down federal matching funds. The amount of federal matching funds needed was estimated based on total DSH payments.*
*[c]These percentages represent the share of total gains from DSH, including residual funds, that are kept by state entities.*
*[d]Gains to state-owned acute-care hospitals in Oklahoma include payments to a former state operated hospital that has entered into a joint operating agreement with a private hospital system.*
*[e]Oregon did not provide revenue or payment information for the state's mental health DSH program in its survey response, but the state makes approximately $17 million in DSH payments to mental hospitals annually, according to CMS data.*

## APPENDIX — TABLE 4
## Distribution of DSH Program Revenues and Expenditures
(in percent)

| State Share of DSH Revenues | 1993[a] | 1997[b] | 2001[b] |
|---|---|---|---|
| Provider Taxes and Donations | 48.4 | 18.2 | 11.6 |
| County/Local Funds[c] | 27.0 | 42.0 | 47.2 |
| State Funds[d] | 24.7 | 39.8 | 41.2 |
| Total | 100.0 | 100.0 | 100.0 |
| **Federal Percentage of DSH Revenues** | 49.4 | 52.2 | 54.4 |
| **DSH Expenditures** | | | |
| Payback to Private and County/Local | 38.1 | 28.8 | 26.8 |
| Private and County/Local Gain | 17.6 | 27.4 | 38.6 |
| Payback to State | 12.5 | 19.0 | 18.8 |
| State Hospital Gain | 17.9 | 14.3 | 9.2 |
| Residual Funds for State Use | 13.8 | 10.5 | 6.6 |
| Total | 100.0 | 100.0 | 100.0 |

*Source: Urban Institute, Survey of State Medicaid DSH and Other Payment Programs.*

*[a]Based on 1993 survey data from 31 states (which differ slightly from states in other years).*

*[b]Based on 1997 and 2001 survey data from 27 states. Percentages differ from those in Table 1, which includes 32 states.*

*[c]County/local funds include both intergovernmental transfers and certified public expenditures from county or local hospitals or entities.*

*[d]State funds include both certified public expenditures and state transfers.*