

## States' Use of Medicaid UPL and DSH Financing Mechanisms in 2001

### PLEASE NOTE:

This document contains the full text of a report submitted to the Henry J. Kaiser Family Foundation in January 2003. An abbreviated version highlighting the key findings was published in the March/April 2004 issue of the journal *Health Affairs*. We expect that most readers will prefer the shorter version. This full text is intended for readers who want additional background on these programs or who are interested in our detailed findings, which include observations from case studies of the development and evolution of DSH and UPL programs in three states.

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## EXECUTIVE SUMMARY

One of the most controversial issues in recent Medicaid policy debates has been states' use of upper payment limit or UPL programs. Members of the Bush administration have referred to UPL programs as "Medicaid scams" that have caused the federal government to pay more than its share of Medicaid expenditures. Both the Bush and Clinton administrations as well as some members of Congress have sought to limit states' use of UPL payments, which were estimated to total more than \$11 billion (federal and state) in 2001 (Congressional Budget Office 2002). State and local officials as well as some provider industry groups, however, have fought this effort.

The Medicaid hospital disproportionate share or DSH program has caused a similar tug-of-war between states and the federal government. Designed to provide financial help to safety net hospitals, the \$15.8 billion (federal and state) Medicaid DSH program has sparked considerable debate between state and federal policymakers. Though not as hotly debated in the last couple of years, controversy surrounding the DSH program will likely resurface soon: Barring a change in current federal law, 35 states are slated to lose about \$1 billion in federal DSH funds in fiscal year 2003 (Miller 2002).

At the heart of DSH and UPL controversy is that many states draw extra federal matching funds with limited or no state money involved. For the past several years, the principal way states have done this is through use of intergovernmental transfers (IGTs) or state transfers which entail the transfer of funds from local governments to the state or fund transfers between different state agencies. These fund transfers are then used as the state share for Medicaid DSH and UPL payments, and, in the process, the state obtains federal matching dollars. By using mechanisms like IGTs and state transfers, states are not contributing their full share of Medicaid expenditures while the federal government is paying more than its share. In short, these mechanisms have shifted the balance of federal Medicaid spending among states and compromised the federal-state partnership as set out in Medicaid law.

Another key issue in the DSH and UPL controversy is that with the infusion of federal Medicaid dollars, some states are not necessarily using the new funds to improve or expand health care services for Medicaid beneficiaries or to broaden health care services to the uninsured (Ku 2000). Indeed, to a very large extent, federal funds generate through these mechanisms become unaccountable once they reach the states and states can use the funds for a range of purposes, including non-health purposes.

Building on earlier surveys (Ku and Coughlin 1995; Coughlin et al. 2000) in this study we report findings from a 2002 survey of states' UPL and DSH programs. Completed by 34 states, the survey focused on revenues and expenditures for both the DSH and UPL programs in state fiscal year (SFY) 2001. In brief, the survey results suggest that an increasing share of available DSH gains appear to be paid to hospitals in 2001 as compared to 1997. In contrast, survey data suggest that the bulk of available UPL gains are being kept by states and not by providers. Of the available provider UPL gains, most accrued to hospitals; very little accrued to nursing

homes. Using simulation analyses, we estimated that, owing to DSH and UPL strategies, the effective federal Medicaid match rate was 3 percentage points higher on average among survey states in 2001 than it would have been otherwise.

The findings in this paper reflect states' DSH and UPL programs prior to actions taken by the federal government to significantly limit states' use of UPL mechanisms. With the passage of the 2001 Benefits Improvement and Protection Act (BIPA), the federal government changed how states calculate UPLs for hospitals, nursing homes, and other facilities. BIPA also set out various transition times for states to ensure that provider payments conformed to new federal regulations, which went into effect in March 2001 (U.S. Department of Health and Human Services, 2001).

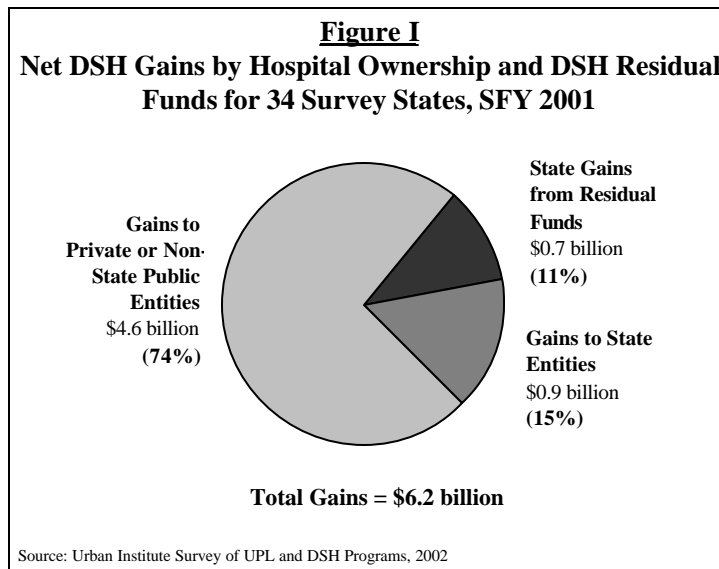
## Highlights of Findings

### Medicaid DSH Program

- The 34 survey states made a total of \$10.7 billion (federal and state) in DSH payments in SFY 2001, with the level of DSH expenditures varying greatly across the states. States put up \$4.5 billion (42 percent) of this total and the federal government provided \$6.2 billion (58 percent) in matching funds.
- Many survey states do not put up their own funds to support their DSH payments. Seventeen states obtained some or all of the state share through IGTs from non-state government entities or through provider taxes. IGTs accounted for about 45 percent of state funding, followed by state general funds at 25 percent, fund transfers from state sources at 20 percent and provider taxes at 11 percent. Most states using general funds or state transfers as funding for DSH recoup some or all of these amounts out of the federal matching funds.
- Survey states generally made DSH payments to more than one type of provider. Acute care hospitals received 82 percent of the DSH payments, with most (68 percent) going to private and local or county-owned facilities. Fourteen percent went to state-owned acute care hospitals such as university hospitals. The remaining share (18 percent) went to mental hospitals, primarily state-owned facilities.
- By comparing funding and payments, we estimated net gains that both states and hospitals received from the DSH program. Assuming that states and individual hospitals get “paid back” (as DSH payments or other transfers) some or all of what they contribute toward the state share, we estimate that, as a group, hospitals in the survey states and states themselves gained about \$6.2 billion through DSH programs in SFY 2001.<sup>1</sup> This gain is equal to the amount of federal matching payments for DSH programs. Non-state public hospitals netted almost 74 percent of the total gains, whereas states (including both state-owned hospitals and state governments) netted about 26 percent of total gains (Figure I).

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<sup>1</sup>Hospital gains may be higher than indicated as some of the state share that we assumed as paybacks actually are retained by the providers and represent new funds.

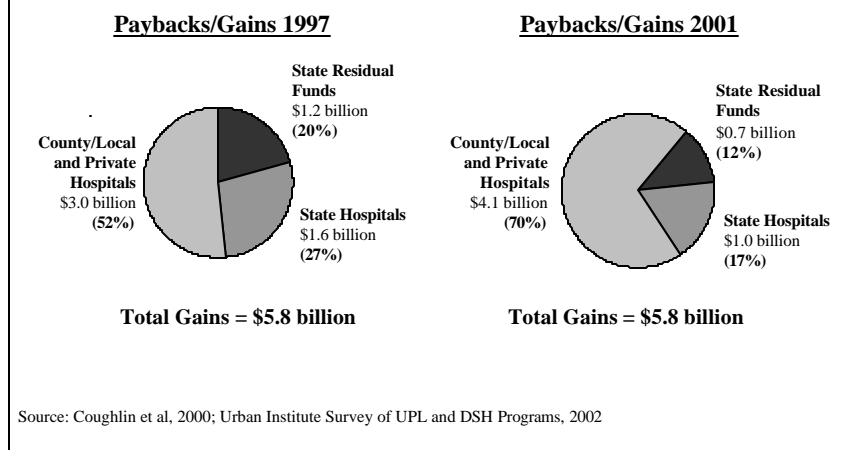


- We determined changes in DSH funding, paybacks and provider gains between 1997 and 2001 by comparing survey responses for 27 states that responded in both years.<sup>2</sup> Funding levels, the distribution of funding among sources (state, county/local, and private), and total DSH payments did not change appreciably over this period. How states allocated their DSH payments shifted considerably. In 1997, non-state public entities received \$3.0 billion (52 percent) of total DSH gains in the 27 states; by 2001, they received \$4.1 billion (70 percent) of total gains (Figure II). Gains to state hospitals and residual funds for state use declined.<sup>3</sup>
- Part of the distributional shift in DSH payments toward county, local and private hospitals observed in 2001 could be due to provisions included in the Balanced Budget Act of 1997 that limited how much of a state's federal DSH allotment can be paid to mental hospitals, most of which are state facilities. At a broader level, during the late 1990s states enjoyed strong economies and may have had less of need to retain potential gains available under the DSH program. Many states also implemented Medicaid UPL programs during this period, which provided another avenue to leverage federal dollars.

<sup>2</sup> Figure II compares revenues and expenditures for 27 states, a subset of the 34 states. As such, the dollar levels and percentages differ from those presented for the full 34 state sample.

<sup>3</sup> In some instances, states take in more revenue through their DSH programs than they payout in DSH payments. This additional revenue, which we have called residual funds, is a way for states to gain through the DSH program.

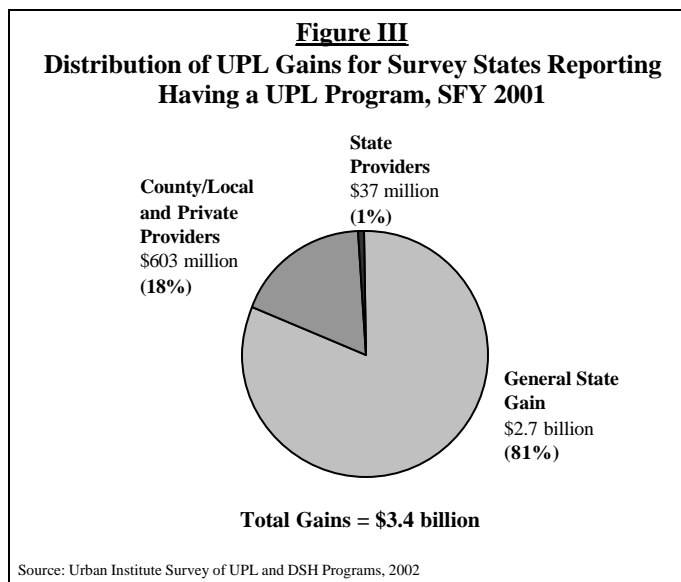
**Figure II**  
**Net DSH Gains by Hospital Ownership and DSH Residual Funds, SFY 1997 and 2001, a 27-State Comparison**



Medicaid UPL Payments

- During SFY 2001 or 2002, 23 of the 34 reporting states operated at least one UPL program. The number of programs within each state ranged from 1 to as many as 9 distinct programs.
- The 19 survey states with active UPL programs in SFY 2001 made a total of \$5.8 billion (federal and state) in UPL payments, with the level of DSH expenditures varying greatly across states. The states put up \$2.4 billion (42 percent) of this total and the federal government provided \$3.4 billion (58 percent) in matching funds.
- None of the survey states incurred a net expense to operate their UPL programs in 2001. Eight states financed some or all of the state share of UPL payments with IGTs from local governments, which accounted for nearly 60 percent of the state share across all survey states combined. The balance of the state share was financed either with state general funds (31 percent) or with certified public expenditures (CPEs) and transfers from state sources (10 percent). Every state that used state funds to support its UPL program(s) kept some or all of the federal matching funds or made payments to state facilities in order to recoup the initial outlays from state sources.
- More than 60 percent of UPL payments in SFY 2001 went to nursing homes, largely publicly owned facilities. Roughly 19 percent went to private or non-state government-owned hospitals for both inpatient and outpatient services. A small share (3 percent) went to state hospitals, primarily university hospitals. Another 15 percent of UPL funds were kept by states as residual funds; that is, several states took in more funding for UPL payments than they paid out and retained the additional funds to be used for other purposes.
- In contrast to the DSH program, we estimate that most of the gains available through UPL payments accrued to states in 2001. We estimate that 81 percent of gains from UPL

programs went to states as a general gains while only 19 percent of payments were provider gains (Figure III). The bulk of provider UPL gain went to non-state providers, primarily hospitals. So, although the majority of UPL payments go to nursing homes, most provider gains accrue to hospitals. This pattern occurs because states generally kept most or all of the federal matching funds for nursing home UPL programs, but such arrangements were less common for hospital UPL programs.



- Most states indicated that state gains from UPL programs in 2001 went to finance health care expenses. A few put gains into dedicated health care accounts, but most put the gains into the Medicaid general fund. Once in Medicaid, UPL gains could be “recycled” to finance the state share of other Medicaid payments, allowing the state to earn additional federal match—or a “match on match” payment. The survey could not determine whether these federal UPL dollars help to maintain or expand states’ commitments to Medicaid, or whether they simply provide general fiscal relief.

Impacts of DSH and UPL Payments on Medicaid Spending Patterns and on Federal Financing

- We used the survey data and Medicaid administrative data to assess how DSH and UPL payments affected Medicaid spending patterns and federal financing of the program among survey states in SFY 2001. We estimated that \$6.5 billion of DSH and UPL expenditures reported by the states do not represent real state outlays, as states used private or non-state government funds to support the programs or paid themselves back (using federal funds) for some or all of the state dollars that they initially used to finance the state share. This amount represents 5 percent of total reported Medicaid expenditures in these states.
- After reducing the reported state share of spending in each state to reflect real state outlays, we estimated that DSH and UPL programs resulted in effective federal Medicaid match rates in the survey states that were, on average, three percentage points higher in 2001 than they

would have been otherwise. Though this increase seems relatively small, it has considerable implications given the structure of the Federal Assistance Matching Percentage (FMAP) formula. By shifting the effective FMAP up three percentage points, we estimate that federal spending per dollar of state general revenue spent increased by an average of 13 percent as a result of how some states finance their share of UPL and DSH payments.

### Looking Beyond 2001

- Although our survey describes state UPL and DSH programs in 2001, many changes to these programs have occurred or will soon occur. These include:
  - How UPLs are determined;
  - Elimination of the 150 percent UPL for non-state public hospitals;
  - New state option to operate a 175 percent DSH program for public hospitals; and
  - Reductions in federal DSH allotments.

Most of these changes will limit states ability to draw down federal funds through DSH and UPL financing mechanisms over the long term, although the higher DSH limit for public hospitals could provide relief for some states.

### **Conclusions**

The Medicaid DSH program continues to evolve. Although the level of DSH spending and state financing has not substantially changed in recent years, the way that states distribute DSH funds shifted dramatically. Importantly, more of the available DSH gains are paid to hospitals. However, our data do not allow us to determine whether DSH payments simply substitute for state or local hospital funding or represent real new supplemental funding for hospitals.

Although the survey data suggest that more DSH gains are accruing to hospitals, several issues still persist in the DSH program. For example, states still retain a sizable share of the gains. Another lingering issue is that the distribution of DSH spending still varies considerably among states—accounting for less than 1 percent of state spending in some states to more than 10 percent in others—and is not based on need or a national formula but more on the willingness of a state to use the DSH program to leverage federal funds during the early 1990s, before federal policymakers started imposing program limits. Finally, the current survey data show that states often contribute little or no state funds to DSH, causing the federal government to pay for more than its share of Medicaid program expenditures.

We find that the DSH and UPL programs are alike in many ways. For example, the data reveal that states finance UPL enhancements incurring little to no state expense. Also, like DSH, the extent to which individual states engaged in UPL activity varied widely across states and does not appear to be tied to any single factor. Although DSH and UPL are a lot alike, an important difference between the two programs is that under DSH most of the gains accrue to providers whereas under UPL programs the bulk of the gains go to the state.

Without doubt, the DSH and UPL programs are going to go through yet more changes in the near term. Indeed, changes have already been implemented or are about to be implemented. While it is too early to determine how these new provisions will affect DSH and UPL, our results indicate that reforms are warranted so that programs become based on sound and defensible policies. Without implementing reforms, state and federal policymakers will continue to do battle over the DSH and UPL programs to the detriment of the spirit of federal-state cooperation on which Medicaid is based.

## INTRODUCTION

One of the most controversial issues in recent Medicaid policy debates has been state use of upper payment limit or UPL programs. Some members of the Bush administration have referred to UPL programs as “Medicaid scams” that have caused the federal government to pay more than its share of Medicaid expenditures. Both the Bush and Clinton administrations as well as some members of Congress have sought to limit states’ use of UPL payments, which were estimated to total more than \$11 billion (federal and state) in 2001 (Congressional Budget Office 2002). State and local officials as well as some provider industry groups, however, have fought this effort. States maintain that monies generated from UPL programs provide much needed financial support to health care safety net providers. Moreover, states argue that UPL funds have helped pay for rapidly rising Medicaid costs, and that they are especially valuable in the current tough fiscal climate.

The Medicaid hospital disproportionate share or DSH program has caused a similar tug-of-war between states and the federal government. Designed to provide financial help to safety net hospitals, the Medicaid DSH program sparked considerable debate between state and federal policymakers, prompting federal policymakers to pass legislation aimed at controlling the DSH program several times during 1990s. Total DSH payments were \$15.8 billion (federal and state) in 2001.<sup>1</sup> Like UPL payments, much of the debate surrounding the DSH program centered around states’ use of the DSH payment mechanism to draw down extra federal matching funds with limited or no state money involved. Though not as hotly debated in the last couple of years, controversy surrounding the DSH program will likely resurface soon: Barring a change in current federal law, 35 states are slated to lose about \$1 billion in federal DSH funds in fiscal year 2003 (Miller 2002).<sup>2</sup>

In this study we report findings from a 2002 survey of states’ UPL and DSH programs. Completed by 34 states, the survey focused on revenues and expenditures for both the DSH and UPL programs in state fiscal year (SFY) 2001. Despite the considerable controversy surrounding UPL programs, very limited information on the programs exist. Basic questions about UPL remain unanswered, such as the share of UPL funds that go to hospitals, nursing homes or other providers. It is also not known what share of UPL payments are being used to support Medicaid providers and what share are being diverted for other purposes. Though more is known about the

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<sup>1</sup> \$15.8 billion is the total DSH spending reported by all 50 states and the District of Columbia to the Centers for Medicare & Medicaid Services on Form CMS-64 for Federal Fiscal Year 2001.

<sup>2</sup> Briefly, among other DSH provisions, the Balanced Budget Act of 1997 (BBA) set out, on a state-by-state basis, federal DSH spending limits for fiscal years 1998 to 2002. After 2002, BBA permitted states to increase DSH spending at the rate of inflation as long as a state’s DSH spending did not exceed 12 percent of its total spending on Medicaid. However, the Medicaid, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) temporarily amended the BBA DSH limits for 2001 and 2002 and allowed states to increase their DSH spending in those two years. For 2001 and 2002 DSH limits were calculated from 2000 levels set out in BBA, indexed for the prior’s years consumer price index. (Like under BBA, BIPA limited a state’s DSH spending to 12 percent of its total spending on Medicaid.) For 2003, if current law prevails, states’ DSH will be based on the lower BBA DSH spending limits rather than the amended BIPA limits. This scheduled cutback in federal DSH funding is often referred to as the “DSH cliff.”

Medicaid DSH program, states design of their UPL programs are driven in part by the design of their DSH program and vice versa. Further, given the ongoing policy debate about federal DSH spending, recent information on states' DSH programs will be useful to policymakers.

The findings in this paper reflect states' DSH and UPL programs prior to actions taken by the federal government to significantly limit states' use of UPL mechanisms. With the passage of the 2001 Benefits Improvement and Protection Act (BIPA), the federal government changed how states calculate UPLs for hospitals, nursing homes, and other facilities. BIPA also set out various transition times for states to ensure that provider payments conformed to new federal regulations, which went into effect in March 2001 (U.S. Department of Health and Human Services, 2001).

Before we present the survey findings, we provide a brief background on DSH and UPL financing mechanisms and a description of our study methods.

## **BACKGROUND ON MEDICAID DSH AND UPL PROGRAMS**

### **Medicaid DSH Program**

Under Medicaid law, states are required to “take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs” when setting inpatient hospital payment rates. The rationale behind the special payments is that hospitals rendering high volumes of care to Medicaid recipients typically lost money because of historically low Medicaid reimbursement rates. They also lost money because these hospitals are often the same facilities that provide high volumes of care to indigent patients, causing them to have high levels of uncompensated care. In the early 1980s, Congress established the Medicaid DSH program to provide some financial relief to hospitals serving the poor. Another goal of the DSH program was to maintain hospital access for the poor: By helping to support hospitals that serve large numbers of the poor, it was hoped these hospitals could continue to operate, and access for the indigent would not deteriorate.

Like many other features of the Medicaid program, states are granted considerable freedom in designing their DSH programs. For example, they are given a great deal of latitude in determining which hospitals qualify for DSH payments. They also have substantial discretion in setting the level of DSH payments made to individual hospitals. At a minimum, though, federal law mandates that states have a DSH program and make payments to hospitals that have a Medicaid inpatient use rate of at least one standard deviation above the mean for the state, or a low-income inpatient use rate of 25 percent or more. However, states can go beyond the federal minimum criteria and make DSH payments to hospitals with Medicaid inpatient use rates as low as 1 percent. Because of this flexibility, state DSH programs vary greatly both in how DSH payments are rendered and the types of hospitals that receive payments.

DSH programs also vary because, beginning in the late 1980s, many states started to use novel financing mechanisms—such as provider taxes and donations and, later, intergovernmental

transfers (IGTs) and certified public expenditures (CPEs)—to help fund their programs. Under these mechanisms, revenues obtained from hospitals in the form of provider taxes and donations, IGTs, or CPEs were used as the state's share of its DSH payments. IGTs are fund exchanges between different levels of government and are a common feature in state finance. Under the DSH program, for example, a county-owned hospital may transfer funds to the state Medicaid agency to support the state share of the DSH payment. CPEs are certified by the contributing public agency as representing expenditures that they have incurred in rendering care to either Medicaid or uninsured patients, and are eligible for federal matching dollars through the DSH program. Thus, while CPEs are expenditures providers incur, they are also a revenue source for some states' shares of DSH spending.

The ability to leverage federal dollars prompted many states to establish large DSH programs that relied on creative financing in the early 1990s. Reflecting this trend, DSH payments rose from \$1.4 billion to \$17.5 billion between 1990 and 1992 and were a major reason for the rapid growth in overall Medicaid expenditures in early 1990s (Holahan et al. 1993; Coughlin and Liska 1997). By 1996, DSH payments accounted for 1 of every 11 dollars spent on Medicaid. The extent to which states used the DSH maximization strategy varied widely. In 1998, for example, DSH spending accounted for 22 percent of Louisiana's total Medicaid expenditures and nearly 20 percent in Missouri and South Carolina. By contrast, DSH accounted for less than 1 percent of many states' programs spending, including those in Arkansas, Nebraska and Wisconsin.

Importantly, some of DSH payments do not represent real additional dollars to help cover hospitals' uncompensated care costs, in part because IGTs, CPEs or state transfers are used to pay the state share of DSH payments. Although some of these may represent funds that are retained by providers and ultimately used to fund health care services, often only the federal share of the DSH payments represent new funds to providers. However, some states retain most of the federal share of DSH payments so that hospitals actually receive little, if any, additional Medicaid revenue under the DSH program. A 1997 survey revealed that only about 40 percent of DSH payments in that year went to help hospitals cover their costs of caring for Medicaid and uninsured individuals (Coughlin, Ku and Kim 2000). Thus, the bulk of DSH spending in 1997 was not going to cover safety net hospitals' uncompensated care costs, as was the original intent behind the special payments. The combination of many states not using real state funds for their share of DSH payments and federal DSH dollars were often not being kept by providers, made the DSH program a highly contentious issue between the states and the federal government, and, as mentioned earlier, Congress has enacted legislation on several occasions to restrict states' use of DSH programs.

### **Medicaid UPL Programs**

More recently states have developed UPL programs as a way to draw down extra federal matching dollars (Coughlin et al. 2000; Ku 2000; U.S. GAO 2000, 2001). These programs are essentially a variant of the DSH program: A state makes an additional Medicaid payment (that is,

payment that is over and above regular Medicaid reimbursement) to a targeted group of providers—such as nursing homes or hospitals—that are typically owned by a county or local government. (States generally use county and locally owned providers in UPL programs because IGTs or CPEs can be used to fund the state share.) The enhanced payments can be well in excess of the actual cost of medical services provided to Medicaid beneficiaries. The state claims federal Medicaid funds for the enhanced payments and then requires the providers to give back much or all of the enhanced payment to the state in the form of IGTs. Thus, similar to DSH financing, the state receives federal matching dollars without putting up any real state funds. Also like DSH, some states are not necessarily using the new infusion of federal funds made available through UPL to improve or expand health care services for Medicaid beneficiaries or to broaden health care services to the uninsured (Ku 2000). Indeed, to a very large extent, federal funds generate through these mechanisms become unaccountable once they reach the states and states can use the funds for a range of purposes, including non-health purposes.

Though Medicaid law grants states broad discretion in setting provider reimbursement levels, it does impose the Medicare upper payment limit which stipulates that Medicaid payments can be no higher than the amount that Medicare would have paid for the same service.<sup>3</sup> Importantly, whether Medicaid payments exceed the UPL is not determined by Medicare payment for a single procedure or even on payment for all Medicaid services an individual provider renders. Rather, the UPL is based on the *aggregate* amount that can be paid to an entire class of providers assuming that every provider in that class were paid the Medicare rate for all services it provided to Medicaid beneficiaries. Until 2001, when the federal government issued regulations establishing three classes of providers,<sup>4</sup> upper payment limits were determined for two classes of providers—state-owned and non-state-owned. The latter class included both local, publicly owned facilities and private providers.

Prior to the 2001 regulation, a state could thus determine its UPL for, say, nursing homes by calculating, on a statewide basis, the difference between its local Medicaid payments to all county-owned nursing homes and private nursing homes and what Medicare would have paid to these facilities. To use the UPL maximization strategy, the state would then pay this entire difference in supplemental Medicaid payments just to the publicly owned nursing homes. States were allowed to pay the full UPL difference to only the public nursing homes because, as noted in the preceding paragraph, public and private providers were in the same provider class for UPL determination purposes. Given that the Medicaid payment levels historically have been considerably lower than Medicare levels, the potential for gaining additional federal dollars through UPL arrangements was enormous.

While some states have had Medicaid supplemental payment programs for many years, the number of programs has grown dramatically in recent years (Ku 2000; U.S. GAO 2000, 2001).

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<sup>3</sup> The one important exception to the Medicare UPL rule is Medicaid DSH payments. This exception, passed in the 1980s, was done to encourage states to make DSH payments and to channel more funds to safety net hospitals.

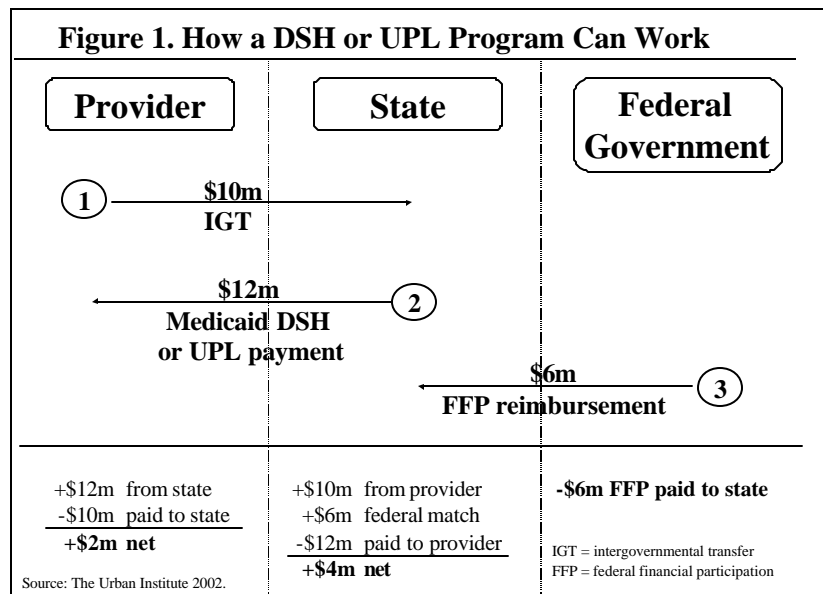
<sup>4</sup> In brief, the January 2001 UPL regulation separated local publicly owned facilities from private providers. So now one Medicare UPL is determined for non-state government-owned facilities, and another for private facilities.

Earlier surveys showed that in 1995 states spent \$313 million on supplemental payment programs; by 1998, states spent \$1.4 billion (Coughlin, Ku, and Kim 2000). Two years later, in 2000, 28 states had at least one UPL program and, nationwide, an estimated \$10 billion in Medicaid UPL expenditures were made (Mangano 2001).

### How A UPL or DSH Program Works

States can have multiple DSH programs and multiple UPL programs all working simultaneously. For example, some states will have a DSH program targeted to public hospitals and another targeted to private hospitals. Further, each will have distinct program features, such as funding levels, funding sources and payment distribution formulas. While programs are unique, they share many common features. Figure 1 provides a hypothetical schematic of a DSH or UPL program in which the state relies on funding from intergovernmental transfers (IGTs) for the state share. The schematic shows the links between program funding, the DSH or UPL payment, and federal funding:

- 1) **State Funding:** State receives funding. In this example, the state receives \$10 million from a non-state public provider in the form of an IGT.
- 2) **Medicaid Payment:** State then makes a DSH or UPL payment back to the provider as a lump sum payment or an increase in the Medicaid inpatient reimbursement rate. Here, the state makes a \$12 million payment to the same provider that made the IGT. At this point in the transaction, the provider has gained \$2 million while the state is “out” \$2 million.
- 3) **Federal Match Funds:** Since DSH and UPL payments are matchable Medicaid expenses, the federal government reimburses the state anywhere from 50 to almost 80 percent of the payment, depending upon the state’s federal Medicaid matching rate. In this example, the state’s matching rate is 50 percent, and the federal government reimburses the state half of the \$12 million, or \$6 million.



At the end of the transaction, the provider has received \$12 million in *gross* DSH or UPL payments with a net payment gain of \$2 million (\$12 million gross payment--\$10 million in IGT). The state has a net gain of \$4 million in federal money without having spent any of its own funds. The federal government has paid \$6 million in payments. However, only \$2 million was channeled to the provider; the balance was retained by the state. At this point, there are no restrictions on states as to how they use these new funds. For example, they could elect to use to the funds to finance future Medicaid expenses (discussed later). Alternatively, they could use the funds for purposes completely outside of health.

## STUDY METHODOLOGY

To gather information about DSH and UPL activity in the states, we developed and fielded a survey asking states for information about their Medicaid DSH and UPL programs for state fiscal years 2001 and 2002. The first two parts of the survey asked state officials to describe each DSH and UPL program in operation in the state and to complete summary tables showing the amounts of funding, expenditures, and net provider and state gain (if any) for each program. States were also given an opportunity to provide additional information about how they used possible gains from their DSH or UPL programs.

The survey went into the field in January 2002. A total of 34 states responded to the survey (Table 1). Together, responding states accounted for 71 percent of total (federal and state) national DSH expenditures in 2001. Though the precise level of UPL spending is not known, the Congressional Budget Office estimates that nationwide about \$11.6 billion in UPL payments were made in 2001 (CBO 2002). Thus our survey states accounted for about 65 percent of national UPL spending in that year.<sup>56</sup>

Five states (Illinois, Minnesota, New Mexico, New York and South Dakota) formally declined to respond. The states that declined to participate gave various reasons for their reluctance to participate. Some noted that they could not spare the staff time needed to answer the survey. Others expressed concern about providing detailed information about their DSH and UPL activities given the current level of federal scrutiny of these programs.

The responding states represent a cross-section of all states as far as their DSH spending as a share of total Medicaid spending. Some states had had high levels of DSH spending while other has lower levels. As shown in Table 1, which lists characteristics of responding states in the first panel and non-responding states in a second panel, responding states look broadly typical. Likewise, responding and non-responding states are alike in that both groups contain some states with UPL programs and some without. Further, the level of UPL spending is wide-ranging in non-responding states, just as it is among responding states (see Table 6 below).

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<sup>5</sup> In making this estimate we include California's supplemental payments made through its Selective Contracting Program. See footnote 3 to Table 1 for more details.

<sup>6</sup>UPL Program information on several of the non-reporting states (including Illinois and Pennsylvania) can be found in Mangano 2001).

Perhaps the biggest difference between reporting and non-reporting states is the size of their DSH programs: On average, administrative data from the Centers for Medicare and Medicaid Services (CMS) show that about 5.5 percent of Medicaid expenditures in non-reporting states was for DSH payments, whereas for reporting states the average was 7.6 percent.

As part of the study, we also conducted case studies using telephone interviews in three states to obtain more detailed information about their programs. In the case studies we spoke to state Medicaid officials and representatives from provider industry groups such as the state nursing home and hospital associations. The case study states were Connecticut, Florida and Louisiana. In choosing these states, we sought to get states with noticeable variations in their Medicaid UPL and DSH programs. Specific criteria we looked at in selecting states included, whether the state had a UPL program, whether the state was facing a DSH spending cliff, and the extent to which providers retained DSH and UPL funds. Observations from these studies appear throughout the text, and brief write-ups of case study findings can also be found in Appendix B.

## FINDINGS

All of the states that responded to the survey operate a DSH program except for Hawaii, where DSH payments are factored into its managed care payment rates. Consistent with past findings (Ku and Coughlin 1995; Coughlin et al 2000), the size of DSH programs varied greatly across the states as shown in the first column of Table 1. While on average DSH spending accounted for 7.6 percent of overall 2001 Medicaid spending, in some states (for example, Nebraska and Wisconsin) DSH accounted for less than 1 percent of spending whereas in other states (for example, Indiana, Louisiana and New Jersey) DSH accounted for more than 10 percent of overall Medicaid spending.<sup>7</sup>

Although we present most of our results in aggregate terms, this format understates the complex nature of states' DSH and UPL programs. Many states operate more than one DSH program. For example, Massachusetts reported having 10 active DSH programs during the study period and Washington reported having 9 programs. These programs often vary in both hospitals' qualifying criteria and the method used to calculate provider payments.

Twenty-three of the 34 reporting states also operated at least one UPL program during state fiscal year (SFY) 2001 or 2002 (Table 1).<sup>8</sup> The number of UPL programs within each state ranged from 1 to as many as 9 distinct programs in Florida. Between 2001 and 2002, the number of UPL programs in the states went from 41 in 2000 to 55 in 2001. This increase is due to more states initiating programs for the first time (e.g. Ohio) as well as states implementing more programs (e.g. Florida). As will be shown in later tables, the number of programs is not a good

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<sup>7</sup> While the survey asked about UPL and DSH programs in 2001 and 2002, our report focuses on 2001 as several states did not have final 2002 spending estimates at the time of our survey.

<sup>8</sup> California is counted among states without a UPL program. State officials maintain that the roughly \$1.3 billion California pays out through its 1915(b) Selective Contracting Waiver Program are not UPL payments but are supplemental payments. Despite this, however, federal regulators consider them UPL payments and new federal regulations phasing out UPL payments are slated to apply to California's payments (Federal Register 2001).

**Table 1 DSH and UPL Activity by Responding and Non-Responding States**

**Overview of DSH and UPL Activity for 34 Survey States, 2001 and 2002**

State	DSH as a Share of Total Medicaid Expenditures, FFY 2001 <sup>1</sup>	UPL as a Share of Total Medicaid Expenditures, FFY 2001 <sup>2</sup>	UPL Activity			
			SFY 2001		SFY 2002	
			Number of Active UPL Programs	Types of Active UPL Programs <sup>3</sup>	Number of Active UPL Programs	Types of Active UPL Programs <sup>3</sup>
Total	7.6%	4.4%	41	-	55	-
Alabama	12.3	7.0	3	NF, INPT, OUTPT	3	NF, INPT, OUTPT
Alaska	2.2	7.0	1	INPT	1	INPT
California <sup>4</sup>	7.5	n/a	-	-	-	-
Connecticut	8.9	n/a	-	-	-	-
District of Columbia	5.5	n/a	-	-	-	-
Florida	3.7	1.7	1	INPT	9	INPT
Georgia	7.9	7.5	1	INPT	1	INPT
Hawaii <sup>5</sup>	n/a	n/a	-	-	-	-
Idaho	1.3	n/a	-	-	-	-
Indiana	16.9	3.3	3	NF, INPT, OUTPT	3	NF, INPT, OUTPT
Iowa	0.8	17.7	1	NF	1	NF
Kansas	2.6	11.7	1	NF	1	NF
Kentucky	5.6	1.1	6	NF, INPT, OUTPT	7	NH, INPT, OUTPT
Louisiana	20.2	11.0	1	NF	3	NF, INPT, OUTPT
Maryland	1.8	n/a	-	-	-	-
Massachusetts <sup>6</sup>	6.6	*	1	INPT	1	INPT
Michigan	5.5	15.1	2	NF, OUTPT	2	NF, OUTPT
Mississippi <sup>6</sup>	7.1	*	1	INPT	1	INPT
Missouri	9.2	7.3	2	NF, INPT	2	NF, INPT
Nebraska	0.1	7.6	2	NF	2	NF
New Jersey	15.2	13.9	3	NF, INPT, OUTPT	3	NF, INPT, OUTPT
North Dakota	0.2	6.0	1	NF	1	NF
Ohio	7.2	n/a	-	-	1	INPT
Oklahoma	1.1	2.7	1	INPT	1	INPT
Oregon	1.0	6.3	3	NF, INPT	3	NF, INPT
South Carolina <sup>7</sup>	12.0	n/a	-	-	-	-
Texas	10.1	n/a	-	-	3	INPT, OUTPT
Utah	0.4	n/a	-	-	-	-
Vermont	4.1	n/a	-	-	-	-
Virginia	7.3	n/a	-	-	1	NF
Washington	6.9	11.8	1	NF	1	NF
West Virginia	5.7	n/a	-	-	-	-
Wisconsin	0.3	17.9	6	NF, INPT, OUTPT	4	NF, INPT, OUTPT
Wyoming	0.1	n/a	-	-	-	-

(continued on next page)

measure of the relative size and scope of states' utilization of UPL. All of the UPL programs consist of supplemental payments to nursing facilities or inpatient hospitals (sometimes for both inpatient and outpatient services).

We did not observe any clear pattern to a state's UPL activity. To some extent, the states in our survey reporting that they do not operate a UPL program tended to be small states (e.g. Idaho, Utah, Vermont, Wyoming) that did not aggressively pursue building up a large DSH program, either. At the same time several small states with limited DSH program actively pursued UPL, such as Alaska and North Dakota. Further, some states—such as Connecticut and South Carolina—that have large DSH programs do not have UPL programs. Officials from

**Table 1 DSH and UPL Activity by Responding and Non-Responding States (cont.)**

**Overview of DSH and UPL Activity for Non-Responding States, circa 2000-2001**

Non-Survey State	DSH as a Share of Total Medicaid Expenditures, FFY 2001 <sup>1</sup>	UPL as a Share of Total Medicaid Expenditures, SFY 2001 <sup>2</sup>	UPL Activity, FFY 2000 <sup>8</sup>		
			Number of Active UPL Programs	Types of Active UPL Programs <sup>3</sup>	Annual Payments (millions of dollars)
Total	5.5%	5.6%	12		\$4,448.6
Arizona	3.6	n/a	-	-	-
Arkansas	1.2	3.2	1	HOSP	\$55.9
Colorado	8.3	n/a	-	-	-
Delaware	0.7	n/a	-	-	-
Illinois	4.5	14.5	1	HOSP	\$1,139.0
Maine	3.5	n/a	-	-	-
Minnesota	1.6	0.3	1	NF	\$9.3
Montana	0.0	0.2	1	HOSP	\$1.0
Nevada	10.7	n/a	-	-	-
New Hampshire	17.2	3.2	1	NF	\$28.4
New Mexico	0.6	3.0	2	HOSP	\$42.7
New York	7.2	3.2	1	NF	\$991.5
North Carolina	6.8	3.8	1	HOSP	\$239.3
Pennsylvania	5.5	13.9	1	NF	\$1,521.0
Rhode Island	6.4	n/a	-	-	-
South Dakota	0.2	6.4	1	NF	\$29.8
Tennessee <sup>5</sup>	0.0	6.8	1	NF	\$390.7

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

1) "FFY" stands for federal fiscal year. Based on Medicaid Financial Management Reports for FFY 2001 from the Centers for Medicare & Medicaid Services.

2) "SFY" stands for state fiscal year. Based on survey information from reporting states, data from Mangano (2000), and Medicaid Financial Management Reports for FFY 2001 from the Centers for Medicare & Medicaid Services.

3) NF = nursing facility, INPT = inpatient hospital, OUTPT = outpatient hospital, HOSP = inpatient or outpatient hospital.

4) California reported no UPL programs for both survey years. Officials claim that the approximately \$1.3 billion in supplemental Medicaid payments the state made in SFY 2001 through its Selective Contracting Program 1915(b) waiver are not UPL payments.

5) Hawaii and Tennessee do not have DSH programs because DSH payments are factored into the managed care capitation payments for both states' Section 1115 research and demonstration waiver programs.

6) UPL expenditure data were not available for Massachusetts or Mississippi for SFY 2001.

7) South Carolina reported no UPL programs for both survey years. Officials claim that the \$55 million in supplemental Medicaid payments the state made in SFY 2001 through its High Volume Medicaid Adjustor (HVA) program are not UPL payments.

8) From Mangano, 2000. Annual payment amounts shown in this table include both federal matching funds and the state share required to draw down these funds.

Connecticut, one of our case study states, cited several reasons for their lack of UPL activity, the most important being that Connecticut has very little county government and thus does not have the appropriate infrastructure (e.g. county-owned hospitals or nursing homes) to fund and operate a UPL program. Other states may have had similar constraints in establishing UPL programs.

California and South Carolina reported having no UPL programs and are listed as such in Table 1. While these states make targeted supplemental payments to providers, officials maintain that these were not UPL payments. For example, for more than a decade California has made supplemental payments to selected hospitals through its Selective Contracting Program waiver. In 2001, California issued more than \$1 billion in hospital supplemental payments through the waiver program. While our analysis does not include California and South Carolina's supplemental payments program as UPL programs, federal regulators do and the states will need

to make adjustments to these programs to be in compliance with the new UPL regulations (Mangano 2001; Federal Register 2001).

### **DSH Funding Sources in Reporting States**

We asked states to tell us what sources they use to fund the state share of their DSH program(s). Table 2 presents DSH funding amounts from the survey states.<sup>9</sup> We classify DSH funding into three major categories: private/local, state, and federal. Private and local funds include funding from provider taxes as well as IGTs and CPEs from local or county-owned sources. State funds include state general funds and other state appropriations, transfers from other state sources outside of the agency operating the Medicaid DSH program, and CPEs from state-owned facilities. Although presented separately, all of the state funds could be viewed as coming from a single original source—state appropriations.

We estimated the amount of federal funds for each state by applying each state’s federal medical assistance percentage (FMAP) for federal fiscal year 2001 to the total amount of DSH payments reported in our survey. In some cases, states collected more funds than necessary to account for the state share of DSH payments. We assumed the state kept this additional revenue and refer to it here as “residual funds” (see Table 4). The federal funding amounts shown in Table 2 do not include any matching funds on these residual funds—they only include federal funds that are received based on the reported DSH payment amounts.

Most of the states responding to our survey use some state funds to finance the state share of their DSH programs. In 2001, 15 states used state funds for their entire state share of DSH payments, including Connecticut, Iowa, Maryland and Virginia. Sixteen other states used a combination of state and local or private revenue sources for their DSH programs in 2001, for example Louisiana, New Jersey and South Carolina. Only two states (California and Missouri) relied solely on non-state (local or private) funds to support their DSH programs.

Unlike most Medicaid payments—for which states generally use state general funds--we found that states finance their share of DSH payments using several sources. By far, the largest source was IGTs or CPEs from county and local entities. Taken together, IGTs/CPEs totaled \$2.3 billion or about 45 percent of state DSH funding among the survey states. At \$1.3 billion, state general funds accounted for 25 percent of the DSH state share while fund transfers from state sources accounted for 20 percent and provider taxes 11 percent. Federal matching funds totaled \$6.3 billion.

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<sup>9</sup> Information from Kansas on state DSH funding was insufficient to include in this report.

**Table 2**

**Funding Sources for Medicaid DSH Program for 34 Survey States, SFY 2001**

State	Total Funds	State Share (millions of \$)					Federal Share
		Total State Share	Private and Local Funds		State Funds		(millions of \$)
			Provider Taxes	IGTs & CPEs	Transfers & CPEs	General Fund & Appropriations	Medicaid Match <sup>1</sup>
Total	\$11,446.8	\$5,209.1	\$567.2	\$2,296.2	\$1,068.9	\$1,276.9	\$6,237.6
Alabama	367.0	110.0	-	99.0	11.0	-	257.0
Alaska	7.8	3.0	-	-	-	3.0	4.8
California	1,991.3	970.7	-	970.7	-	-	1,020.6
Connecticut	320.1	160.0	-	-	-	160.0	160.0
District of Columbia	45.7	13.7	-	-	-	13.7	32.0
Florida	361.4	157.5	-	79.3	66.8	11.4	203.9
Georgia	418.0	169.0	-	139.0	25.0	5.0	249.0
Hawaii <sup>2</sup>	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Idaho	1.4	0.4	-	-	-	0.4	1.0
Indiana	299.0	113.5	-	50.2	0.7	62.6	185.5
Iowa	13.6	5.1	-	-	2.5	2.6	8.6
Kansas			<DSH information missing from survey>				
Kentucky	191.1	57.3	-	-	21.2	36.1	133.8
Louisiana	870.2	256.4	-	26.4	-	230.0	613.8
Maryland	80.9	40.4	-	-	-	40.4	40.4
Massachusetts	727.9	485.2	243.5	12.0	162.8	66.9	242.6
Michigan	435.3	190.8	-	20.5	95.7	74.6	244.5
Mississippi	268.1	128.7	-	84.4	44.3	-	139.4
Missouri	459.9	179.8	99.3	80.5	-	-	280.1
Nebraska	10.2	4.1	-	-	0.7	3.4	6.1
New Jersey	1,464.0	887.0	-	195.0	350.0	342.0	577.0
North Dakota	1.0	0.3	-	-	-	0.3	0.7
Ohio	618.7	255.7	217.7	-	38.0	-	363.0
Oklahoma	23.3	6.7	-	-	-	6.7	16.6
Oregon <sup>3</sup>	14.4	5.7	-	2.7	-	3.0	8.6
South Carolina	372.0	110.0	-	69.4	40.6	-	262.0
Texas	1,369.0	539.0	-	355.0	184.0	-	830.0
Utah	3.8	1.1	-	-	-	1.1	2.7
Vermont	24.5	9.3	-	-	-	9.3	15.2
Virginia	187.9	90.7	-	-	-	90.7	97.2
Washington	409.3	233.4	-	112.0	25.6	95.8	175.9
West Virginia <sup>4</sup>	78.8	19.9	6.6	-	-	13.2	58.9
Wisconsin	11.2	4.6	-	-	-	4.6	6.6
Wyoming	0.1	0.1	-	-	-	0.1	0.1

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

1) Medicaid match funds were estimated based on each state's FMAP for FFY 2001 and the amount of total DSH payments that each state reported on the survey. The estimates shown do not include federal match on state revenue in excess of the amount needed to draw down the amount of federal funds based on total payments.

2) Hawaii does not have a DSH program because DSH payments are factored into the managed care capitation payments for participants in QUEST, the state's Section 1115 research and demonstration waiver program.

3) 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.

4) West Virginia's survey described the sources of funding for the state's DSH program, but did not allocate funding among these sources. Revenue amounts in this table are divided equally among the sources given.

## DSH Payments in Reporting States

In the first column of Table 3, we list states' total DSH payments. The top line shows that the survey states (excluding Kansas) made a total of \$10.7 billion in DSH payments in 2001.<sup>10</sup> The remaining columns in Table 3 show how states distributed their DSH payments by type of hospital (acute care or mental) and by ownership status (private, local or county, and state). States generally made DSH payments to more than one type of provider. Acute care hospitals received most (82 percent) of the \$10.7 billion in DSH payments, about \$8.8 billion.

Most states made payments to all three types of acute care hospitals. All reporting states but Georgia made some payments to private acute care hospitals. All but 12 reporting states made payments to local and county-owned acute care hospitals and two of these states, Maryland and North Dakota, do not appear to have any non-state public facilities. Fourteen states did not make any payments to state-owned acute care hospitals, but again, some of these states may not have any state-owned acute care hospitals.

Mental hospitals received 18 percent of DSH payments in the survey states in 2001. All but five states—Georgia, Idaho, Iowa, Vermont and Wyoming—reported payments to such hospitals. State-owned mental hospitals received nearly all of the DSH payments made to this type of provider.

In terms of hospital ownership, local and county-owned hospitals (acute care and mental combined) received the most DSH payments in 2001, \$3.8 billion or about 35 percent of overall payments. Private hospitals were close behind, receiving \$3.6 billion, roughly 34 percent of overall payments. State-owned hospitals accounted for \$3.3 billion, or about 30 percent, of the total. In some cases, state acute care hospitals receive most of the DSH payments. These are often state university hospitals, for example in Louisiana and Virginia. In other cases, such as in Indiana and Michigan, state-owned mental hospitals receive a large share of overall DSH payments.

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<sup>10</sup> The \$10.7 billion figure is \$700 million less than the states received in DSH revenue (Table 2). As discussed above these are what we have called residual funds; that is, states did not always pay out in DSH payments all that they took in as revenues.

Table 3

## DSH Payments by Type of Hospital and Ownership Status for 34 Survey States, SFY 2001

State	Total DSH Payments	DSH Payments (millions of dollars)					
		Acute Hospitals			Mental Hospitals		
		Private	Public, Non-State	Public, State	Private	Public, Non-State	Public, State
Total	\$10,745.1	\$3,630.7	\$3,707.7	\$1,466.5	\$6.1	\$110.8	\$1,823.4
% of Total		33.8%	34.5%	13.6%	0.1%	1.0%	17.0%
Alabama <sup>1</sup>	367.0	149.9	181.1	33.0	-	-	3.0
Alaska	7.8	-	-	-	-	-	7.8
California	1,991.3	486.5	1,503.8	-	-	1.0	-
Connecticut	320.1	232.4	-	-	-	-	87.6
District of Columbia	45.7	36.0	-	7.6	-	-	2.1
Florida	361.4	94.6	112.8	4.3	-	-	149.7
Georgia	418.0	-	367.0	51.0	-	-	-
Hawaii <sup>2</sup>	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Idaho	1.4	0.8	0.6	-	-	-	-
Indiana	299.0	63.2	116.2	-	2.0	-	117.6
Iowa	13.6	1.1	0.7	11.9	-	-	-
Kansas		<DSH information missing from survey>					
Kentucky	191.1	83.9	-	70.7	2.7	-	33.8
Louisiana	870.2	13.4	87.0	692.2	0.2	-	77.4
Maryland	80.9	40.2	-	0.2	-	-	40.4
Massachusetts	485.3	282.5	64.3	35.6	-	-	103.0
Michigan	435.3	141.7	74.7	-	-	0.6	218.3
Mississippi	181.4	2.6	117.3	52.8	-	-	8.7
Missouri	459.9	281.9	-	-	-	-	178.0
Nebraska	10.2	8.4	-	-	0.1	-	1.7
New Jersey	1,154.0	699.0	93.0	-	-	102.0	260.0
North Dakota	1.0	0.3	-	-	-	-	0.7
Ohio	618.7	452.6	56.1	18.2	-	-	91.9
Oklahoma <sup>3</sup>	23.3	1.0	0.0	19.3	-	-	3.0
Oregon <sup>4</sup>	14.4	7.5	-	-	-	6.9	-
South Carolina	372.0	105.5	162.2	53.0	-	-	51.3
Texas	1,369.0	298.0	605.0	211.0	-	-	255.0
Utah	3.8	1.4	-	1.6	-	-	0.7
Vermont	24.5	24.5	-	-	-	-	-
Virginia	187.9	16.9	0.5	168.4	0.4	-	1.7
Washington	346.9	43.7	161.3	31.3	0.6	-	110.0
West Virginia	78.8	52.7	4.2	4.5	-	-	17.4
Wisconsin	11.2	8.3	-	-	0.1	0.3	2.5
Wyoming	0.1	0.1	< 0.1	-	-	-	-

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

- 1) Payments to private and local/county public acute care hospitals in Alabama are distributed through the state's Partnership Hospital Program. The state did not provide a distribution by type of hospital or ownership status. Amounts shown for these hospital types are estimated based on previous survey results published in Coughlin, Ku and Kim, 2000.
- 2) Hawaii does not have a DSH program because DSH payments are factored into the managed care capitation payments for participants in QUEST, the state's Section 1115 research and demonstration waiver program.
- 3) Payments 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.
- 4) 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.

## Net Gains from the DSH Program in Reporting States

Owing to the financing arrangements (for example, IGTs and fund transfers), some of the DSH payments a provider receives may not represent new funds to be used to help pay for care provided to Medicaid and uninsured patients. For example, some of a provider's DSH payments may be a "payback" for the IGT it provided for the state share of the DSH payment. In this section, we try to account for such financing policies and estimate net gains, both for the state and providers.

States can achieve gains through DSH in two ways—through hospitals or state residual funds. To calculate hospital gains, we divided hospitals (both acute care and mental) by ownership status into two groups: state and non-state (private and local/county-owned). To calculate hospitals' net gains, we assumed that hospitals, county or local governments and the state get "paid back" most (if not all) of the funds that they may have contributed for the state share. For example, assume that a county hospital transferred \$100 million in IGTs to support the DSH program. The state then made a \$120 million DSH payment to this hospital. The net gain for that hospital would be listed as \$20 million (\$120 million minus \$100 million IGT) in the second column of Table 4. By making this assumption, we infer that whatever funds (taxes, IGTs, CPEs, or state transfers) that providers or other entities submit to the state for DSH will be paid back to the contributor and do not represent new funds available to hospitals. For the aggregate sectors presented here (private, non-state, state) this assumption is sound. At the individual hospital level, however, there may be "winners" and "losers" under the DSH program, especially if provider taxes are the funding source.

In the example from the preceding paragraph, the state gains at least \$40 million: Assuming the state had an FMAP of 50 percent (the lowest match possible), the state would receive \$60 million in federal funds as a result of making the \$120 million payment to the hospital. Of this \$60 million, \$20 million went to the county hospital and \$40 million was retained by the state.<sup>11</sup> We call money retained by the state a "state gain." The level and distribution of state gains among the survey states is shown in the third column of Table 4.

Some states expend more state funds for DSH payments than they pay out to state owned providers as DSH payments or recover through federal matching funds. In those cases, such as in Connecticut and Vermont, the state will show a negative gain—i.e., a loss—in the third column of Table 4. Other states may have a loss from their DSH transactions but recover some or all of this loss by taking in extra funding initially. For example, New Jersey and Massachusetts take in more revenue from private, local and state sources than they need for the state share of their total DSH payments. These residual amounts, listed in the fourth column of Table 4, are counted as an additional gain to the state. The total gain to the state is the sum of both the gains/losses to state entities through DSH payments and any state gains from residual funds.

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<sup>11</sup> In actuality, the state would need to put up \$20 million of its own funds to make DSH payment to the county hospital in this example, so the full \$60 million of federal funds would be kept by the state. The state uses \$20 million to recover its share of the payment to the hospital, and the remaining \$40 million represents its net gain.

Table 4

Net DSH Gains by Hospital Ownership<sup>1</sup> and DSH Residual Funds for 34 Survey States, SFY 200

State	Total Gains	Net DSH Gains (millions of dollars)			Net Gain or Loss to State	Percent of DSH Gains to State <sup>3</sup>
		Gains to Private or Non-State Public Entities from DSH Payments	Gains/Losses to State Entities from DSH Payments	General Gains to State from Residual Funds <sup>2</sup>		
Total	\$6,237.7	\$4,592.0	\$944.1	\$701.7	\$1,645.8	26%
Alabama	257.0	232.0	25.0	-	25.0	10%
Alaska	4.8	-	4.8	-	4.8	100%
California	1,020.6	1,020.6	-	-	-	0%
Connecticut	160.0	232.4	(72.4)	-	(72.4)	-45%
District of Columbia	32.0	36.0	(4.0)	-	(4.0)	-13%
Florida	203.9	128.1	75.8	-	75.8	37%
Georgia	249.0	228.0	21.0	-	21.0	8%
Hawaii <sup>4</sup>	n/a	n/a	n/a	n/a	n/a	n/a
Idaho	1.0	1.4	(0.4)	-	(0.4)	-43%
Indiana	185.5	131.2	54.3	-	54.3	29%
Iowa	8.6	1.8	6.8	-	6.8	79%
Kansas		<DSH information missing from survey>				
Kentucky	133.8	86.6	47.2	-	47.2	35%
Louisiana	613.8	74.2	539.6	-	539.6	88%
Maryland	40.4	40.2	0.2	-	0.2	0%
Massachusetts	242.7	91.2	(91.2)	242.6	151.5	62%
Michigan	244.5	196.5	48.0	-	48.0	20%
Mississippi	139.4	35.5	17.2	86.7	103.9	75%
Missouri	280.1	102.1	178.0	-	178.0	64%
Nebraska	6.1	8.5	(2.4)	-	(2.4)	-39%
New Jersey	577.0	699.0	(432.0)	310.0	(122.0)	-21%
North Dakota	0.7	0.3	0.4	-	0.4	52%
Ohio	363.0	290.9	72.1	-	72.1	20%
Oklahoma <sup>5</sup>	16.6	1.0	15.6	-	15.6	94%
Oregon <sup>6</sup>	8.6	11.6	(3.0)	-	(3.0)	-35%
South Carolina	262.0	198.3	63.7	-	63.7	24%
Texas	830.0	548.0	282.0	-	282.0	34%
Utah	2.7	1.4	1.3	-	1.3	49%
Vermont	15.2	24.5	(9.3)	-	(9.3)	-61%
Virginia	97.2	17.8	79.4	-	79.4	82%
Washington	176.0	93.7	19.9	62.4	82.3	47%
West Virginia	58.9	50.3	8.7	-	8.7	15%
Wisconsin	6.6	8.7	(2.1)	-	(2.1)	-32%
Wyoming	0.1	0.1	(0.1)	-	(0.1)	-56%

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

- 1) DSH payments to both acute care and mental hospitals are combined for each ownership type shown.
- 2) 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, we cut back the level of funding reported from each source (e.g., 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.
- 3) These percentages represent the share of total gains from DSH, including residual funds, that are kept by state entities.
- 4) Hawaii does not have a DSH program because DSH payments are factored into the managed care capitation payments for participants in QUEST, the state's Section 1115 research and demonstration waiver program.
- 5) 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.
- 6) 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.

We estimate that, collectively, hospitals in the survey states and the states themselves gained about \$6.2 billion through the DSH program in 2001. Non-state public hospitals netted almost \$4.6 billion, or 74 percent of the total estimated available gains under DSH. States (including both state-owned facilities and state governments) gained \$944 million from DSH transactions, which includes losses of \$617 million among 10 states. Massachusetts, Mississippi, New Jersey and Washington gained a total of \$702 million from residual funds. Overall, the states net roughly \$1.6 billion, or 26 percent of total gains.

The last column of Table 4 presents total state gains/losses—either through DSH payments to state-owned facilities or residual funds—as a percent of total DSH gains to the state. This statistic varied considerably among states. Some states, such as Alaska, Iowa, Louisiana, Mississippi, Oklahoma and Virginia, kept at least 75 percent of the gains. By contrast, nine states (Connecticut, Idaho, Nebraska, New Jersey, Oregon, Vermont, Wisconsin, Wyoming, and the District of Columbia) paid more in state funds to support their DSH programs than they recovered.

### **Comparison of the Medicaid DSH Program in 1997 and 2001**

Throughout the 1990s, federal policymakers have sought to reform the DSH program. To get a sense of how the program has changed over time, we compare our 2001 survey results to those from a 1997 survey (Coughlin et al. 2000). Twenty-seven states responded to both surveys; only data from these states are reported in Table 5.<sup>12</sup> The top panel lists revenue sources in each of the two years. As shown, the level of funding collected by the 27 states was about the same in both years. Further, the distribution across funding sources did not substantially shift. The biggest change was a drop in provider tax revenue. In 1997, 9 percent of DSH revenues came from provider taxes; by 2001, only 5 percent came from taxes. Correspondingly, states became more reliant on county and local funds and on federal funds.

The second panel of table 5 gives an account of DSH spending in the two survey years. The 27 states spent \$11.1 billion in 1997 and \$10.6 billion in 2001, accounting for 63 percent of national DSH expenditures in 1993 and 68 percent in 2001. While the level of DSH spending remained roughly the same, how states distributed funds changed dramatically over the four-year period. Most notable is the increase in the gains to private and county/local hospitals: In 1997 these hospitals gained an estimated \$3 billion from the DSH program; by 2001, their gains were estimated at \$4.1 billion. As private and locally owned facilities gains increased, state gains declined: Both a drop in state hospital gain (\$1.6 billion in 1997 to about \$1 billion in 2001) and states' residual funds (\$1.2 billion in 1997 to \$0.7 billion in 2001) was observed.

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<sup>12</sup> For each of the survey years, the distribution of funding sources and expenditures were not significantly different between the full set of reporting states and the 27-state subset.

**Table 5****DSH Funding, Payback and Gains, SFY 1997 and 2001, a 27 State Comparison**

<b>Funding</b>	<b>Millions of Dollars</b>		<b>Percent of Total</b>	
	1997	2001	1997	2000
Total	\$11,110.3	\$10,577.9	100%	100%
State Share	5,308.7	4,825.1	47.8	45.6
Provider Taxes	966.2	560.6	8.7	5.3
County/Local Funds	2,230.3	2,275.7	20.1	21.5
State Funds	2,112.2	1,988.9	19.0	18.8
Federal Share				
Matching Payments	5,801.6	5,752.8	52.2	54.4
<b>Expenditures</b>				
Total	\$11,110.3	\$10,577.9	100%	100%
Payback to County/Local/Private Sources	3,196.5	2,836.2	28.8	26.8
County/Local/Private Hospital Gain	3,041.1	4,079.8	27.4	38.6
Payback to State	2,112.2	1,988.9	19.0	18.8
State Hospital Gain	1,592.2	971.5	14.3	9.2
Residual Funds for State Use	1,168.3	701.5	10.5	6.6

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

## UPL Funding Sources in Reporting States

We asked states to tell us what funding sources they use to generate the state share for their UPL programs. Table 6 shows reported funding for each UPL program in the 20 survey states reporting having an operational UPL programs in 2001. As with DSH, we classify UPL funding into three two major categories: the state share and the federal share. The state share includes local and county funds such as IGTs and CPEs. None of the reporting states used revenues from private sources—for example, provider taxes—for their UPL programs in 2001. The state share also includes state general funds and other state appropriations, transfers from other state sources outside of the agency operating the Medicaid program, and CPEs from state-owned facilities. Federal funds are Medicaid matching funds. We estimated the amount of federal funds for each state by applying each state’s FMAP for federal fiscal year 2001 to the total amount of UPL payments reported by the states in the survey.

Most of the state share of UPL payments came from local funds (Table 6). In 2001, states used nearly \$2 billion in IGTs and CPEs from private and non-state government sources to fund their share of UPL payments. State general funds accounted for an additional \$1.1 billion of the state share, while transfers and CPEs from state sources accounted for \$364 million. The federal share of UPL payments was \$3.4 billion, or about 49 percent of total UPL funding. Federal funds accounts for less than half of the UPL funding because several states (for example, Georgia, Missouri, and New Jersey) take in more funds than they need to make their UPL payments. As with the DSH program, we consider these extra funds to be residual funds, which are retained by states for other uses.<sup>13</sup>

## Distribution of UPL Payments

As shown in Table 7, the bulk of total UPL payments provided by survey states (\$3.8 billion out of \$5.8 billion, or 63 percent) went to nursing homes, which were almost exclusively county-owned facilities. Another \$1.8 billion (31 percent) went to private or county and locally owned hospitals for both inpatient and outpatient services. A small share (\$170 million, about 3 percent) went to state hospitals, which were primarily university hospitals. The total amount of payments shown in Table 7 is lower than the total amount of UPL funding collected by states shown in Table 6 because some states take in more revenues to support their UPL programs than they send out as payments to providers.

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<sup>13</sup> As in our treatment residual funds under DSH, no federal match is applied to residual funds.

Table 6

**Sources of Revenue for Medicaid UPL Programs for the Survey States Reporting Having a UPL Program in SFY 2001<sup>1</sup>**

State	Program Type	Total Funding	State Share (millions of \$)				Federal Share (millions of \$)
			Total State Share	Private and Local Funds IGTs & CPEs	Transfers & CPEs	State Funds General Fund & Appropriations	Medicaid Match <sup>2</sup>
Total		\$6,806.8	\$3,446.8	\$1,975.5	\$364.3	\$1,107.0	\$3,360.1
Alabama	NF	32.0	10.0	10.0	-	-	22.0
	INPT	138.0	41.0	16.0	25.0	-	97.0
	OUTPT	32.0	10.0	8.0	2.0	-	22.0
Alaska	OUTPT	39.0	15.5	-	-	15.5	23.5
Florida	INPT	144.3	62.6	62.6	-	-	81.7
Georgia <sup>3</sup>	INPT (A)	474.0	297.0	268.0	29.0	-	177.0
	INPT (B)	56.0	23.0	-	-	23.0	33.0
Indiana	INPT/OUTPT	92.4	35.1	35.1	-	-	57.3
	INPT/OUTPT	10.2	3.9	3.9	-	-	6.3
	NF	13.8	5.2	5.2	-	-	8.6
Iowa	NF	313.8	116.9	-	-	116.9	196.9
Kansas	NF	201.1	80.7	-	-	80.7	120.4
Kentucky <sup>4</sup>	INPT	34.0	10.2	-	10.2	-	23.9
	INPT	0.7	0.2	-	-	0.2	0.5
	INPT	*	*	*	*	*	*
	NF	*	*	*	*	*	*
	INPT/OUTPT	*	*	*	*	*	*
	INPT	*	*	*	*	*	*
Louisiana	NF	437.8	129.0	-	-	129.0	308.8
Massachusetts			<UPL information missing from survey>				
Michigan	OUTPT	350.0	153.4	-	-	153.4	196.6
	NF	738.0	323.0	-	-	323.0	415.0
Mississippi <sup>4</sup>	INPT	*	*	*	*	*	*
Missouri <sup>3</sup>	INPT	60.2	37.4	37.4	-	-	22.8
	NF (A)	236.1	92.1	-	-	92.1	144.0
	NF (B)	60.0	23.4	-	-	23.4	36.6
Nebraska	NF	2.3	0.9	0.9	-	-	1.4
	NF	86.2	34.1	-	-	34.1	52.1
New Jersey	NF	1,335.0	890.0	890.0	-	-	445.0
	INPT/OUTPT	52.0	26.0	-	-	26.0	26.0
	INPT/OUTPT	58.0	29.0	-	29.0	-	29.0
North Dakota	NF	24.7	7.3	-	-	7.3	17.4
Oklahoma	INPT	50.9	14.7	-	14.7	-	36.2
Oregon	INPT	27.1	11.1	-	-	11.1	16.0
	INPT	19.4	7.9	-	-	7.9	11.5
	NF	98.2	39.3	-	-	39.3	58.9
Washington	INPT/OUTPT	510.4	253.3	-	253.3	-	257.1
Wisconsin <sup>5</sup>	NF	1,013.9	637.0	637.0	-	-	376.9
	INPT/OUTPT	16.1	6.6	1.4	1.1	4.1	9.5
	INPT/OUTPT	4.8	1.9	-	-	1.9	2.9
	INPT	2.0	0.8	-	-	0.8	1.2
	OUTPT	2.4	1.0	-	-	1.0	1.4
	NF	40.1	16.4	-	-	16.4	23.7

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

1) California reported no UPL programs for both survey years. Officials claim that the approximately \$1.3 billion in supplemental Medicaid payments the state made in SFY 2001 through its Selective Contracting Program 1915(b) waiver are not UPL payments. Likewise, South Carolina reported no UPL programs for both survey years. Officials claim that the \$55 million in supplemental Medicaid payments the state made in SFY 2001 through its High Volume Medicaid Adjustor (HVA) program are not UPL payments.

2) Federal matching funds are estimated based on each state's FMAP for FFY 2001 and the amount of total UPL payments reported by the state. These estimates do not include federal match on state revenue in excess of the amount needed to draw down the amount of federal funds based on total payments.

3) Georgia and Missouri have UPL programs that operate in two transactions. The funds listed in General Fund & Appropriations for transaction B are gained from the Medicaid match in transaction A of these programs.

4) Kentucky and Mississippi have UPL programs with effective dates of April 2001. In two of Kentucky's programs, retroactive payments were made in SFY 2002. The funding was approximately \$0.5 million and \$2 million in each of these programs. In two other Kentucky programs and the Mississippi program, no payments had been made at the time of this writing.

5) The details of Wisconsin's nursing facility UPL program were obtained from the Wisconsin Legislative Fiscal Bureau. Information for all of Wisconsin's other UPL programs was obtained from our survey.

Table 7

**UPL Payments by Provider Type and Ownership Status for the Survey States Reporting Having a UPL Program in SFY 2001<sup>1</sup>**

State	Total Payments	Hospitals			Nursing Homes	
		Private	Public, Non-State	State	Private	Public, Non-State
Total	\$5,784.9	\$271.3	\$1,533.0	\$169.8	\$55.2	\$3,755.6
Alabama	202.0	39.0	73.0	58.0	-	32.0
Alaska	39.0	-	39.0	-	-	-
Florida	144.3	44.4	98.5	1.4	-	-
Georgia	353.0	-	321.0	32.0	-	-
Indiana	116.4	71.3	31.3	-	-	13.8
Iowa	314.0	-	-	-	-	314.0
Kansas	200.9	-	-	-	-	200.9
Kentucky <sup>2</sup>	34.7*	0.7*	*	34.0*	*	*
Louisiana	437.8	-	-	-	-	437.8
Massachusetts						
Michigan	1,088.0	-	350.0	-	-	738.0
Mississippi <sup>2</sup>	*	*	*	*	*	*
Missouri	333.2	-	11.3	26.1	55.2	240.7
Nebraska	88.5	-	-	-	-	88.5
New Jersey	1,000.0	58.0	52.0	-	-	890.0
North Dakota	24.7	-	-	-	-	24.7
Oklahoma	50.9	32.6	-	18.3	-	-
Oregon	144.7	-	46.5	-	-	98.2
Washington	510.4	-	510.4	-	-	-
Wisconsin <sup>3</sup>	702.4	25.3	-	-	-	677.1

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

1) California reported no UPL programs for both survey years. Officials claim that the approximately \$1.3 billion in supplemental Medicaid payments the state made in SFY 2001 through its Selective Contracting Program 1915(b) waiver are not UPL payments. Likewise, South Carolina reported no UPL programs for both survey years. Officials claim that the \$55 million in supplemental Medicaid payments the state made in SFY 2001 through its High Volume Medicaid Adjustor (HVA) program are not UPL payments.

2) Kentucky and Mississippi have UPL programs with effective dates of April 2001. In two of Kentucky's programs, retroactive payments were made in SFY 2002. The funding was approximately \$0.5 million and \$2 million in each of these programs. In two other Kentucky programs and the Mississippi program no payments had been made at the time of this writing.

3) The details of Wisconsin's nursing facility UPL program were obtained from the Wisconsin Legislative Fiscal Bureau. Information for all of Wisconsin's other UPL programs was obtained from our survey.

## Net Gains from UPL Programs in Reporting States

While the bulk of UPL funding went to nursing homes, most of the gains available through UPL programs did not. As outlined in Table 6, much of the state's share of UPL funding comes from IGTs or CPE from by public entities (either state, local or county providers). As reported by states, in almost every UPL program, the state pays the same providers "enhancements" or "supplemental payments" equal to the funding transferred, claims federal Medicaid matching funds based on those payments, and either keeps the entire federal share or passes a small portion of it on to providers. Even when states use state general funds or other appropriations to fund their UPL program(s), these funds tend to be recouped by the state from federal matching funds.

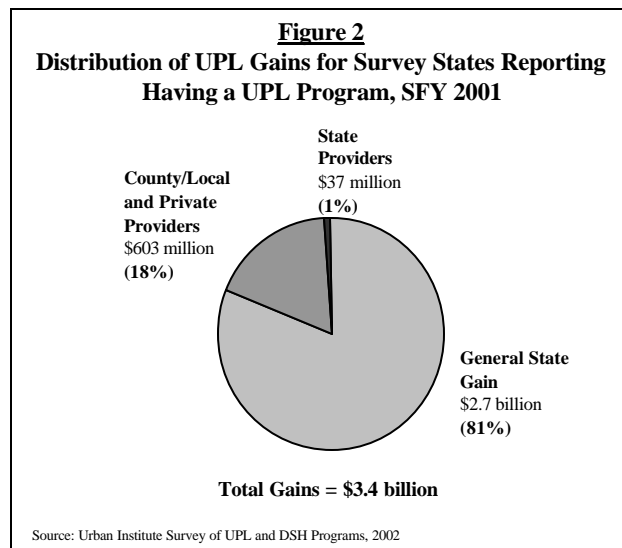


Figure 2 shows the net gains from UPL programs for the states reporting operational UPL programs in SFY 2001. Distinct from the DSH program, most of the gains available through UPL payments accrue to the state. Roughly 82 percent (about \$2.8 billion) of the total gains went to the states, while 18 percent went to non-state providers. Further, most of state gains were general gains: less than 1 percent of total gains went to state providers. Table 8 provides more detailed UPL gains information for survey states that operated UPL programs in SFY 2001.

Though not shown in Table 8, the majority of non-state provider gains accrued to hospitals. Of the roughly \$600 million in non-state provider gains, about 75 percent (\$461 million) went to hospitals; nursing homes received only 25 percent of non-state UPL gains. So, although most UPL payments are made to nursing homes, their gains under the programs are small. By contrast, under hospital UPL programs, more gains accrue to hospitals.

We also asked states if they realized a gain through their programs to describe what they did with the new funds. Most states indicated that UPL gains were put into the Medicaid general fund or a dedicated health spending account and used for health care. Only New Jersey reported that UPL gains went into the state general fund. Some states indicated that UPL gains were used for very specific items within Medicaid.

**Table 8**

**Net Gains from Medicaid UPL Programs for the Survey States Reporting Having a UPL Program in SFY 2001<sup>1</sup>**

State	Program Type	Total UPL Gain	Allocation of Gains (millions of dollars)			Percent of Gains to State	Use of General State Gain
			Gain by Non-State Entities	Gain by State Provider	General Gain by State		
Total		\$3,364.2	\$602.8	\$30.7	\$2,730.6	82.1%	
Alabama	NF	22.0	1.0	-	21.0	95.5%	Medicaid General Fund
	INPT	97.0	69.0	-	28.0	28.9%	Medicaid General Fund
	OUTPT	22.0	19.0	3.0	-	13.6%	n/a
Alaska	OUTPT	23.5	4.0	-	19.5	89.7%	Medicaid General Fund
Florida	INPT	81.7	80.3	1.4	-	1.7%	
Georgia	INPT (A)	177.0	-	-	177.0	100.0%	Medicaid General Fund
	INPT (B)	33.0	53.0	3.0	(23.0)	-60.6%	n/a
	<i>net effect</i> <sup>2</sup>	210.0	53.0	3.0	154.0	74.8%	Medicaid General Fund
Indiana	INPT/OUTPT	57.3	57.3	-	-	0.0%	n/a
	INPT/OUTPT	6.3	6.3	-	-	0.0%	n/a
	NF	8.6	4.3	-	4.3	50.0%	Medicaid General Fund
Iowa	NF	196.9	0.1	-	196.8	100.0%	Medicaid nursing home payments
Kansas	NF	120.4	0.3	-	120.1	99.7%	Medicaid/General health account
Kentucky <sup>3</sup>	INPT	23.8	-	23.8	-	100.0%	n/a
	INPT	0.5	0.7	-	(0.2)	-42.9%	n/a
	INPT	*	*	*	*	*	*
	NF	*	*	*	*	*	*
	INPT/OUTPT	*	*	*	*	*	*
	INPT	*	*	*	*	*	*
Louisiana	NF	308.8	2.2	-	306.6	99.3%	General health account
Massachusetts	INPT/OUTPT		<UPL information missing from survey>				
Michigan	OUTPT	196.6	4.1	-	192.5	97.9%	Medicaid General Fund
	NF	415.0	17.0	-	398.0	95.9%	Medicaid General Fund
Mississippi <sup>3</sup>	INPT	*	*	*	*	*	*
Missouri	INPT	22.8	(26.0)	26.0	22.8	214.1%	Medicaid General Fund
	NF (A)	144.0	-	-	144.0	100.0%	Medicaid General Fund
	NF (B)	36.6	59.9	< \$0.1	(23.4)	-63.9%	n/a
	<i>net effect</i> <sup>2</sup>	180.6	59.9	< \$0.1	120.6	66.8%	Medicaid General Fund
Nebraska	NF	1.4	1.4	-	-	0.0%	n/a
	NF	52.1	0.5	-	51.6	99.0%	General health account
New Jersey	NF	445.0	-	-	445.0	100.0%	State General Fund
	INPT/OUTPT	26.0	52.0	-	(26.0)	-100.0%	n/a
	INPT/OUTPT	29.0	58.0	(29.0)	-	-100.0%	n/a
North Dakota	NF	17.4	-	< \$0.1	17.3	99.9%	Health trust fund
Oklahoma	INPT	36.2	32.6	3.6	-	9.9%	n/a
Oregon	INPT	16.0	16.0	-	-	0.0%	n/a
	INPT	11.5	11.5	-	-	0.0%	n/a
	NF	63.2	4.3	-	58.9	93.3%	Medicaid UPL account
Washington	NF	257.1	10.0	-	247.1	96.1%	General health account
Wisconsin <sup>4</sup>	NF	376.9	-	-	376.9	100.0%	Medicaid/General health account
	INPT/OUTPT	9.5	14.7	(1.1)	(4.1)	-54.7%	n/a
	INPT/OUTPT	2.9	4.8	-	(1.9)	-65.5%	n/a
	INPT	1.2	2.0	-	(0.8)	-66.7%	n/a
	OUTPT	1.4	2.4	-	(1.0)	-71.4%	n/a
	NF	23.7	40.1	-	(16.4)	-69.1%	n/a

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

1) California reported no UPL programs for both survey years. Officials claim that the approximately \$1.3 billion in supplemental Medicaid payments the state made in SFY 2001 through its Selective Contracting Program 1915(b) waiver are not UPL payments. Likewise, South Carolina reported no UPL programs for both survey years. Officials claim that the \$55 million in supplemental Medicaid payments the state made in SFY 2001 through its High Volume Medicaid Adjustor (HVA) program are not UPL payments.

2) Georgia and Missouri have UPL programs that operate in two transactions. These lines show the net effects of these programs.

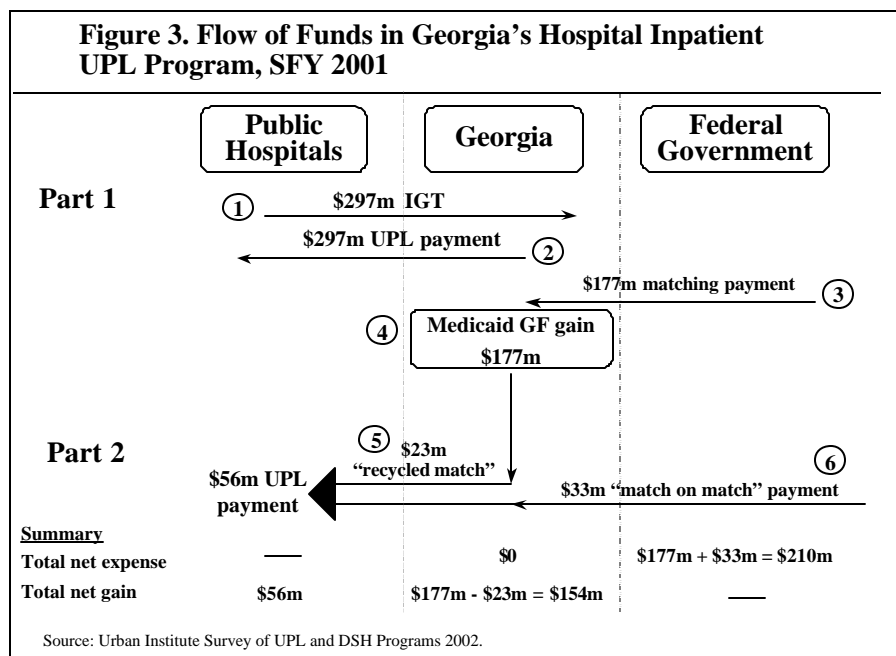
3) Kentucky and Mississippi have UPL programs with effective dates of April 2001. In two of Kentucky's programs, retroactive payments were made in SFY 2002. The gain to providers was approximately \$1.5 million and \$0.2 million, and the gain to the state was \$0.0 and approximately \$4.3 in each of these programs. In two other Kentucky programs and the Mississippi program, no payments had been made at the time of this writing.

4) The details of Wisconsin's nursing facility UPL program were obtained from the Wisconsin Legislative Fiscal Bureau. Information for all of Wisconsin's other UPL programs was obtained from our survey.

## EXAMPLE: FLOW OF FUNDS IN GEORGIA'S INPATIENT HOSPITAL UPL PROGRAM

In many cases UPL programs can be quite complicated, involving several transactions and entities. In this section we provide an example from one of the UPL programs from our survey.

Figure 3 depicts an inpatient hospital UPL program operated by the Georgia Medicaid program in 2001. The program has two basic parts, each entailing a few steps. In the first part, the Georgia Medicaid agency receives \$297 million—\$268 million through IGTs from non-state public providers and \$29 million in transfers from another state agency. (For ease of presentation we show this as a single transfer.) The state then makes a supplemental Medicaid payment of \$297 million—\$268 million to non-state owned publicly hospitals and \$29 million to state-owned facilities. In making the payment, Georgia, with a 61 percent FMAP rate, gets \$177 million in federal matching payments, which are deposited in the Medicaid general fund.



In the second part, Georgia makes a second supplemental payment totaling \$56 million to the set of providers that received payments in the first transaction. This second payment is funded with \$23 million from FMAP received from the first transaction (labeled “recycled match”) and with an additional \$33 million in FMAP, labeled “match on the match.” The providers keep the entire \$56 million. The net result is that providers gain \$56 million whereas the state has gained \$154 million, which is placed in its Medicaid general fund to be used for other program spending (and to earn more match on the match). Though the federal government paid \$210 million in match on \$353 million in supplemental payments, only a small share of the funds represents new funds to providers to provide health care services. Further, Georgia committed no state resources to the payments.

## EFFECTS OF UPL AND DSH SPENDING ON MEDICAID PROGRAM EXPENDITURE PATTERNS AND ON THE FEDERAL SHARE OF SPENDING

With very few exceptions, the UPL programs states reported in the survey operate along similar lines as the Georgia program, raising important questions for Medicaid. Among others, through the UPL financing mechanism states have increased the federal share of the Medicaid program costs beyond what is dictated by the FMAP, which is designed to provide a higher federal match to the poorest states. Since some states have leveraged federal funds through UPL, the balance of Medicaid funding between states and the federal government has shifted. Further, given the wide variation in state use of UPL programs (with some states not using the UPL mechanism at all and others operating large-scale programs), the balance of federal Medicaid spending among states has also been affected.

Beyond disrupting the federal-state financing balance, UPL programs have obscured Medicaid spending patterns. For instance, in the UPL program described above, Georgia's reported Medicaid spending would show an increase of at least \$353 million (more if they use the \$154 million gain for other Medicaid purposes), but only a small share of that went to the providers to care for Medicaid beneficiaries. Given that many DSH programs operate along the same lines as UPL, DSH payments have similar effects on the Medicaid program. To add further complexity, once the federal dollars are received by states through DSH and UPL mechanisms, there is limited accountability of the dollars, allowing states to use these dollars for purposes sometimes completely unrelated to Medicaid.

In this section, we estimate how the DSH and UPL programs have affected Medicaid spending patterns and the federal share of program spending. In brief, we recomputed the reported amount of state Medicaid spending for those states that used private or non-state government funds to support their DSH or UPL programs. We also accounted for instances where the state pays itself back the funds it used to finance the state share of DSH or UPL payments. For example, such a payback occurs when non-state providers are required to return some or all the money they receive under the DSH or UPL program. These adjustments are made to reflect the fact that some part—or, in some cases, all—of the state share for DSH or UPL payments does not represent real health care expenditures from state government sources. (The details of the estimation are discussed in Appendix A).

In the first column of Table 9 we show estimates of total Medicaid spending (federal and state) for medical services, UPL payments and DSH payments based on administrative data from the Centers for Medicare and Medicaid Services. Together, the survey states spent nearly \$134 billion in 2001. The second column shows effective Medicaid spending after adjusting for state use of various transfers and/or CPEs to finance their DSH and UPL payments. After these adjustments, total spending drops to \$127 billion. Thus, we estimate that reported Medicaid spending in our survey states is about 5.5 percent higher than the calculated effective spending. Reflecting the structure of individual programs, there was considerable state variation in the difference between reported and effective spending. For some states (e.g. Hawaii, Idaho, Vermont) reported and effective spending was identical. But for others, the difference was

substantial. For example, the difference between Georgia's reported and effective spending was more than 6 percent, and for New Jersey it was more than 13 percent.

In the last two columns we show the reported federal share of spending in each state as well as the adjusted or effective share. Overall, we estimated that the survey states increased their average match rate from 58 percent to 61 percent, or three percentage points. Again, states varied widely on this estimate. For example, Missouri's federal share increased by 4 percentage points while Wyoming's remained the same.

Though a three percentage point increase seems relatively small, given the structure of the FMAP formula it has considerable implications for spending.<sup>14</sup> Under the FMAP, at a 50 percent matching rate, for every dollar spent by the state, the federal government spends one dollar. However, at a 58 percent match rate, each state dollar requires the federal government to spend \$1.38 (=federal share/(1-federal share)=.58/.42). By shifting the effective match up to 61 percent, the federal government would have to spend \$1.56 for every state dollar, rather than \$1.38. Therefore, among the survey states, we estimated that federal spending per dollar of state general revenue spending increased, on average, by about 13 percent as a result of state use of transfers and CPEs in their DSH and UPL programs.

Importantly, in making the estimates shown in Table 9, we did not account for the possibility that states recycle the gain and earn a match on the match as discussed earlier. Match on match payments would further distort spending patterns and increase the effective federal share of program expenditures. At least for the UPL program, virtually all states indicated that they engaged in getting match on match. Thus, our estimates likely underestimate the impact of DSH and UPL on Medicaid financing.

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<sup>14</sup> The FMAP formula is as follows:

$$\text{FMAP} = 100 \text{ percent minus state share}$$

$$\text{state share} = [(\text{state per capita income})^2 / (\text{national per capita income})^2] \times .45$$

State per capita income and national per capita income figures are based on the three most recent calendar years for which data are available from the Department of Commerce.

**Table 9**

**Impact of DSH and UPL Programs on Medicaid Expenditures and the Federal Share of Expenditures for Survey States, SFY 2001**

State	Medicaid Expenditures for Benefits and DSH (in millions)			Federal Share of Total Expenditures	
	Total, Reported*	Total, Effective*	Federal Share*	Based on Reported*	Based on Effective*
Total	\$133.8	\$127.0	\$77.9	58.0%	61.0%
Alabama	\$2.9	\$2.7	\$2.0	70.0	74.5
Alaska	\$0.6	\$0.5	\$0.4	66.5	69.0
California <sup>1</sup>	\$23.3	\$22.3	\$12.1	51.5	54.0
Connecticut	\$3.2	\$3.1	\$1.6	50.0	51.5
District of Columbia	\$1.0	\$1.0	\$0.7	69.5	70.0
Florida	\$8.4	\$8.2	\$4.8	56.5	58.0
Georgia	\$4.7	\$4.4	\$2.8	60.0	63.5
Hawaii	\$0.6	\$0.6	\$0.3	54.0	54.0
Idaho	\$0.7	\$0.7	\$0.5	71.0	71.0
Indiana	\$3.6	\$3.4	\$2.2	62.0	65.0
Iowa	\$1.8	\$1.7	\$1.1	63.0	67.5
Kansas <sup>2</sup>	\$1.6	\$1.6	\$1.0	60.0	63.0
Kentucky	\$3.2	\$3.1	\$2.2	70.5	72.0
Louisiana	\$4.0	\$3.6	\$2.8	70.5	78.0
Maryland	\$3.2	\$3.2	\$1.6	50.0	50.5
Massachusetts	\$6.7	\$6.4	\$3.4	50.5	52.0
Michigan	\$7.2	\$6.6	\$4.1	56.0	62.0
Mississippi	\$2.3	\$2.2	\$1.7	77.0	78.5
Missouri	\$4.6	\$4.3	\$2.8	61.5	65.5
Nebraska	\$1.2	\$1.1	\$0.7	60.5	62.5
New Jersey	\$7.2	\$6.3	\$3.6	50.0	56.5
North Dakota	\$0.4	\$0.4	\$0.3	70.5	72.0
Ohio	\$8.3	\$8.0	\$4.9	59.0	61.0
Oklahoma	\$1.9	\$1.9	\$1.4	72.5	73.5
Oregon <sup>3</sup>	\$2.3	\$2.2	\$1.4	60.5	62.0
South Carolina <sup>4</sup>	\$2.9	\$2.8	\$2.1	70.5	73.5
Texas	\$11.7	\$11.2	\$7.1	60.5	63.5
Utah	\$0.9	\$0.9	\$0.6	71.5	71.5
Vermont	\$0.6	\$0.6	\$0.4	62.5	62.5
Virginia	\$2.9	\$2.8	\$1.5	53.0	54.5
Washington	\$4.3	\$3.9	\$2.2	51.0	56.5
West Virginia	\$1.5	\$1.4	\$1.1	75.5	76.5
Wisconsin	\$3.9	\$3.7	\$2.3	59.5	63.5
Wyoming	\$0.2	\$0.2	\$0.2	65.0	65.0

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

\* See text for descriptions of how the columns in this table are defined and the values were calculated.

- 1) California reported no UPL programs for SFY 2001. Officials claim that the approximately \$1.3 billion in supplemental Medicaid payments that the state made in SFY 2001 through its Selective Contracting Program 1915(b) waiver are not UPL payments. Consequently, we did not treat these as UPL payments in this table; if we had, the effective federal share of spending would increase to approximately 55.60%.
- 2) Total spending for Kansas includes estimated DSH spending based on Medicaid Financial Management Reports from CMS. Although we did not receive complete DSH information from Kansas on our survey, what we received indicated that the state's DSH program is funded entirely by state funds. Therefore, DSH would not affect the effective share of federal spending.
- 3) Oregon did not provide information about its DSH payments to IMDs on our survey. These payments (about \$17 million) are not included in total spending, nor is the IMD DSH program factored into the calculation of the effective federal share of spending.
- 4) South Carolina reported no UPL programs for both survey years. Officials claim that the \$55 million in supplemental payments that the state made in SFY 2001 through its High Volume Medicaid Adjustor (HVA) program are not UPL payments. These payments are not accounted for in the calculation of the effective share of federal spending.

## LOOKING BEYOND 2001

Although our survey describes state UPL and DSH programs in 2001, many changes to these programs have taken place since that time or are will soon take place. Key ones include:

- How the Medicaid UPL is determined;
- Elimination of the 150 percent UPL exception for non-state public hospitals;
- New state option to operate a 175 percent DSH program for public hospitals; and
- Reductions in federal DSH allotments or the so-called DSH “cliff.”

To obtain some insights into how states are dealing with these and other issues relating to DSH and UPL, we conducted case studies in three of our survey states—Connecticut, Florida, and Louisiana. Below we provide some highlights from the case studies and our survey data.

### Changing the Medicaid UPL Determination

One of the biggest changes that many states are facing is amending how they calculate their UPLs to conform to new federal regulations. As discussed earlier, in a rule issued in January 2001, the federal government revised the Medicaid upper payment limits for hospital, nursing facility, ICF/MR and clinic services, establishing separate limits for state-owned facilities, non-state government-owned facilities, and privately owned facilities.<sup>15</sup> Depending upon how long the UPL program had been in existence, the rule set out various transition times, ranging from two to eight years. Twelve states have a two-year transition and are scheduled for the UPL change in late 2002. Among these 12 states are several of our survey states—for example, Alaska, Georgia, Missouri and Louisiana.

Depending upon the specifics of a state’s program, this new regulation can have major spending implications. Louisiana, one of the case study states, noted that the change in the UPL calculation would bring a significant reduction in federal Medicaid funds. Specifically, the state estimates that the amount of federal funds secured through its nursing home UPL program—which was heavily promoted by the Louisiana nursing home association—will drop from about \$600 million per year to about \$40 million per year. However, nearly all of the federal money received to date through this program (totaling about \$900 million) is currently held in a trust dedicated to long-term care services. Up to now, little money has been used from the fund. The state nursing home association, which heavily promoted the development of the program, views the trust fund as an opportunity to raise Medicaid payment rates and to provide security against possible future payment cuts.

### Eliminating the 150% UPL Provision

The January 2001 UPL regulation also established that aggregate Medicaid payments for inpatient and outpatient services provided by non-state government-owned hospitals could be up to 150 percent (rather than 100 percent) of a reasonable estimate of the amount that would have

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<sup>15</sup> Federal Register (66 FR 3148)

been paid for the services furnished by these hospitals under Medicare payment principles. However, a year later, on January 18, 2002, the federal government issued another rule eliminating the 150 percent UPL for non-state public hospitals.<sup>16</sup>

Several of the survey states—including Oregon, New Jersey, Missouri—indicated that they went ahead and implemented a 150% hospital UPL program during the roughly 16-month window where the expanded payment was allowed. Florida, another case study state, was one of the states that implemented a 150% program for its local public hospitals. Florida officials stated that the rollback of the 150% rule would have important consequences for their public hospitals. They estimate that the reduction from 150% to 100% of UPL will reduce proposed payments to these hospitals by \$185 million. According to other published reports, Mississippi expects to lose \$40 million per year and Arkansas expects to lose \$20 million as the rule takes hold (Pear, 2002).

#### Expanding DSH Payments to Public Hospitals.

In separate legislation, Congress allowed states to increase DSH payments to public hospitals from 100 percent of unreimbursed care costs to 175 percent for a two-year period beginning FFY 2003. All three of our case study states planned to take advantage of this allowance. Florida, for example, created a public hospital DSH program to compensate for the loss of UPL funding due to the cutback from 150 percent to 100 percent for non-state public hospitals, and appears likely to apply the 175 percent limit for this program. Louisiana and Connecticut (our third case study state) were still exploring their options as of August 2002, but officials in both states hoped to implement 175 percent DSH programs for their non-state public providers. Officials in Louisiana, however, noted that political issues might prevent them from implementing such a program, as it will take DSH funds away from other facilities—for example, private hospitals. These officials also noted that targeting more funds to selected providers—that is, public hospitals—might also prove difficult because of scheduled cutbacks in federal DSH spending (see below).

#### The DSH Cliff

Another area of concern to states is the so-called “DSH cliff.” Mentioned at the beginning of the paper, state governments stand to lose an estimated \$1 billion in federal fiscal year 2003 because of the cliff (Miller, 2002). Briefly, among other DSH provisions, the Balanced Budget Act of 1997 (BBA) set out, on a state-by-state basis, federal DSH spending limits for fiscal years 1998 to 2002. After 2002, BBA permitted states to increase DSH spending at the rate of inflation as long as a state’s DSH spending did not exceed 12 percent of its total spending on Medicaid. However, the Medicaid, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) temporarily amended the BBA DSH limits for 2001 and 2002 and allowed states to increase their DSH spending in those two years.<sup>17</sup> However, for 2003, if current law prevails,

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<sup>16</sup> Federal Register (67 FR 2602).

<sup>17</sup> For 2001 and 2002 DSH limits were calculated from 2000 levels set out in BBA, indexed for the prior’s years consumer price index. Like under BBA, BIPA limited a state’s DSH spending to 12 percent of its total spending on Medicaid.

federal DSH allotments will be based on the lower BBA DSH spending limits rather than the amended BIPA limits. This scheduled cutback in federal DSH funding is often referred to as the “DSH cliff.”

All three of our case study states expressed some concern about the DSH cliff, though for different reasons. According to one estimate, Florida stands to have its DSH ceiling lowered from an estimated \$209 million in federal funds in FFY 2002 to \$164 million in federal funds in FFY 2003 (Miller, 2002). Florida spent its full federal DSH allotment in 2001 and 2002, so without a change in federal law the state will need to cut its DSH payments in 2003 by a total of about \$77 million (state and federal funds combined).

By contrast, both Connecticut and Louisiana spent amounts well below their federal DSH allotment in 2002. Connecticut significantly reduced its DSH spending in 2002 after eliminating a provider tax previously used to fund the program, and Louisiana officials noted that the hospital-specific cap which limitations DSH payments to no more than 100 percent of unreimbursed care costs have prevented them from coming close to spending their entire allotment. Both states noted, however, that their current spending levels would be much closer to their DSH ceilings as a result of the DSH cliff, which might complicate their efforts to create 175 percent DSH programs for non-state public facilities.

## DISCUSSION

Relying on survey data, we examined state use of Medicaid DSH and UPL programs. For DSH, study results indicate that the program continues to evolve. Though the level of DSH spending and state financing has not substantially changed in recent years, the way that states distributed DSH funds shifted dramatically. Importantly, in keeping with an earlier trend, more of the available DSH gains are being paid to hospitals. In the 27-state comparison sample, nearly 75 percent of available DSH gains (\$4.5 billion) went to private and county or local hospitals in 2001, up from 60 percent (\$3 billion) in 1997. At the same time, the share of DSH gains accruing to states declined, dropping about \$1 billion between 1997 and 2001.

Part of the distributional shift could be due to a DSH provision included in the 1997 BBA, which limited how much of a state's federal DSH allotment could be paid to mental institutions. Among the 27-state comparison sample, DSH payments to mental hospitals, accounted for 19 percent of overall payments in 1997 but only 17 percent in 2001. Given that the bulk of DSH payments to mental hospitals has traditionally been paid to state facilities, this new limit could account for some of the decline in state hospital gain and overall state gain.<sup>18</sup> At a broader level, during the late 1990s states enjoyed strong economies and may have had less of need to retain potential gains available under the DSH program. Further, the late 1990s was also the period in

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<sup>18</sup> The share of DSH funds paid to mental hospitals is expected to decline yet further owing to provisions contained in the BBA. For example, the maximum percentage of DSH funds allowed to be spend on mental hospitals will drop from 40 percent in 2002 to 33 percent in 2003.

which many states implemented Medicaid UPL programs, which provided another avenue to leverage federal Medicaid dollars.

While we find that more DSH funds are being paid to non-state hospitals, the data do not allow us to determine whether these hospitals keep the DSH payments and use them to cover uncompensated care costs. Unfortunately, our survey did not allow us to determine whether hospitals are required to transfer all or part of the DSH payment back to the state or local treasury leaving them no better off. We were also not able to determine whether funding from other sources—for example, a state or local hospital subsidy—is reduced, leaving the hospital with no real new funding. For example, Louisiana pays the bulk of its DSH funds to its state hospitals. While the hospitals keep the DSH funds, Louisiana has virtually eliminated paying any state subsidies to these hospitals. Unfortunately, fully determining which DSH payments represent substitutes or true supplements was beyond the scope of our study but is a key unanswered question.

Though the survey data suggest that more of the DSH gains are accruing to non-state owned hospitals, several problems issues still persist in the DSH program. Among others, states still retain a sizable share of the gains. In 2001, we estimated that the survey states gained about \$1.6 billion through the Medicaid DSH program. Some of the gains went to state hospitals but about \$700 million were state residual funds, which can be used for a range of state purposes. Another lingering issue is that the distribution of DSH spending states still varies considerably among states, accounting for less than 1 percent of state spending in some states to more than 10 percent in others. As past research has shown, the allocation of federal DSH funds is not based on need or a national formula but more on the willingness of a state to use DSH payments to leverage federal funds during the early 1990s, before federal policymakers started imposing program limits (Ku and Coughlin 1995; Coughlin et al. 2000).

Finally, the current survey data show that states are still not putting up the their full share of DSH payments. In 2001, state funds—including both state transfers/CPE and general fund expenditures—accounted for only 20 percent of overall DSH revenues and less than half of the state share of DSH payments. Non-state funds, principally IGTs and CPEs from locally owned public hospitals, make up the balance of the state share. Since states are not contributing in full to DSH payments, the federal government is paying for more than its share of total Medicaid payments (see below).

The survey data also highlight how much alike the DSH and UPL programs are. For example, the data reveal that states finance these payment enhancements primarily with IGTs and CPEs from local entities, incurring little to no state expense. Also like DSH, the extent to which individual states engaged in UPL activity varied widely across states. Further, the level of state UPL activity does not appear to be determined by any particular factor. For instance, UPL activity does not seem to be tied to DSH activity. While several states that have large DSH programs also have large UPL programs, many states that did not pursue DSH have developed large UPL programs including Iowa, Nebraska, Oklahoma and Wisconsin. However, in part a

state's ability to develop UPL programs is determined by the configuration of a state's health care infrastructure—for example, the supply of county nursing homes. It is also determined by a state's willingness to use the strategy to leverage federal dollars through the Medicaid program.

Although DSH and UPL are a lot alike, our survey suggest that an important difference between the two programs is that under DSH most of the gains at least initially appear to accrue to providers whereas under UPL programs the bulk of the gains go to the state: Among the survey states, we estimated that more than 80 percent of available UPL gains accrued to the state, with most being general state gains.<sup>19</sup> Overwhelmingly, states reported that UPL gains were used to fund other Medicaid services or put into a special account that was dedicated to finance health care initiatives. While it is laudable that states are using their UPL gains to finance health care, our survey did not allow us to determine whether the spending of UPL gains to pay for Medicaid services caused states to spend more on Medicaid or simply offered states general fiscal relief. Some states, for example, may have substituted federal UPL gains for general revenue funds that otherwise would have been invested in Medicaid, freeing up resources for other purposes.

Using UPL gains for Medicaid and other health programs raises other important policy issues. For example, states that use UPL gains to fund general health care initiatives are effectively using federal matching dollars for purposes beyond the scope of the Medicaid program. Similarly, states that use UPL gains to fund other Medicaid payments are effectively recycling the federal match from the UPL payment to earn another federal match payment—or match on a match. In short, through UPL and DSH programs some states have not maintained their part of financial partnership as set out in Medicaid law.

To obtain some insight into how DSH and UPL programs have affected this partnership we did a series of estimations that combined our survey data with Medicaid administrative data. The estimations suggest that among our survey states, the federal share of Medicaid spending increased by an average of 3 percentage points as a result of DSH and UPL activities. Put another way, we estimated that federal spending per dollar of state general revenue spending increased an average of 13 percent as a result of state financing practices for their DSH and UPL programs. Using additional databases, we estimated how these programs affected federal spending at the national level and found a similar increase. While these estimates should be viewed only as approximations, they do highlight how state financing of DSH and UPL has reshaped the funding of the Medicaid program.

Without doubt the DSH and UPL programs are going to go through yet more changes in the near term. Indeed more changes have already been implemented since the time of our survey or are about to be implemented. Under current federal law, the Congressional Budget Office projects both DSH and UPL payments to fall in 2003 as a result of the DSH cliff and the recent federal regulations that restricting states' use of UPL financing mechanisms. Most states also face revenue shortfalls for 2003 and will be looking to the Medicaid program for savings. States

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<sup>19</sup> As mentioned above, our survey did not allow us to fully determine whether hospitals are required to transfer all or part of the DSH payment back to the state or local treasury leaving them no better off financially.

that currently put their own funds into DSH or UPL programs may have incentive reduce the level of state funding for these programs and use local/county IGTs as revenue sources instead. Further, only a few reporting states have provider taxes in place. Providers in more states may be willing to accept such taxes to support DSH or UPL programs if budget woes threaten states' ability to fund these programs through other means.

While it is too early to determine exactly how the existing provisions that have not yet been implemented will affect DSH and UPL, our results indicate that more reforms are warranted so that the programs are based on sound and defensible policies. Reforms could include having states and hospitals document how DSH funds are used. Alternatively, a national Medicaid DSH program could be established that would reallocate federal DSH funds to states or individual hospitals on the basis of need—for example, the share of a state's population with incomes below poverty or a hospital's financial risk in serving poor patients. For UPL payments, Medicaid reimbursement could be more directly linked to the facility costs of providing care to a Medicaid beneficiary. Without implementing reforms to the programs, state and federal policymakers will continue to do battle over the DSH and UPL programs to the detriment of the spirit of federal-state cooperation on which Medicaid is based.

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## APPENDIX A

### Estimating the Impact of DSH and UPL Programs on Medicaid Expenditures and the Federal Share of Spending

As illustrated in this report, numerous states developed DSH and UPL mechanisms that obtain federal Medicaid funds without committing their share of the required matching funds. Among the states included in this analysis, over half of the state share of expenditures for DSH programs came from intergovernmental transfers (IGTs) from local governments or provider taxes. These expenditures, it could be argued, do not represent real state spending. Likewise, providers returned the majority of enhanced payments made under states' UPL programs to the states, resulting in millions of dollars available to states for other uses. Because millions of dollars in enhanced payments were returned to the states, it could again be argued that the states did not incur expenditures for which federal matching funds were claimed. Consequently, these mechanisms have increased the federal share of the Medicaid program costs beyond what is dictated by the Federal Medical Assistance Percentage (FMAP), which is designed to provide a higher federal match to the poorest states.

To assess the impact of states' DSH and UPL programs on Medicaid expenditures and the federal share of spending, we computed total Medicaid expenditures assuming that the entire state share of Medicaid spending reported by states represents a real expenditure of state general funds. We refer to these values as "total reported expenditures." Next, we calculate the "total effective expenditures" for each state. To calculate effective expenditures, we reduce each state's share of total Medicaid spending to account for three circumstances:

- 1) Where a state uses IGTs and/or provider taxes to finance its DSH and/or UPL programs;
- 2) Where a state makes DSH and/or UPL payments directly to state-owned facilities; and
- 3) Where private or non-state government owned facilities return some or all of their UPL payments to the state.

By netting out IGTs and taxes, we are assuming that these financing sources do not represent real state outlays. By netting out payments to state-owned providers we are assuming that states finance these providers with DSH or UPL funds in lieu of other state appropriations. Lastly, by netting out UPL payments that are returned to the state, we recognize that while states may initially fund their UPL transactions with state outlays, the reporting states recover most, if not all, of these outlays out of the federal matching funds.

The first column of Table 9 shows our estimates of states' total Medicaid expenditures for medical services and DSH, based on data collected by the Centers for Medicare and Medicaid Services (CMS). These are what we refer to as "total reported expenditures." Specifically, we used data from Form CMS-64, a quarterly expenditure report submitted by states. We estimated federal and state Medicaid expenditures for medical services as closely as possible for each states' fiscal year. For example, most states in this analysis have July-June fiscal years, so we

added total reported spending for medical services from the last quarter (July-September) of federal fiscal year 2000 to the total for the first three quarters (October-June) of federal fiscal year 2001. The expenditure data from CMS include payments made through both DSH and UPL mechanisms. However, rather than keeping the federal and state DSH spending as reported in the federal data, we replaced these values with the amounts reported in our survey.

We used each state’s reported expenditures to calculate the federal share of spending for each state according to the following formula:

$$Federal\ Share = \frac{Total\ Federal\ Expenditures}{Total\ Federal\ Expenditures + Total\ State\ Expenditures} .$$

The federal share of spending for each state based on reported expenditures is shown in the fourth column of Table 9. The calculated federal share often differs from FMAP for each state that is printed in the Federal Register. Reasons for the discrepancies include higher match rates for certain services (such as family planning) and adjustments for amounts reported for prior fiscal years when the state may have had a different match rate. The federal share based on reported spending is a more accurate starting point to measure the impact of DSH and UPL programs than the published rate because these other factors often cause the federal share of spending to exceed a state’s FMAP, and we don’t want to falsely attribute these effects to DSH and UPL activities.

The reported federal share assumes that all state Medicaid expenditures represent actual outlays by state governments. However, as noted above, it can be argued that some of the state share of total spending does not represent real state outlays. Our second match rate calculation—which we refer to as the effective federal share of total expenditures—addresses this issue by employing an alternative formula,

$$Effective\ Federal\ Share = \frac{Total\ Federal\ Expenditures}{Total\ Federal\ Expenditures + Adjusted\ State\ Expenditures} .$$

The first step in calculating the adjusted state expenditures is to subtract the state share of DSH or UPL expenditures funded by IGTs and provider taxes as reported in our survey. We also reduce state expenditures for DSH or UPL by the amount of any payments made to state-owned providers, up to (but not exceeding) the amount of funding from state sources. The second step is to subtract the entire state share of Medicaid UPL payments (as reported in our survey) from each state’s reported spending. As noted above, we make this adjustment because every state in our survey kept an amount of federal funds that was at least equal to the amount of state funds spent to support the UPL program, meaning that states effectively spent no state funds on these programs. The second column of Table 9 shows “effective” Medicaid spending, which equals total federal spending plus adjusted state expenditures. The last column of Table 9 shows the share of effective spending represented by federal expenditures. Total federal spending is shown in the third column of the table.

## APPENDIX B

### Observations from Case Study States

As part of this study, we conducted case studies using telephone interviews in three states to obtain more detailed information about their programs. We spoke to state Medicaid officials and representatives from provider industry groups such as the state nursing home and hospital associations. In choosing case study states, we sought to get states with noticeable variations in their Medicaid UPL and DSH programs. Specific criteria we looked at in selecting states included, whether the state had a UPL program, whether the state was facing a DSH spending cliff, and the extent to which providers retained DSH and UPL funds. The states chosen were Connecticut, Florida and Louisiana.

#### Connecticut

Connecticut historically operated a relatively large DSH program, but the state's survey response indicated that the state cut back its DSH program significantly between state fiscal years (SFY) 2001 and 2002. As a result, Connecticut's currently level of DSH spending is well below its federal allotment. The state does not have any UPL programs.

Up to the current fiscal year, Connecticut used provider taxes to support its DSH program. Initially, all of the revenue used to support the program came from a special tax on hospitals. After federal law limited the ability of states to use provider taxes to fund their DSH programs, Connecticut continued to tax hospitals and put the revenues into the state general fund. The state then appropriated these funds to provide the state match for the DSH program. State officials acknowledged that through this process, the state essentially operated its DSH program at little or no cost in terms of state funds. In fact, the state generally took in more money than it needed from the tax, thereby profiting from the arrangement.

As state revenues grew in the 1990s, the hospital tax became a point of contention between hospitals and the state. The state scaled back the tax and used state revenues to make up any additional funding needs for the DSH program. State officials noted that the state essentially came out even during this period, so there was still no net expense to the state to operate its DSH program. In 2001, facing political pressure generated by the hospital industry, the state repealed the provider tax. The state had been operating with budget surpluses for several years, and the industry objected to paying a tax to support the DSH program when the state was "swimming in money." However, at the same time as it dropped the provider tax, Connecticut dramatically scaled back its DSH program, cutting total DSH payments from \$320 million in SFY 2001 to \$203 million in SFY 2002. In exchange, the state increased regular Medicaid rates for hospitals to compensate for lost DSH funds. All of the funding for the DSH program and the higher provider payment rates comes from state appropriations, so now the state incurs actual costs to support these payments.

Although Connecticut's DSH allotment will be reduced between 2002 and 2003 as a result of the DSH cliff, state officials do not foresee a noticeable impact on the state's DSH program. The state currently spends well below its allotment because of the program changes implemented in 2001, and state officials project DSH spending will remain below the cap in the near future.

Connecticut does plan to use some of its available cap room to implement a special DSH program for fiscal years 2003 and 2004 to take advantage higher 175% DSH cap for public hospitals now allowed under federal law. This program will be run through the state's only non-state public hospital, operated by the University of Connecticut. This hospital currently draws most of its funding from the state general fund and has not participated in the DSH program in the past because of the provider tax. Officials plan to use the current level of state funding for this hospital (approximately \$11 million) as state match under this new program, but the Medicaid agency also is under pressure to find ways to maximize the amount of revenue obtainable through this mechanism.

Connecticut does not operate any UPL programs and has no plans to implement any. Officials note that the state never gave serious consideration to UPL. For starters, the state has been "doing pretty well" maximizing federal revenue with the DSH program and officials did not see a need for a UPL program. Officials also noted that there is "very little" county government in the state and no network of county-owned facilities. The lack of appropriate infrastructure to fund and operate a UPL program essentially prevents the state from implementing one.

### Florida

Florida spends a relatively modest share of its total Medicaid budget on DSH, but has a complex DSH structure consisting of eight distinct programs. The state spends close to its full DSH allotment, and is due to face a significant drop in its DSH allotment in 2003 as a result of the DSH cliff. Florida's UPL program encompasses nine separate payment streams. Florida's total UPL spending was relatively modest in 2001, but it increased significantly in 2002.

The first of Florida's DSH programs, which officials referred to as the state's "Regular DSH" program, was implemented in July 1988. This program was intended to direct dollars to hospitals serving low-income and uninsured populations, to promote primary healthcare, and to provide financial stability to hospitals that care for the majority of Florida's Medicaid population. In recent years, approximately 70 hospitals have participated in the Regular DSH program. Total payments under the Regular DSH program were \$155.8 million in SFY 2001.

Initially, Florida used a hospital assessment to fund the state share for its DSH programs. In SFY 1993, the state began to receive intergovernmental transfers (IGTs) from three counties (Dade, Duval, and Hillsborough) that now account for most of the state's share of the DSH funding for its Regular DSH program and other targeted DSH programs (described below). Later a fourth county, Broward, also began to provide funding through IGTs. State officials indicated that Florida has historically funded healthcare for low-income people and the uninsured through partnerships with local governments, and that these IGTs continue this tradition.

Over time, Florida added seven DSH programs that target funds to specific types of hospitals. They include:

- *Regional Perinatal Intensive Care Centers (RPICC)*: Added July 1989. To qualify for this DSH program, hospitals must satisfy the Regular DSH criteria and meet several requirements pertaining to neonatal intensive care and high-risk maternity care. In SFY 2001, 11 hospitals qualified for \$6.9 million in funding.
- *Teaching Hospital (Graduate Medical Education or GME)*: Added July 1991. Provides supplemental payments to statutorily defined teaching hospitals for costs associated with medical education and services provided to the poor. Six hospitals qualified for funding of \$19.8 million during SFY 2001.
- *Mental Health Hospital (MH)*: Implemented October 1992. The Department of Children and Families (DCF) administers the program. DCF certifies funds to be used as the state match, and the Medicaid agency transfers the federal match to DCF. Four qualifying state mental hospitals received a total of \$149.7 million in SFY 2001.
- *Rural Hospital*: Added May 1994. Hospitals must meet be certified as an obstetrical facility to receive federal funds and meet other statutory and programmatic requirements. In SFY 2001, 24 rural hospitals qualified for \$9.8 million in funding.
- *Primary Care Hospital*: Implemented July 1997. Provides supplemental payments to hospitals that have established a network for providing health care to uninsured individuals. Seven hospitals received \$10.2 million in SFY 2001.
- *Specialty Hospitals (TB)*: Also implemented July 1997. Provides supplemental payments to hospitals that treat communicable diseases and receive all inpatient clients through referral from county health departments. One hospital (A.G. Holley State Hospital) met the criteria in SFY 2001 and received \$4.3 million.
- *Specialty Hospitals for Children*: Added July 2000. Hospitals must meet the Regular DSH criteria and be licensed as a specialty hospital for children. Two hospitals received a total of \$3.5 million in SFY 2001.

Florida stands to have its DSH allotment lowered from an estimated \$209 million in federal funds in FFY 2002 to \$164 million in federal funds in FFY 2003 because of the DSH cliff. State officials and hospital industry representatives expressed concern that the state would be unable to maintain its current level of funding for DSH hospitals unless the cutback is prevented.

In SFY 2001, Florida's legislature authorized the creation of "Special Medicaid Payments" (UPL payments) for children's and teaching hospitals, with potential for additional allocations to DSH hospitals based on their Regular DSH allocations. The state made \$144.3 million in total UPL payments in SFY 2001. All of the funding came from IGTs from county sources. The state dramatically expanded its UPL program after SFY 2001, calling for \$493.9 million in payments to Florida hospitals in SFY 2002 and \$400.6 million in SFY 2003. State officials indicated that

67 percent of Florida's UPL payments go to safety net hospitals; these hospitals provide 65 percent of uncompensated care in the state and serve 49 percent of the Medicaid population.

Florida's UPL program included a 150 percent program for non-state public facilities. The 150 percent program was eliminated May 14, 2002. State officials indicated that the loss of the 150 percent UPL program was expected to reduce payments to hospitals by \$185 million. To compensate, the state created a public DSH hospital program. This change was intended to lessen the loss from the rule change by allowing the public hospitals to use the IGTs limited by the rule change for the DSH program and allowing the IGTs for private hospitals previously used for DSH to be utilized in the UPL program.

Florida's UPL payments are divided between nine programs or "silos," described below. The funding amounts given are the amounts appropriated for SFY 2003.

- *Special Medicaid Payments to Rural Hospitals* (\$9.3 million): Distributed to the rural hospitals that participate in the Rural Disproportionate Share Program.
- *Special Medicaid Payments to Trauma Hospitals* (\$12.9 million): Distributed to hospitals that operate trauma centers.
- *Special Medicaid Payments to Teaching Hospitals* (\$13.6 million): Distributed to the state's six statutory teaching hospitals.
- *Special Medicaid Payments for Primary Care* (\$13.6 million): Distributed to hospitals that participate in the state's Primary Care Disproportionate Share Program.
- *Special Medicaid Payments for Family Practice* (\$1.8 million): Distributed to the seven family practice teaching hospitals, excluding public facilities.
- *Special Medicaid Payments to Hold Harmless* (\$94.7 million): Specific amounts to be paid to hospitals designated by the state legislature. This program increased from \$28.0 million in SFY 2002 due to the creation of a public hospital DSH program to help compensate for the reduction in the UPL cap (from 150% to 100%) for public hospitals. The expansion allows payments to hospitals that no longer participate in the DSH program, as is necessary to make room under the state's DSH cap for the public hospital program.
- *Special Medicaid Payments for Enhanced Services* (\$232.7 million): Distributed to hospitals that have formed partnerships with their local governments to provide health care services to the community. Payments are based on IGTs from local governments plus a 17.5% rate of return on the IGT.
- *Special Medicaid Payments AHEC/Poison Control* (\$14.9 million): Paid to five programs in the state for enhancing graduate medical education, and to three poison control centers.
- *Special Medicaid Payments for Primary Care/FQHC* (\$7.3 million): Paid to hospitals that collaborate with the Department of Health, FQHCs or primary care centers to provide primary care services to indigent residents.

State officials and hospital representatives note that future reductions to Florida's UPL payments required by current federal law will directly affect the financial viability of hospitals that are the main source of healthcare for Medicaid populations, and that the impact of the loss will fall directly on the largest providers of health care to low-income and uninsured individuals. However, respondents also noted that the state is exploring options to maximize federal funding by creating UPL programs involving nursing facilities, outpatient hospitals and physicians.

### Louisiana

Louisiana has a very large DSH program, a relatively small inpatient/outpatient hospital UPL program and a large nursing facility UPL program. The state reported that it spent less than its full federal DSH allotment in our survey. The state does not face the DSH cliff in 2003 because its current level of spending is below the cap for that year.

Louisiana has long operated one of the largest DSH programs in the country, both in dollar terms and especially as a share of total Medicaid expenditures in the state. Prior to the imposition of hospital-specific caps in the mid-1990s, Louisiana consistently claimed more than \$1 billion in total DSH payments. While public hospitals received a vast majority of these funds, private hospitals also received significant amounts. The hospital-specific caps affected Louisiana's ability to come up with matching funds for its DSH program, and the state cut back payments to private hospitals.

During our survey period, Louisiana was not close to spending its full allotment. The state reported total (federal and state) DSH spending of \$870 million in SFY 2001 and \$835 million in SFY 2002. Part of the reason the state spends below its cap is that the cap is high—about \$1.1 billion, including state funds. Officials noted that the base year (FFY 1995) used to calculate allotments under the Balanced Budget Act of 1997 was a very high spending period for the state's DSH program, leading to the high allotment.

State hospitals receive most of the DSH funds under the current program. These include 4 psychiatric hospitals and 10 hospitals in the state university system. Most of the funding for these facilities comes from DSH and regular Medicaid payments. The DSH funds essentially eliminated the need for state funding to support these hospitals. Public service district hospitals also receive significant DSH funding. There are 45 of these hospitals statewide, and they were noted hold significant political clout in Louisiana.

Louisiana's DSH spending increased in 2001 when the state started to use IGTs to fund DSH payments to public rural hospitals. The legislature opposed increases to DSH because of fears that the state would eventually exceed its cap, but rural hospitals used their political clout to gain additional payments.

There are 14 non-rural public hospitals participating in the DSH program that do not get to keep all the DSH funds that they receive. Six of these hospitals are involved in the state's UPL

program and 8 others provide CPEs to support payments. The state keeps most of the match for these hospitals and uses it to fund additional Medicaid payments.

Louisiana's DSH cap is scheduled to drop from \$713 million in 2002 (about \$1.1 billion total) to \$631 million in 2003 (about \$880 million total). The state currently spends below the 2003 cap, so officials acknowledged that the state does not really face a DSH cliff. However, after the DSH cliff occurs, the state will be very close to the new allotment levels, so both the hospital industry representatives and state officials believe that the DSH cliff would have an impact eventually. For example, there is interest in developing a 175 percent DSH program for public hospitals, but there may not be enough room left under the allotment. If there is room, the decision about which hospitals should benefit from this program is likely to be very political. LSU hospitals and rural hospitals are most likely going to compete for these funds.

Recent policy changes may influence the state's DSH funding. The state currently spends about \$25 to \$30 million per year on health care for prisoners that is counts as uncompensated care. CMS will no longer allow this practice, effective July 2002. CMS also issued a directive that states must use actual rather than prospective uncompensated costs to calculate uncompensated care. Both the hospital industry representatives and state officials mentioned these issues as important concerns at present.

Hospital representatives noted that hospitals are concerned about low Medicaid reimbursement levels and the high numbers of uninsured people in the state. Different hospital types receive varying reimbursement levels under Medicaid, which is a source of tension. However, industry representatives noted that the various systems (public, rural, etc.) are increasingly coming together to try to come up with common reimbursement methodologies. They noted that both DSH and UPL provide valuable funds to hospitals that somewhat make up for "otherwise low" reimbursement levels in Medicaid.

Louisiana has a large nursing facility UPL program. The Louisiana Nursing Home Association (LNHA) initially approached the Medicaid agency with a plan to establish a UPL program for parish (county) owned nursing facilities in 1999. The LNHA viewed the plan as a way to increase Medicaid funding for nursing facilities, patterned after a similar program operating in Pennsylvania. State Medicaid officials opposed the plan. While the federal government was not focused on UPL programs at the time, officials were concerned that the amount of money flowing through such a program would quickly escalate. Implicit in this argument is that they feared that they would then face a situation where the federal funding source would be cut back or eliminated completely, leaving the state either to find other ways to support nursing homes or to impose cuts.

In 2000, the LNHA approached the state legislature and lobbied for legislation to require state officials to establish a UPL program for nursing facilities. They presented the plan to legislators as a way to raise nursing home payments, and secured passage of legislation. The LNHA controlled much of the program's development; as a result, the legislation included limits

on how the UPL funds could be used. These limits set aside 2/3 of funding for nursing facilities and 1/3 for home and community based services for the elderly. Part of the reason that a relatively large share of the money was set aside for home and community based services was that the state settled an Olmstead-type lawsuit around the time that the legislation was being considered, putting the state in a position where officials needed to increase funding for non-institutional long-term care.

Louisiana began operating its enhancement pool for parish (county) owned nursing facilities in January 2001. Virtually all of the federal revenue generated by the enhancement pool is put into a trust fund dedicated to nursing facilities and home and community based care. The parish nursing facilities keep a very small portion of the enhanced payments and transfer the remainder back to the state. The state recovers the amount appropriated as the state match for the program and puts the federal revenue into the trust fund. Using this process, Louisiana was able to draw down approximately \$125 million in federal revenue per quarter until September 2002.

At present, the trust fund contains nearly \$900 million. Under the new federal regulations for UPL programs, the state will only be able to calculate the UPL using non-state public nursing homes (as opposed to all nursing homes). This change will cut the amount of additional federal funds available to the state to about \$10 million per quarter. Very little principal from the trust fund has been used at this point. Nursing facilities see these funds as an opportunity to raise “inadequate” reimbursement levels and provide security against future payment cuts, and the LNHA is active in monitoring the trust fund.

The state added a hospital UPL program in 2001, immediately after CMS issued the preliminary rule to restrict use of 150 percent UPL mechanisms. Unlike the nursing home UPL program, Medicaid officials wanted to create such a program. The hospital industry also lobbied for it. The impetus for the program was a desire to fully fund uncompensated care for rural hospitals and to provide additional funds to other hospitals, if possible. The result was that Louisiana established a 150 percent UPL program for non-state, non-rural public hospitals.

Like the nursing home UPL program, hospitals keep only a small portion of the total payments made under the inpatient and outpatient UPL programs. Hospital officials note that regular Medicaid reimbursement is “far below” their actual costs, and that the money kept by the hospitals is used to cover their uncompensated costs. Most of the UPL payments are returned to the state, which fully reimburses the state for its initial investment (the matching funds) and provides extra federal funding that is placed into the Medicaid general fund to be used as the state match for future Medicaid payments.

State officials noted that the ability to make UPL payments allowed the state to make some payments to other non-rural hospitals under DSH, and the use of the IGT mechanisms to fund DSH and UPL in SFY 2002 helped to prevent cuts. Both hospital representatives and state officials noted that the loss of the 150 percent program for public hospitals “will hurt,” but the state plans to establish a UPL program for large service district public hospitals in its place.