Changing State And Federal Payment Policies For Medicaid Disproportionate-Share Hospitals

How states are responding to changes in the federal rules that govern their ability to support hospitals that serve the poor.

by Teresa A. Coughlin and David Liska

ABSTRACT: The Medicaid disproportionate-share hospital (DSH) program has been the subject of considerable policy debate throughout the 1990s, prompting Congress to revise the program three times since 1991. Using Medicaid administrative data and information obtained from twelve state case studies, we examined how the study states dealt with the federal reforms. We found a variety of state responses, ranging from not spending their full DSH allotments to seeking new, "DSH-like" federal money to help support safety-net providers.

THE MEDICAID DISPROPORTIONATE-SHARE hospital (DSH) program has sparked intense federal/state debate. The federal government has criticized some states for "abusing" the program by using it to diminish their fiscal responsibilities at the expense of the federal government. The states counter that the program is essential to maintaining the health care safety net for vulnerable populations. And many hospitals (especially public ones) argue that DSH payments are critical to their survival.

Federal law requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. This requirement is known as the Medicaid DSH payment adjustment. DSH expenditures have soared in the 1990s; by 1996 they accounted for one out of every eleven dollars spent on Medicaid.

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Congress has reformed the Medicaid DSH program three times since 1991. To comply with these reforms, many states have made sweeping changes to their DSH programs. In this paper we examine some state responses to the federal DSH provisions. We also discuss the potential effects of the DSH provisions in the Balanced Budget Act (BBA) of 1997. We rely on Medicaid administrative data as well as information obtained from the Assessing the New Federalism (ANF) case-study states.[1]

Controlling Spending Growth

Although the DSH mandate was enacted in the early 1980s, states were slow to implement DSH programs. To encourage them, Congress passed several DSH provisions in the mid-1980s. A key provision (included in the Omnibus Budget Reconciliation Act, OBRA, of 1986) allowed states to pay hospitals rendering high volumes of care to low-income patients rates above those paid by Medicare and exceeding the so-called Medicare upper payment limit.[2] This exception fed the rapid growth of Medicaid DSH expenditures that began in the early 1990s.

Another key to DSH expenditure growth was the development of provider tax and donation programs in the late 1980s, under which states taxed or received "donations" from health care providers. Using the revenue generated, states would issue a Medicaid payment (for example, a DSH payment), generally to the same providers that had been taxed or had made a donation. Since state Medicaid expenditures are eligible for partial reimbursement from the federal government, the state then would seek federal matching dollars.

Provider tax and donation programs had enormous financial advantages for a state. Each dollar raised from a tax or donation program could generate one to four dollars in federal Medicaid matching funds. To earn the match, however, the state had to spend the tax or donation revenues, because the federal Medicaid match is based on expenditures, not revenues. The Medicaid DSH payment provided the mechanism to spend these revenues. The DSH payment was singled out because it was not subject to the Medicare upper payment limit. Thus, states could make virtually unlimited DSH payments and, in the process, earn federal matching dollars.

Once states discovered that they could leverage additional federal dollars, many established provider tax and donation programs in the early 1990s. DSH payments rose from $1.3 billion in 1990 to $17.7 billion in 1992. DSH spending accounted for 13 percent of total Medicaid spending in 1992, up from only 1.9 percent in 1990. By 1996, DSH payments had moderated at $15.1 billion.

■ **The first DSH reform: 1991.** Congress first responded to the rapid rise in Medicaid DSH payments by passing the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 101-234). Key provisions included (1) essentially banning provider donations; (2) limiting provider taxes so that provider tax revenues could not exceed 25 percent of the state's share of Medicaid expenditures; (3) imposing provider tax criteria so that taxes were "broad based" and providers were not "held harmless"; and (4) capping state DSH payments at roughly 1992 levels.[3]

The 1991 law curtailed DSH payment growth and also forced many states to restructure DSH financing. Providers could no longer be promised DSH payments that at least equaled their taxes or donations. The new law required donations to be "bona fide" and taxes to be "real" assessments. As a result, many states had trouble establishing tax and donation programs that complied with the 1991 law.

Because of these difficulties, states turned to intergovernmental transfer (IGT) programs as the primary revenue source for their DSH programs. Under these programs, states transferred funds from public institutions such as state psychiatric facilities, university hospitals, and county or metropolitan hospitals to the state Medicaid agency. The state then would make DSH payments back to these hospitals, collecting federal Medicaid matching dollars in the process.

■ **The second DSH reform: 1993.** Although the 1991 law leveled DSH spending growth, federal policymakers remained concerned about the appropriateness of DSH payments in certain circumstances. A particular worry was that some states were making DSH payments to providers that were not large Medicaid providers, while other states were making DSH payments that more than compensated providers for the unreimbursed costs they incurred in caring for Medicaid and indigent patients. Moreover, some providers were receiving DSH payments in excess of the revenue they received for rendering care to Medicaid patients. In short, federal policymakers believed that DSH payments were not fully being used for their intended purpose of helping safety-net providers but rather to help general state financing. Indeed, a 1993 survey of thirty-nine state DSH programs found that one-third of DSH funds were being retained by states and not being paid to DSH hospitals.[4] Congress responded in OBRA 1993 with provisions such as the following: (1) Only those hospitals that had a Medicaid use rate of at least 1 percent could receive DSH payments. (2) Total DSH payments to a single hospital could not exceed the unreimbursed costs of providing inpatient care to Medicaid and uninsured patients. These limits typically took effect in 1994 for public and 1995 for private hospitals.[5]

How The States Responded

To investigate how states dealt with the 1991 DSH law and OBRA 1993, we examined Medicaid expenditure data from Health Care Financing Administration (HCFA) Form 64, which is submitted by all states.[6] We also relied on information obtained from the ANF case studies of thirteen states. We asked several respondents (including state Medicaid officials, hospital executives, and hospital association representatives) about their state's DSH program.

Although the ANF states were not selected to be representative of states' DSH programs, they account for a large share of national DSH expenditures (about 60 percent in 1996). They also represent a cross-section of Medicaid DSH programs. The thirteen states varied greatly in the size of their programs (Exhibit 1).

States also varied in how they financed their DSH programs. Most of the states relied exclusively on IGTs for state financing, but

EXHIBIT 1
Characteristics Of Medicaid Disproportionate-Share Hospital (DSH) Payment Programs, 1995–1996

State	1995 DSH status[a]	Primary revenue source for state financing[b]	Share of FFP retained by state[c]	Facility type receiving DSH funds[d]	1995–96 average DSH spending (millions)	DSH as percent of total 1995–96 spending
All states	–[e]	–[e]	–[e]	–[e]	$16,907	11%
ANF states[f]	–[e]	–[e]	–[e]	–[e]	8,885	11
Alabama	High	IGT	High	Public	406	20
California	High	IGT	Low	Public/private	2,162	14
Colorado	High	IGT	High	Largely public	113	8
Florida	Low	IGT	–[g]	Largely public	337	6
Massachusetts	Low	HRT	High	Public/private	590	11
Michigan	Low	IGT	High	Largely public	393	8
Minnesota	Low	GR	Low	Public/private	30	1
Mississippi	Low	IGT	–[g]	–[g]	191	12
New York	Low	HRT	High	Public/private	2,790	11
Texas	High	IGT	Low	Largely public	1,513	17
Washington	Low	IGT	–[g]	Largely public	348	12
Wisconsin	Low	IGT	Low	Public/private	12	0.5

SOURCES: Health Care Financing Administration Form 64 data; and authors' research.
NOTES: FFP is federal financial participation. ANF is Assessing the New Federalism. IGT is intergovernmental transfers. HRT is health-related taxes. GR is general revenue.
[a] As part of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, states were classified as either high or low DSH. High-DSH states were capped at their 1992 spending levels unless DSH spending dropped below 12 percent. Low-DSH states could increase DSH spending at the same rate as the growth in their overall Medicaid spending.
[b] Details how individual states raise state funds for DSH following the 1991 law restricting provider taxes and donations.
[c] States differ in the proportion of federal DSH dollars that are actually returned to providers. In a few states a portion of the federal match generated by DSH is retained by the state government for other purposes.
[d] For some states, DSH payments are designed to flow primarily to public hospitals (mental and acute care). For other states, DSH payments are made to both private and public hospitals.
[e] Not applicable.
[f] Although New Jersey is one of the ANF states, it is not included in this analysis because of lack of data.
[g] Not available.

some (such as Massachusetts and New York) relied on health-related taxes, and only a few relied on state general revenue.[7] The share of federal DSH dollars paid to hospitals as intended varied as well. California and Colorado, for example, paid out more than 70 percent of their federal DSH funds to providers. By contrast, Massachusetts and New York retained the bulk of federal DSH funds to use for other purposes, both health and nonhealth. Different types of hospitals (public and private, acute care and mental) received DSH expenditures in various states.

States made a number of changes to accommodate the 1991 DSH law and the OBRA 1993 DSH provisions, which are summarized in Exhibit 2. Although many of the changes were prompted by federal mandates, other factors also were influential. One such influence was the state's goals for the DSH program: Had it been viewed as a way to leverage federal dollars, or had it been used for its intended

EXHIBIT 2
Summary Of States' Policy Decisions Regarding The 1991 Disproportionate-Share Hospital (DSH) Law And The OBRA 1993 DSH Provisions

ANF states[a]	Expanded DSH payments to IMDs[b]	Reduced DSH spending[c]	Expanded state fiscal year[d]	Enhanced Medicaid provider reimbursements[e]	Maintained funding to original contributors[f]	Obtained federal legislative/regulatory relief	
						1991 law[g]	OBRA 1993[h]
Alabama					●		●
California			●	●			●
Colorado		●			●		
Florida	●				●		
Massachusetts				●		●	
Michigan	●	●		●	●		
Minnesota		●					●
Mississippi					●		
New York						●	
Texas	●				●		
Washington	●		●		●		
Wisconsin				●			

SOURCE: Authors' research.
NOTES: IMD is institution for mental disease. OBRA is Omnibus Budget Reconciliation Act.
[a] One of the Assessing the New Federalism (ANF) states, New Jersey, was not included in this analysis.
[b] States that increased total payments to IMDs as the hospital-specific caps became binding for inpatient facilities.
[c] Some states have maintained DSH funding levels as allowed under the 1991 DSH law.
[d] DSH caps are based on the state fiscal year. Two states expanded their 1995 state fiscal year to take further advantage of the final year of the more liberal hospital-specific caps for public facilities that expired after 1995.
[e] Highlights states that increased provider reimbursements for hospitals (and in some instances other providers) where there was room under the Medicare upper payment limit as the 1991 and 1993 DSH provisions took hold.
[f] Before the 1991 law states were able to more easily direct DSH funds to hospitals that donated funds or paid targeted provider taxes. After 1991 some states modeled their state Medicaid plans so that this relationship was maintained even with the requirements for broad-based taxes and bona fide donations. Other states, while shifting to intergovernmental transfers as the primary funding mechanism, allowed DSH funds to flow to facilities that did not pay into the system.
[g] For two states (Massachusetts and New York) the state-specific DSH caps legislated in the 1991 law became binding, and the states sought federal regulatory relief to develop DSH-like programs.
[h] Three states were able to convince either Congress or the Health Care Financing Administration to release some restrictions imposed by the OBRA legislation to maintain historical levels of DSH funding.

purpose? State politics also played a role, as did the general health care environment (for example, the competitiveness of the market, growth in Medicaid managed care, and the numbers of uninsured persons).

■ **Switch to intergovernmental transfers.** An almost immediate response to the 1991 law was that most states fundamentally changed how they financed their DSH share. As mentioned earlier, many states had trouble establishing provider tax and donation programs that met the 1991 criteria. Many responded by switching to IGTs, which shifted funds from public institutions (such as psychiatric facilities and university and public hospitals) to the state Medicaid agency. IGTs generally were made by state- or locally owned public hospitals. Most of our study states used IGTs to support their DSH programs.[8]

The remaining states made little or no adjustment to their financing structure, since their existing mechanisms were not invalidated (or claimed as such) by the 1991 law. New York's and Massachusetts's DSH payments (paid out through their uncompensated care pools) have been consistently supported by provider tax programs.[9] The tax programs remained similar in structure after the 1991 law took effect. California did not switch its DSH financing, because the state's program had been supported by IGTs since it began in 1991.

■ **Payments to mental health institutions.** An early response to OBRA 1993 was that several states began making or expanding DSH payments to institutions for mental disease (IMDs), for two reasons. First, IMDs are generally public institutions owned by state or local governments. The link between the financing (with IGTs) and DSH payment thus could be tight, thereby keeping DSH funds in the public domain. Second, including both acute care and mental hospitals made it easier for states to fully spend their DSH allotments while staying within the OBRA 1993 facility-specific caps.

Increasing DSH payments to IMDs was a temporary shift for some states, more permanent for others. Alabama paid 64 percent of its total DSH payments to IMDs in 1994 (no IMD DSH payment was reported in 1993) and then reduced this amount to 1 percent in 1995 (Exhibit 3). In other states, such as Florida, a more fundamental shift occurred, with the share of DSH funds going to IMDs increasing every year. Still other states (Mississippi, California, and Colorado) made little or no use of these payments.

The use of IMDs for DSH funds has been an especially contentious area between the federal government and the states. By making large Medicaid DSH payments to mental hospitals, states are to some degree federalizing their funding. Because of statutory limits, Medicaid has not been a large payer of inpatient mental health

EXHIBIT 3
Medicaid Disproportionate-Share Hospital (DSH) Payments To Mental Health Institutions As A Percentage Of Total DSH Spending, 1994–1996

	1994	1995	1996
All states	20%	21%	21%
ANF states[b]	16	19	21
Alabama[c]	64	1	12
Alaska	69	95	100
Arizona	0	0	0
Arkansas	0	0	0
California[c]	0	0	0
Colorado[c]	< 1	< 1	< 1
Connecticut	30	33	37
Delaware	100	100	100
District of Columbia	23	16	14
Florida[c]	37	45	50
Georgia	0	0	0
Hawaii	0	0	0
Idaho	0	0	0
Illinois	0	16	27
Indiana	87	56	49
Iowa	0	0	0
Kansas	95	87	89
Kentucky	0	0	22
Louisiana	< 1	9	14
Maine	24	27	30
Maryland	74	75	74
Massachusetts[c]	38	17	23
Michigan[c]	< 1	70	69
Minnesota[c]	10	0	11
Mississippi[c]	0	0	0
Missouri	19	28	21
Montana	0	0	0
Nebraska	46	27	4
Nevada	0	0	0
New Hampshire	45	31	60
New Jersey[c]	33	29	33
New Mexico	< 1	0	0
New York[c]	7	15	11
North Carolina	96	69	55
North Dakota	93	82	83
Ohio	0	15	0
Oklahoma	12	14	13
Oregon	62	56	77
Pennsylvania	55	54	52
Rhode Island	< 1	1	0
South Carolina	10	17	10
South Dakota	0	0	71
Tennessee	1	0	0
Texas[c]	17	19	21
Utah	17	20	25

EXHIBIT 3
Medicaid Disproportionate-Share Hospital (DSH) Payments To Mental Health Institutions As A Percentage Of Total DSH Spending, 1994–1996 (cont.)

	1994	1995	1996
Vermont	47%	26%	30%
Virginia	7	5	6
Washington[c]	14	51	30
West Virginia	0	21	66
Wisconsin[c]	21	35	73
Wyoming	0	0	0

SOURCE: Health Care Financing Administration Form 64 data.
NOTE: ANF is Assessing the New Federalism.
[a] Calculated as DSH spending on institutions for mental disease (IMDs) divided by total DSH spending (inpatient and mental health benefits). Administrative costs and accounting adjustments are not included.
[b] Although New Jersey is one of the ANF states, it was not included in this calculation because of insufficient case-study information.
[c] ANF state.

services; instead, states have been.[10] Thus, when states started to make large DSH payments to IMDs, federal dollars effectively supplanted state dollars. DSH payments to IMDs were greatly curtailed in the 1997 Balanced Budget Act; we return to this point later.

■ **Reduced DSH spending.** While some states are spending their full DSH allotment as allowed under the 1991 law, some either cannot or have chosen not to. Nationally, states spent 77 percent of the total DSH allotment in 1996, down from 92 percent in 1994 (Exhibit 4).[11] Among our study states, Colorado, Michigan, and Minnesota have shown the greatest declines. The case studies revealed a number of reasons why these states were not spending their full allotments. Colorado spent $122 million on DSH in 1996, less than half of its $320 million allotment. According to respondents, a key reason was that Colorado policymakers have intentionally sought to keep the state's DSH program small so that if the federal government ever cut the DSH program they would not have to face hospitals' expectations of maintaining DSH funding. Another reason officials cited was that if Colorado spent its full DSH allotment it would be in violation of state spending limits, as codified in the state's constitution. Colorado hospitals have tried unsuccessfully to get the state to increase DSH spending. In 1997 hospitals developed a strategy that would allow the state to spend more of its DSH allotment while keeping within the state spending limits. The legislature, however, was not interested.

Michigan has greatly reduced its DSH spending, for different reasons. Between 1994 and 1996 Michigan's DSH spending fell from $617 million to $347 million; in 1996 the state spent only half of its allotment. These large decreases are explained by the changes Michigan made to its DSH program to comply with OBRA 1993.

EXHIBIT 4
Medicaid Disproportionate-Share Hospital (DSH) Spending, By Percentage Of Total Allotment Spent, 1994–1996

	DSH spending as percent of total 1995–1996 spending[a]	DSH spending as percent of total allotment[b]		
		1994	1995	1996
All states	11%	92%	98%	77%
ANF states[c]	11	93	102	82
Alabama[d]	20	100	100	95
Alaska	5	89	90	66
Arizona	–[e]	–[e]	–[e]	–[e]
Arkansas	< 1	100	97	100
California[d]	14	92	133	64
Colorado[d]	8	59	35	40
Connecticut	16	100	110	108
Delaware	2	100	101	100
District of Columbia	6	130	108	62
Florida[d]	6	99	100	100
Georgia	11	93	100	87
Hawaii	–[e]	46	–[e]	–[e]
Idaho	< 1	22	192	97
Illinois	5	76	91	45
Indiana	11	88	139	48
Iowa	< 1	110	74	76
Kansas	7	87	39	29
Kentucky	9	25	83	53
Louisiana	28	109	104	66
Maine	17	100	100	100
Maryland	6	116	112	97
Massachusetts[d]	11	95	106	99
Michigan[d]	8	100	65	51
Minnesota[d]	1	79	39	56
Mississippi[d]	12	100	100	100
Missouri	26	97	100	99
Montana	< 1	20	18	17
Nebraska	< 1	79	81	26
Nevada	16	100	100	100
New Hampshire	34	97	84	59
New Jersey[d]	21	94	118	91
New Mexico	1	50	39	58
New York[d]	11	89	96	87
North Carolina	10	100	100	79
North Dakota	< 1	100	100	71
Ohio	10	88	100	100
Oklahoma	2	100	76	76
Oregon	2	85	89	84
Pennsylvania	10	84	82	66
Rhode Island	10	100	155	0
South Carolina	22	109	100	100
South Dakota	< 1	20	74	68
Tennessee	–[e]	25	–[e]	–[e]
Texas[d]	17	100	100	100
Utah	< 1	88	76	83

EXHIBIT 4
Medicaid Disproportionate-Share Hospital (DSH) Spending, By Percentage of Total Allotment Spent (cont.)

	DSH spending as percent of total 1995–1996 spending[a]	DSH spending as percent of total allotment[b]		
		1994	1995	1996
Vermont	10%	71%	128%	99%
Virginia	7	75	71	66
Washington[d]	12	100	103	99
West Virginia	1	85	20	2
Wisconsin[d]	< 1	107	100	98
Wyoming	0	0	0	0

SOURCE: Health Care Financing Administration Form 64 data.
NOTE: ANF is Assessing the New Federalism.
[a] Calculated as total DSH (inpatient and mental health) spending divided by total DSH spending plus benefits. Administrative costs and accounting adjustments are not included.
[b] States may spend over their allotment in terms of the federal fiscal year and remain in compliance with the federal caps on a state fiscal year basis. States may have also overspent DSH funds in one year only to have the excess disallowed later by the Health Care Financing Administration; these percentages do not reflect the disallowances.
[c] Although New Jersey is one of the ANF states, it was not included in this calculation because of insufficient case-study information.
[d] ANF state.
[e] Not applicable. These states' 1115 waivers allow for DSH spending to be folded into general demonstration spending.

Before 1993 Michigan's DSH program channeled the bulk of its DSH payments through one hospital—the University of Michigan (UM) Hospital. As documented by the U.S. General Accounting Office, UM Hospital was really used as a pass-through of federal DSH funds, and most of the federal dollars were kept by the state.[12]

When the hospital-specific caps took effect, DSH payments to UM Hospital were cut from $570 million in 1994 to $42 million in 1996. In their stead, Michigan began to make large payments to state mental hospitals; between 1994 and 1996 the state's DSH payments to IMDs went from $2 million to $240 million.

Although the IMD DSH payments made up some of the funds that had previously been paid to UM Hospital, Michigan wanted to maintain federal Medicaid dollars coming to the state at a level comparable to the pre–OBRA 1993 period. To do this, the state began to make a series of Medicaid supplemental payments (which totaled more than $600 million in 1996) over and above regular Medicaid reimbursement to a range of publicly owned health care providers. Thus, while Michigan's formal DSH spending has declined, the state has significantly increased Medicaid supplemental payments to a select group of providers.

Minnesota has a relatively small DSH program that, since its inception, has been financed with state general funds. In recent years Minnesota's DSH spending has declined; by 1996 the state was spending about 60 percent of its $64 million allotment. The decrease

is explained in large part by how it sets capitation rates for its Medicaid managed care program. In 1992 Minnesota began folding DSH payments into Medicaid managed care capitation rates (as one of several adjustment factors) in lieu of paying hospitals directly. DSH payments were to "trickle down" to hospitals. Once the DSH adjustment is included in the rate, it is no longer considered a DSH payment for federal reporting. Thus, although Minnesota's reported DSH spending has declined, the state continues to expressly account for safety-net hospitals' financial needs when setting cap rates. However, whether the DSH payment adjustment does in fact trickle down to hospitals is difficult, if not impossible, to track.

■ **Expanded state fiscal year.** Two states expanded their state's fiscal year to take advantage of the phase-in of the OBRA 1993 hospital caps. To ease the transition, Congress allowed states to reimburse certain hospitals up to 200 percent of their Medicaid and uncompensated care shortfalls during 1995. Then, in 1996 the 100 percent cap would apply to these hospitals. In effect, by extending state FY 1995 from four to five quarters, California and Washington moved DSH spending from state FY 1996 back to state FY 1995, when the 200 percent cap still applied. Obviously, this approach is a one-time strategy. However, it allowed these states to delay the full impact of the cap for a year.

■ **Enhanced provider payments.** Another response to the 1991 and OBRA 1993 DSH provisions was that some states began to make supplemental Medicaid payments to hospitals as well as to other providers. Generally, these payments are made to selected providers (typically public facilities) and are paid over and above regular Medicaid service reimbursement. As such, enhanced payments do not count against a state's DSH allotment or an individual hospital's DSH cap. Instead, they are reported as a regular service expenditure.

California, Massachusetts, Michigan, and Wisconsin are among the states that have used this strategy. California has made supplemental payments for nearly a decade to hospitals that contract with the state to serve Medicaid clients. California's supplemental payment program operates along the same lines as its DSH program: The state receives funds transferred from hospitals that contract to serve Medicaid clients.[13] The funds are then put into a single pool. When determining Medicaid hospital payments during its annual rate negotiations, the state redistributes pool funds to selected hospitals as increased payments. The state then receives federal matching funds for the additional payments, which are not counted against California's DSH allotment. Although the supplemental payment program has been in place since the late 1980s, the state has recently increased the amount of supplemental payments. Some of

this is the result of a general state effort to get more money to Medicaid hospitals in the wake of OBRA 1993 caps.

Among our states, Michigan made the most extensive use of supplemental payments. The state has turned to making targeted Medicaid supplemental payments as a way to maintain its level of federal Medicaid funds. Specifically, beginning in 1995 (as the OBRA caps were taking effect) Michigan began to issue large Medicaid supplemental payments to public facilities. The state's share for these payments came from IGTs paid by the institutions receiving the supplemental payments (such as community mental health boards and schools that deliver Medicaid-funded special education services). In 1996 Michigan made more than $600 million in targeted supplemental payments (reported as a Medicaid service expenditure, not a DSH expenditure), up from about $390 million in 1994. Thus, Michigan has replaced a large share of its DSH expenditures with supplemental Medicaid payments while maintaining the level of federal Medicaid dollars coming to the state.

■ **Maintained link between funding and DSH.** Over the years many states have received revenue in the form of provider taxes or donations from a targeted group of providers, which was later returned to the very same providers in the form of DSH payments. This practice of targeted payment typically continued (and sometimes became more refined) when IGTs were developed: Public facilities provide state financing of DSH payments, and payments generally were made to the transferring facilities. However, when the OBRA caps became effective, states' ability to channel DSH payments to selected providers was greatly limited. States now had to decide how tightly they were going to preserve the link between DSH funding and DSH payment. As part of this decision, states had to determine whether they were going to allow some of the DSH dollars to go to providers that were unable to make IGTs (such as private hospitals).

Our study states adopted a range of policies on this matter. As discussed earlier, Colorado and Michigan decided for different reasons to forgo spending their full DSH allotments but kept the strong tie between IGT funding and DSH payout by largely restricting payments to public facilities.

The OBRA caps posed significant issues for Alabama, which had had an IGT-financed DSH program. Since the early 1990s Alabama had become highly reliant on federal DSH funds: In 1995 federal DSH dollars accounted for at least 40 percent of the state's $2 billion Medicaid program, whereas state general fund dollars accounted for only 11 percent.

As the hospital-specific caps took hold, in 1995 Alabama devel-

oped a network of eight prepaid health plans (PHPs), fully capitating Medicaid inpatient care spending across the state.[14] PHPs are new, for-profit entities owned and operated by hospitals in each of eight service areas across the state. When Alabama sets the PHP cap rates, DSH payments are included. PHPs are then responsible for negotiating reimbursement rates for each hospital. By folding DSH payments into the PHP cap rate, the state has effectively avoided the hospital-specific cap. At the same time, it has successfully kept the link between its DSH funding source and payout very tight.

California has also consistently spent its full DSH allotment. Unlike Alabama, however, the state has allowed some decoupling of the funding and payout of its DSH program. Since the state started its DSH program in 1991, California counties, through IGTs, have supplied the state's share of DSH payments. Although California has always made DSH payments to private hospitals, the bulk of federal DSH funds went to county hospitals. However, the share of federal funds going to county hospitals has declined over time: Between 1991 and 1995 federal DSH funds paid to county hospitals dropped from $649 million to $461 million, while the amount paid to private hospitals more than doubled, from $162 million to $365 million.

According to respondents, the competitiveness of California's health care market is the primary reason for the DSH shift. As managed care for privately insured patients has increased and private hospital payment rates have declined, Medicaid reimbursement rates increasingly have been viewed by California hospitals as attractive, especially with the Medicaid DSH add-on. The OBRA 1993 caps also have affected the distribution of federal DSH dollars among hospitals, although to a lesser extent.[15]

The continued shift of federal DSH dollars to private hospitals has become a highly contentious issue in California. Private hospitals argue that because they serve Medicaid patients, they are entitled to DSH funds. Counties assert that federal DSH dollars should be retargeted and flow instead to providers that serve a disproportionate share of uninsured indigent persons (that is, to county hospitals). The DSH issue in California has temporarily subsided since the passage of the BBA of 1997, which included a special state exemption from the OBRA 1993 hospital-specific cap: For two years California is allowed to pay hospitals 175 percent of unreimbursed costs rather than 100 percent as allowed under OBRA 1993.

■ **Additional DSH-like federal funds.** Three states (California, New York, and Massachusetts) obtained additional DSH-like federal funds (via Medicaid Section 1115 waivers) to help support safety-net hospitals. Although these DSH-like funds are targeted to safety-net hospitals, they are not reported as DSH expenditures.

"For the Medicaid program, DSH was Congress's prime budget target as it looked for ways to cut federal spending."

Thus, these waivers have effectively introduced a new type of federal support to safety-net providers.

In 1995 the federal government granted Los Angeles County an 1115 waiver, which allocated additional federal money to the county health care system, on the condition that the system be restructured to have more of an emphasis on ambulatory care. The county projects that it will receive approximately $900 million in federal funds over the five-year waiver period. Some of the waiver funds also are being used to expand the county's ambulatory care capacity and to assist county hospitals in becoming more competitive.

Likewise, New York, as part of its new 1115 Partnership Plan waiver, was granted additional federal funds to help safety-net hospitals make the transition to mandatory Medicaid managed care. New York plans to move approximately two million Medicaid enrollees from fee-for-service to managed care over the five-year demonstration period. Under New York's Community Health Care Conversion Demonstration Project (CHCCDP), $1.2 billion in federal funds will be made available to safety-net hospitals. These funds are not counted against New York's $3 billion DSH allotment nor against a hospital's DSH cap. Instead, funds paid out through the CHCCDP represent new federal "DSH-like" dollars that are going to the state.

In recent years Massachusetts has been struggling to support its uncompensated care pool, which has operated as part of the state's hospital rate-setting system since 1985. Payments made from the pool are claimed as Medicaid DSH expenditures. The pool, which had been funded by a tax on hospitals' private-payer charges, was designed to distribute the burden of hospital uncompensated care and to eliminate hospitals' incentives to underserve the uninsured.

Several problems developed with the pool. A key one was that the amount of money in the pool, frozen since 1990, became increasingly inadequate as the number of uninsured persons grew. However, the 1991 DSH law limited the amount by which Massachusetts could increase pool payments. Since pool payments are the state's DSH payments and Massachusetts is a low-DSH state, it could increase payments only at the same rate as that at which its total Medicaid expenditures increased. This limit, along with other problems, raised serious questions about the integrity of the pool program as well as about the state's ability to support safety-net providers.

As part of its 1115 waiver program, Massachusetts will reduce pool payments to two large Boston hospitals that had received the bulk of DSH payments made from the pool. Instead of DSH payments, these two hospitals will establish capitated managed care plans for previously uninsured persons who are being extended Medicaid coverage as part of an eligibility expansion included in the waiver. The new plans created by the two hospitals would be paid an enhanced capitation rate, making up for the hospital's loss of DSH or pool payments. The enhanced rates are paid outside the pool and not counted against the state's DSH allotment. The waiver has allowed Massachusetts to issue more dollars to safety-net providers and to bypass the state's DSH allotment.

■ **Federal legislative/regulatory relief.** A few states obtained federal legislative or regulatory relief from the 1991 and 1993 laws. California and Alabama were particularly noteworthy in this regard.

Along with the additional federal dollars granted to Los Angeles County, California was given a special exemption to the BBA's hospital-specific cap. Specifically, the BBA increased the hospital-specific cap on DSH payments so that California is allowed to pay hospitals 175 percent of unreimbursed costs rather than 100 percent as set out in OBRA 1993. This exemption is valid until October 1999.

As described above, in 1995 Alabama established a statewide network of Medicaid PHPs. Initially, HCFA was concerned that the hospital-specific DSH caps were being violated, but the state claimed that the DSH payment rules do not apply to managed care organizations such as the PHPs. After considerable negotiations, HCFA awarded the state a two-year waiver—specifically a 1915(b) waiver—in 1997, allowing the state to mandate enrollment of Medicaid recipients into the PHPs. What will happen at the end of the waiver period is unclear.

DSH Provisions In The 1997 Balanced Budget Act

The DSH program will continue to change. The 1997 BBA included several DSH provisions, including the following.[16] (1) New state-specific DSH allotments are established for each year during 1998–2002, eliminating the allotments established in the 1991 DSH law. Federal DSH expenditures are allowed to increase after 2002 by the percentage change in the Consumer Price Index, subject to a ceiling of 12 percent of each state's total annual Medicaid expenditures. (2) Limits have been placed on how much of a state's federal DSH allotment can be paid to IMDs. By 2002 no more than 33 percent of a state's federal DSH allotment can be paid to IMDs. (3) DSH payments made on behalf of Medicaid clients in managed care must be paid directly to hospitals rather than plans.[17]

For all states, the DSH allotments in the BBA represent a reduction over allotments allowed under previous law. The Congressional Budget Office (CBO) estimated federal DSH spending reductions from the BBA provisions at $10.4 billion over 1998–2002.[18] Indeed, for the Medicaid program, DSH was Congress's prime budget target as it looked for ways to cut federal spending.

In a recent simulation analysis we assessed how the BBA's DSH provisions are likely to affect states.[19] One set of results, which simulated reductions in federal DSH spending from 1998 to 2002 likely to result from the BBA relative to actual 1995 DSH spending, suggested an 11 percent reduction in federal DSH spending nationally.[20] The estimated impact also varied greatly from state to state. Among ANF study states, the estimated cuts were large for some states (such as Alabama, California, Massachusetts, and Texas) but relatively small for others (Minnesota, New York, and Wisconsin).

Another important Medicaid item in the BBA was a special provision for New York State, which would have allowed the state to continue getting federal Medicaid matching dollars for certain health care provider taxes. President Bill Clinton, however, used his new line-item veto authority and struck down the provision, estimated to represent $1.5 billion in Medicaid funds to the state. The veto provoked considerable ire among New York State policymakers.[21] At issue was whether some of New York's provider tax programs violated the health care provider tax criteria set out in the 1991 DSH law. The federal government charged that some of New York's tax programs—one of which supports the state's charity care pool—did not comply with the 1991 legislation and declared that federal matching funds should not be paid. The New York veto has important implications for several other states currently negotiating with the federal government about the permissibility of provider tax programs. Moreover, the dispute raises the highly important matter of how states can finance their share of Medicaid costs. As of this writing, the Clinton administration has reinstated up to $1 billion of the $1.5 billion in question. When announcing the policy change, though, federal officials stated that they want to end the use of impermissible taxes as soon as possible and suggested that Congress may have to revisit the provider tax matter in the future.[22]

Only two of the states that we studied (Minnesota and Wisconsin) did not make any fundamental changes to their DSH programs following the changes to the laws in 1991 and 1993. In these states DSH is largely financed like any other Medicaid service and is paid to providers to help cover the hospitals' unreimbursed costs of caring for Medicaid and other low-income patients.

Most of our states, however, did make changes to their DSH programs in response to federal policy revisions. These changes raise important questions about the purpose and integrity of the DSH program, as well as its future direction. For example, several study states are now making sizable DSH payments to mental hospitals, which are not typically large Medicaid providers and are not the intended beneficiary of DSH funds. A few study states have gone outside the boundaries of the DSH program and have started issuing targeted Medicaid supplemental payments to providers, including hospitals. Indeed, in Michigan supplemental payments have replaced a large share of the state's DSH program. The fact that these supplemental payments are funded primarily with IGTs, and paid to a variety of providers, calls into question the direction in which the state's overall Medicaid financing is heading.

Still other states have started to receive additional federal funds (to which we refer as DSH-like funds) to help shore up their safety-net providers. California, New York, and Massachusetts have all received large amounts of federal dollars for this purpose through the Medicaid Section 1115 waiver process. These new funds are counted not as DSH expenditures but as general Medicaid expenditures. Still other states are now folding DSH payments into global capitation rates for managed care plans, with the notion that DSH monies will "trickle down" to hospitals. Once included in the capitation rates, DSH as a distinct expenditure item is no longer reported. In sum, among our states, what constitutes a DSH expenditure is becoming increasingly more difficult to define and identify.

With the passage of the BBA, the DSH program will go through more changes in the near future. How the New York tax dispute is ultimately resolved, for example, likely will affect the future financing of DSH and of the whole Medicaid program. More immediately, the reduction in federal DSH payments will affect states in 1998. To the extent that DSH payments are being paid to hospitals, the BBA cutbacks represent a decline in Medicaid revenue going to safety-net providers. The reductions come at a time when safety-net providers are already feeling fiscal stress from changes in the overall health care market.

To the extent that federal DSH dollars are being retained by states and used to fund other state functions, the BBA cutbacks represent a decline in state revenues. Although states are enjoying the benefits of a strong U.S. economy, all state budget sectors including Medicaid will feel the loss of federal DSH dollars when a fiscal downturn hits.

How states will handle the DSH reductions is unclear. State policymakers will need to make some key decisions in the near future. For

example, states may opt to offset the loss of federal DSH dollars with state dollars. Alternatively, they may opt to let hospitals or county governments absorb the loss in revenue. Because more than thirty-five million Americans lack insurance, though, the need to support safety-net providers is profound. As such, the federal DSH reductions will pose new challenges to states as they look for ways to finance health care services for their low-income populations.

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NOTES

1. The Assessing the New Federalism (ANF) project is a multiyear study that is monitoring changing social policies in thirteen states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). For more detail on the ANF project, see A. Kondratas, A. Weil, and N. Goldstein, "Assessing the New Federalism: An Introduction," in this volume of *Health Affairs.* Although New Jersey is one of the ANF states, it is not included in this analysis.
2. In 1983 HCFA issued a regulation stating that states could not pay more in the aggregate for Medicaid inpatient care or institutional long-term care services than what would have been paid under the Medicare program.
3. The law limited national DSH payments to 12 percent of total Medicaid costs. States whose DSH payments exceeded this level ("high-DSH" states) in 1992 could not do so in the future unless DSH spending dropped below 12 percent. States that spent less than 12 percent ("low-DSH" states) could increase spending at the same rate as their Medicaid spending growth.
4. L. Ku and T.A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* 16, no. 3 (1995): 27–54.
5. Some exceptions to the implementation deadlines were included. Most notably, certain public hospitals that were determined to be "high-DSH" hospitals were permitted to received payments up to 200 percent of unreimbursed costs of their Medicaid and uninsured patients during 1995.
6. HCFA Form 64 data are the financial reports in which states set out their Medicaid expenditures by service category; these data are the basis for federal Medicaid matching payments to the states.
7. Although not shown in Exhibit 1, a couple of states (Colorado and Massachusetts) used state general revenues to support their DSH programs. Compared with IGT funds, however, general revenue funds were small.
8. Ku and Coughlin, "Medicaid Disproportionate Share." This shift corroborates findings from a 1993 survey on DSH programs.

9. Since 1985 Massachusetts has supported an uncompensated care pool, which was designed to distribute the burden of uncompensated care, reduce cost shifting, and eliminate incentives to underserve the uninsured. The pool was financed by a tax on hospitals' private payer charges. Beginning in 1990 the state began claiming uncompensated care pool payments as DSH payments and earning federal Medicaid matching dollars. Similarly, New York State supports several initiatives (such as its bad debt and charity care pool) designed to help safety-net hospitals. Payments made from these initiatives are funded by hospital provider taxes and claimed as Medicaid DSH payments.
10. Medicaid statute mandates that the program only cover inpatient mental health services for persons under age twenty-one and over age sixty-four; adults ages twenty-one to sixty-four are not covered.
11. Part of this decline can be attributed to the few states that accelerated 1995 DSH spending at the expense of reported 1996 DSH spending. California spent 133 percent ($2.9 billion) of its allotment in 1995 but only $1.4 billion in 1996; over two years, this averages to $2.1 billion, equal to its annual allotment.
12. U.S. General Accounting Office, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government,* GAO/HEHS-94-133 (Washington: GAO, 1994).
13. California operates a hospital selective contracting program in which selected hospitals are contracted to serve the Medicaid population. The state negotiates separate rates with each contracting hospital.
14. Only inpatient hospital care is provided through the PHPs; all other Medicaid services continue to be provided on a fee-for-service basis.
15. However, the full effect of the DSH cap has not been felt by California in 1996 because it made use of the expanded state fiscal year strategy discussed earlier.

16. As mentioned earlier, the BBA contained other DSH provisions than those highlighted in the text. Most noteworthy is the two-year special exemption from the hospital-specific cap California obtained. A. Schneider, *Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33* (Washington: Center for Budget and Policy Priorities, September 1997).
17. This particular provision does not apply to DSH payments that were being paid to managed care plans as of 1 July 1997.
18. Congressional Budget Office, *Budgetary Implications of the Balanced Act of 1997* (Washington: CBO, 12 August 1997).
19. T.A. Coughlin and D. Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues," *New Federalism: Issues and Options for States*, Policy Brief no. A-14 (Washington: Urban Institute, October 1997).
20. A key assumption in the simulation analysis was that in the absence of the new law, no growth in DSH spending over 1995 levels would have occurred between 1998 and 2002. Assuming no growth in DSH spending likely underestimates what the increase would have been under previous law and therefore probably also underestimates the extent of savings realized under the new provisions. Ibid., for more details on the simulation analysis.
21. A. Mitchell, "President Makes Use of New Veto," *New York Times,* 12 August 1997, A1; and J. Dao, "New York Stripped of Tax Setup That Aided Health-Care Services," *New York Times,* 12 August 1997, A1.
22. R. Pear, "U.S. Alters Medicaid Rules, but New York Isn't Mollified," *New York Times,* 10 October 1997, A18.