Medicaid Disproportionate Share and Other Special Financing Programs

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Medicaid disproportionate share hospital (DSH) and related programs, such as provider-specific taxes or intergovernmental transfers (IGTs), help support uncompensated care and effectively reduce State Medicaid expenditures by increasing Federal matching funds. We analyze the uses of these funds, based on a survey completed by 39 States and case studies of 6 States. We find that only a small share of these funds were available to cover the costs of uncompensated care. One method to ensure that funds are used for health care would be to reprogram funds into health insurance subsidies. An alternative to improve equity of funding across the Nation would be to create a substitute Federal grant program to directly support uncompensated care.

INTRODUCTION

One of the major factors causing the rapid growth of Medicaid expenditures from 1989 to 1992 was the increasing State use of DSH and related special financing programs, such as provider-specific taxes and IGTs. Similarly, the key reason for stabilized Medicaid spending growth in 1993 was the implementation of the cap on DSH payments (Coughlin, Ku, and Holahan, 1994; Winterbottom, Liska, and Obermaier, 1995). DSH payments were developed to help hospitals that provided disproportionate shares of care to the poor. But by the late 1980s and early 1990s, DSH payments became linked to provider taxes and related contributions as a strategy to increase Federal payments to States.

A hypothetical example illustrates how typical programs operate (Figure 1). Hospitals pay $50 million in taxes or IGTs to the State. The State, in turn, makes $60 million in DSH payments to hospitals. That is, hospitals receive $10 million more than they would without the program.[1] The State earns Federal matching funds based on the Medicaid DSH expenditure of $60 million. If the State has a 50-percent matching rate, it receives $30 million of Federal funds. Because the State gained $80 million in revenue ($50 million from hospitals and $30 million from the Federal Government) and makes $60 million in DSH payments, it has a net gain of $20 million. The net cost to the Federal Government is $30 million.

Special financing programs allowed States to increase Federal revenue while limiting the level of State-appropriated funds used for Medicaid. In 1993, DSH payments nationwide were about $17 billion and accounted for about 1 out of every 7 dollars spent in the Medicaid program. Put another way, Medicaid DSH payments in 1993 were roughly equal to the sum of Medicaid spending for all physician, laboratory, X-ray, outpatient, and clinic services (Winterbottom, Liska, and Obermaier, 1995).

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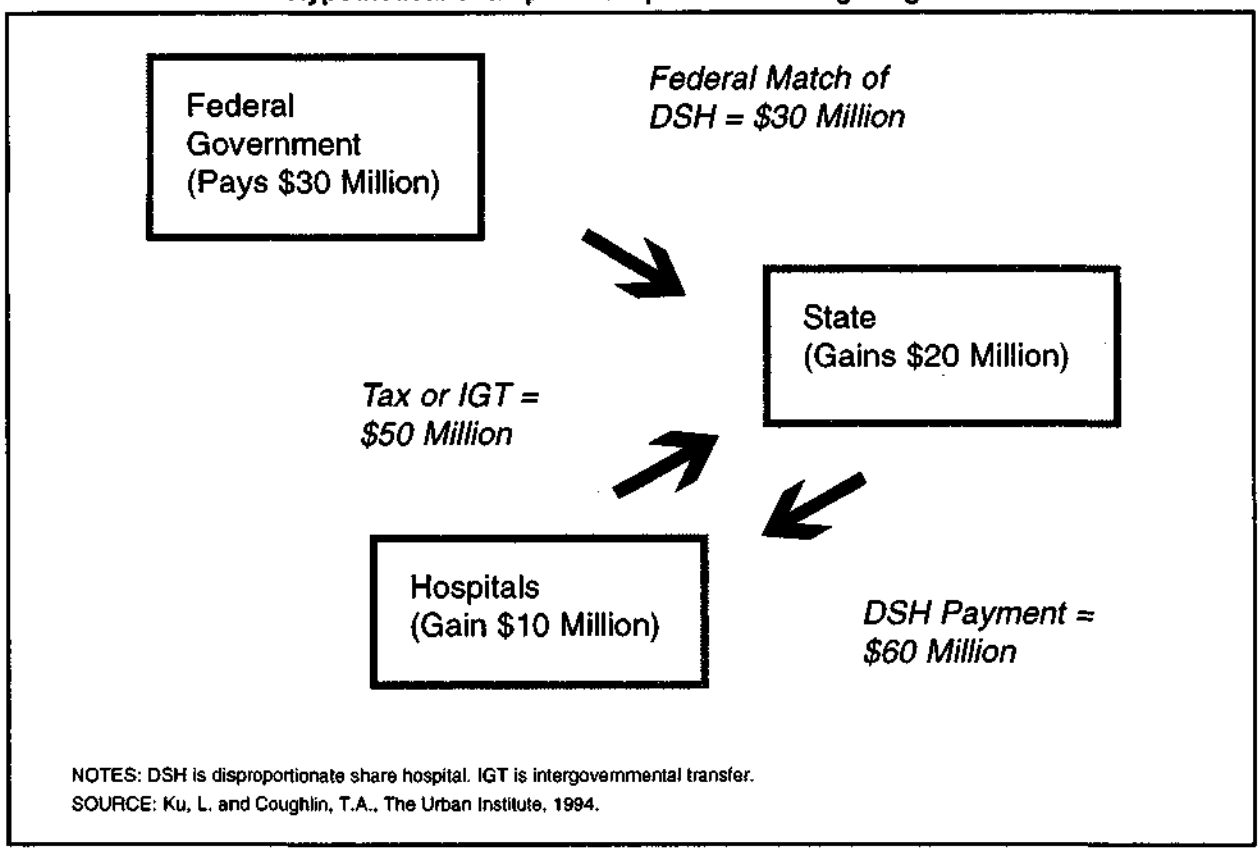
[1] These are aggregate gains. Individual hospitals might pay taxes or IGTs but get few or no DSH funds in return; whereas other hospitals that did not pay a tax or transfer might receive DSH funds.

Figure 1

Hypothetical Example of a Special Financing Program



NOTES: DSH is disproportionate share hospital. IGT is intergovernmental transfer.
SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

In addition to the large fiscal effects of DSH payments, broader public finance questions arose. When the Bush Administration criticized these programs, States questioned the Federal Government's authority to determine what counts as a "State dollar." Although these issues were subsequently settled through legislation, the debate crystallized concerns about delineating appropriate Federal versus State obligations in paying for health care. By shifting costs to the Federal Government, States essentially shifted costs to taxpayers in other States. The Federal-State financing design of Medicaid permits this based on the Federal Medicaid Assistance Percentage (FMAP), but these programs effectively increased the Federal matching rate for Medicaid beyond FMAP levels in many States.

Because special financing programs account for such a large share of Medicaid spending, they are potentially a major funding source for health care reform. Most of the major health reform proposals debated in the last session of Congress called for either eliminating DSH payments or greatly limiting them and using the funds for insurance subsidies. The rationale was that, as more people became insured under reform, the need to pay hospitals additional money to defray the cost of uncompensated care would dissipate. Similarly, States are looking at Medicaid DSH funds as a way to help pay for health reform. Indeed, some States are already reprogramming DSH dollars to extend Medicaid protection to the uninsured as part of broad Medicaid section 1115 waivers.

The complicated flow of funds between providers, States, and the Federal Government makes it difficult to discern how much is actually spent for medical care in State Medicaid programs. For example, in Figure 1 the hospitals received $60 million in DSH payments, but actually only gained $10 million. Financial reports, such as the HCFA Form-64, would indicate that $60 million more was spent for hospital care, not $10 million.

Although special financing programs have received great attention in recent years, little is known about them. For instance: How much revenue is collected through these programs, and who pays? How are DSH funds distributed, and who receives them—county, private, or State hospitals? How have States responded to the recent series of congressional and regulatory actions aimed at restricting special financing programs? To what extent did DSH funds go to support uncompensated hospital care? Were States able to use funds from these programs for other purposes?

This article presents findings from a survey of States and case studies of six States. Before we present our results, we provide some background on Medicaid special financing programs. We then describe our research methods and present the findings. We conclude with a discussion of the policy implications of the study results.

HISTORY OF SPECIAL FINANCING PROGRAMS

Special financing programs are a relatively recent development in Medicaid. In the same 1981 legislation that engendered the Boren amendment, Congress required that States consider special payment needs for hospitals that serve a disproportionate number of low-income patients. The rationale behind such action was that these hospitals often lost money as a result of uncompensated care and low Medicaid reimbursements and should receive supplemental support. That is, the DSH program was originally established to help hospitals, such as public and non-profit hospitals, that serve needy patients. Because these facilities have high Medicaid and uninsured caseloads and low private caseloads, they are less able than other hospitals to shift the costs of uncompensated care to privately insured patients. Although DSH payments were first authorized in 1981, States were initially reticent to implement DSH programs. Through legislation enacted between 1985 and 1988, Congress and HCFA sought to monitor and stimulate State DSH programs (*Federal Register*, 1990).

On the revenue side, in an effort to afford States greater flexibility in raising Medicaid funds, HCFA issued a rule in 1985 that allowed States to receive donations from private providers. Based on the new rules, West Virginia proposed using donations from hospitals in the State share of Medicaid costs. These were combined with Federal matching funds and used to increase hospital payments. Although HCFA initially approved West Virginia's donation program, they later challenged the legitimacy of the transactions. In June 1989, though, a Federal court ruled the donation program did not violate Medicaid law.

States began adopting provider tax programs that tax a specific group of providers about the same time as they did the voluntary donation programs. The first State to implement a provider tax program was Florida, which developed a hospital tax program in 1984. Revenues from the tax program helped pay for expansions of health services for the low income, including starting a medically needy program.

Provider tax and donation (T&D) programs could yield enormous financial

advantages for States. Each dollar of revenue raised from a T&D program could generate $1 to $4 in Federal funds, depending on a State's FMAP. However, Federal matching payments are based on expenditures, not on revenues. States generally completed the special financing strategy by increasing expenditures in the form of DSH payments.[2] DSH payments could be targeted to specific providers, generally those who contributed donations or taxes.

From 1989 to 1991, the linkage of DSH programs with revenue from providers became increasing popular. In addition to the growing State awareness of these fiscal options, many States were experiencing recessions that slowed the growth of State revenues and increased demands for social assistance. The rapid growth of Medicaid, spurred both by new Federal mandates and the growing number of needy people, was straining State budgets (Coughlin et al., 1994; Gold, 1994a). States embraced special financing programs as a strategy to increase Federal dollars in a period of fiscal stress. Recent analyses by Cromwell et al. (1994) indicate the importance of State fiscal stress in explaining levels of DSH funding. They found that State per capita levels of DSH payments in 1991 and 1992 were correlated with increases in State tax efforts (the ratio of actual revenue divided by tax capacity) between 1988 and 1991. If we assume that tax effort increases are a sign of State fiscal distress, then higher fiscal stress led to larger DSH programs.

By 1992, 39 States had adopted T&D programs, up from 6 in 1990. The bulk of these programs involved hospitals, but a few included intermediate care facilities for the mentally retarded (ICFs/MR), nursing homes, physicians, and other providers. Revenues generated from these programs also increased dramatically, rising from about $0.4 billion in 1990 to $8.7 billion in 1992. Mirroring the rapid growth in T&D programs, Medicaid DSH payments also surged, increasing from less than $1 billion in 1989 to more than $17 billion in 1992.

The rapid rise in special financing programs ignited controversy among Federal policymakers. The Bush Administration and representatives of State governments debated these issues and eventually negotiated a compromise that was codified as the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991. Key elements of the amendments included the following:

- Essentially banning provider donations.
- Capping provider taxes so that provider tax revenues could not exceed 25 percent of the State's share of Medicaid expenditures.
- Imposing provider tax criteria so that taxes were "broad-based" and providers were not "held harmless."
- Capping State DSH payments at roughly their 1992 levels.[3]

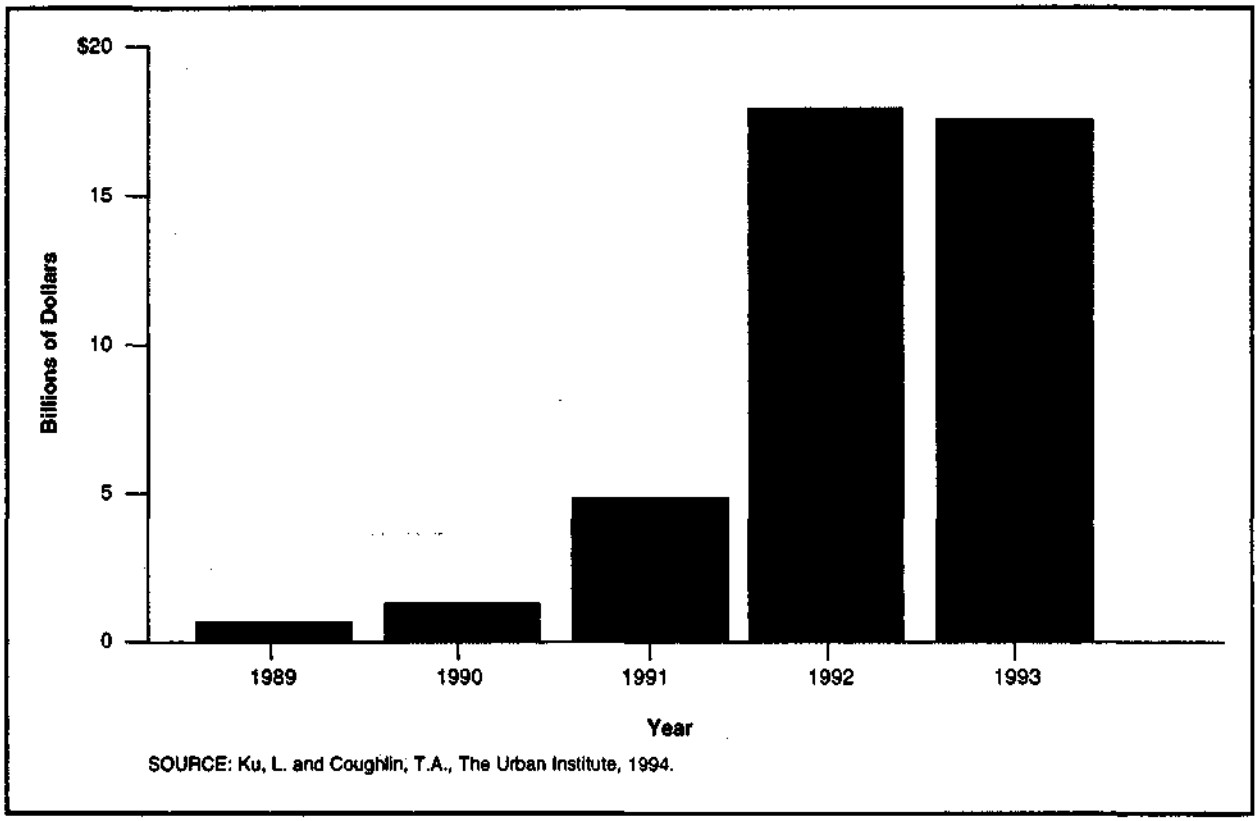
In implementing the law over the next couple of years, most States had to restructure their programs substantially. In particular, the broad-based and hold-harmless criteria caused considerable difficulty. Prior to the 1991 law, providers were generally promised that they would receive DSH payments that at least equaled what they put in. The new law prohibited this;

[2]By law, Medicaid hospital payments cannot exceed Medicare rates, except for special payments to hospitals that serve a "disproportionate share" of low-income patients, such as Medicaid or indigent, uninsured patients, based on criteria developed by the States. There is a similar, though smaller, adjustment for DSH hospitals in Medicare, using Federal criteria.

[3]The final regulations issued in August 1993 specified that States whose DSH payments were 12 percent or more of total Medicaid expenditures ("high-DSH" States) in Federal fiscal year 1992 could not exceed this dollar level in the future. States whose DSH payments were less than 12 percent ("low-DSH" States) could increase them at the same rate as their overall Medicaid expenditure growth.

Figure 2

Nationwide Levels of Disproportionate Share Hospital Payments: 1989-93



SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

instead, the tax is a real assessment and some hospitals might lose money in the transactions. As a result, some States had difficulty enacting provider taxes that complied with the new law.[4]

The most important effect of the 1991 law was that it capped the DSH payments beginning in 1993. As shown in Figure 2, there was actually a slight decrease in DSH payments in 1993, ending a period of extraordinary growth and greatly slowing overall Medicaid expenditure growth. Total Medicaid expenditures grew only 10 percent in 1993, down from 29 percent in 1992.

Although the 1991 amendments helped to resolve many issues, critical issues remained. Most important, the law imposed few restrictions on State use of IGT and other State transfer programs. Under IGTs and State transfers, funds from State psychiatric facilities, university hospitals, or county or metropolitan hospitals are transferred to the State Medicaid agency. Medicaid DSH payments are then made to the contributing hospitals, collecting Federal matching dollars in the process. Using such transfers, States were able to replace previously State-appropriated funds with Federal matching DSH dollars.

Consider again the hypothetical example shown earlier in Figure 1. If the hospitals receiving DSH payments were all State hospitals, then State hospitals would have gained $10 million. If the State hospitals returned these funds to the State treasury, or if the State treasury decreased its

[4]For example, Tennessee was unable to pass a hospital tax and at one point threatened to terminate its Medicaid program altogether. As a compromise, the State developed its section 1115 wiaver program, TennCare.

general grant to these hospitals by an equivalent amount, then all $30 million in additional Federal funds would have gone back to the State, and there would have been no net change in funding for State hospitals.

One type of widely publicized DSH program involved transfers from State mental health agencies and payments to State psychiatric hospitals. This particular transfer was controversial because Medicaid usually does not pay for psychiatric hospital care of adults, but only for children and the elderly. In other words, Federal DSH dollars were being used to fund a service that is not covered under the Medicaid program.

In response to the rise of mental health and related DSH programs, Congress included a provision in the Omnibus Budget Reconciliation Act (OBRA) of 1993 prohibiting DSH payments from exceeding hospital losses on Medicaid and care for the uninsured.[5] The law also contained a provision aimed at limiting mental health DSH programs: Hospitals receiving Medicaid DSH payments must have at least a 1-percent volume of Medicaid patients. These new provisions are being phased in, starting July 1, 1994. In August 1994, HCFA issued brief interim guidance on implementation of the 1994 law, although actual regulations were not available. These changes will limit the ability of States to make large DSH payments to some hospitals and psychiatric facilities, although the specific impact is not yet clear.

METHODS

The purpose of this project was to more carefully assess where revenues for special financing programs came from and where the expenditures went. We developed a survey for all States to cover these topics. To assess how hospitals used the DSH payments, we also implemented case studies of six States.

In December 1993, a survey was sent to all State Medicaid agencies that asked States to describe their special financing programs. We asked how the programs worked: which types of hospitals participated, how much they contributed, and how much they received in DSH and related payments. In addition, we asked States to review historical program data.[6] During the next several months, we received completed surveys from 39 States. Two other States (Arizona and Delaware) also replied, saying that they had no activity in this area.[7] As needed, telephone calls were made to clarify and correct apparent errors. Even so, there may have been errors or omissions in the data reported in the survey; States often had a difficult time reporting the data. Because State programs are so disparate, we do not claim that the 39 States are representative of all States, although they represent the great majority of DSH expenditures. The Technical Note at the end of this article compares the survey data with national data from the HCFA Form-64.

To obtain more information about the use of DSH funds at State, county, and hospital levels, we conducted case studies using telephone interviews in early 1994. Six States (Colorado, Florida, Illinois, Michigan, New Hampshire, and Texas) were selected because they responded to the survey and represented a variety of

[5]There is a 1-year exception for certain "high-disproportionate-share" hospitals that permits them to go up to 200 percent of the unreimbursed costs of Medicaid and the uninsured.

[6]By the time of the survey, States should have been able to provide actual 1993 revenues and expenditures, although payments for 1993 were sometimes made on a retroactive basis. 1994 data were projected at the time of the survey.

[7]Nonetheless, HCFA Form-64 data indicate that both Arizona and Delaware had DSH payments in 1993. Non-respondents were Connecticut, Delaware, the District of Columbia, Georgia, Kentucky, Mississippi, New Jersey, North Carolina, Pennsylvania, Tennessee, and West Virginia.

Table 1

Summary of Special Financing Revenues and Expenditures for 39 States: 1991-94

Item	1991	1992	1993	1994
Revenues to State		In Millions of Nominal Dollars		
Total Revenues to State	$5,754.7	$14,950.4	$15,266.1	$16,693.4
Provider Taxes	2395.1	3,968.7	3,820.9	3,102.7
Provider Donations	897.4	773.6	125.5	4.3
Intergovernmental Transfers (IGTs)	183.1	2,552.7	1,857.7	2,569.8
Transfers From State Agencies	NA	NA	1,749.9	2,381.5
Other State Funds	NA	NA	136.3	250.7
Total Provider Funds	3,475.6	7,295.0	7,690.3	8,309.0
Federal Matching Payments	2279.1	7,655.4	7,575.7	8,384.5
Expenditures (State and Federal)				
Total Provider Payments	4,119.4	13,318.8	13,291.9	14,544.4
Disproportionate Share Hospital (DSH) Payments	4,119.4	13,318.8	13,017.6	14,151.0
Other Provider Payment Increases	NA	NA	274.3	393.4

NOTES: 1991 and 1992 data are for Federal fiscal years. 1991 data are adapted from a survey conducted in April 1992 by the Health Care Financing Administration (HCFA). 1992 data are from the HCFA DSH notice of August 1993. Both were edited based on corrections reported by States. 1993 and 1994 data are for State fiscal years and are based on the Urban Institute survey. IGTs may sometimes include transfers from State hospitals, especially in 1992. Other State funds primarily include special State appropriations for DSH programs. Federal matching payments are computed based on the level of DSH and other provider payment increases, times the Federal matching rate. Other provider payment increases include payments to nursing homes, intermediate care facilities, and increases in regular hospital payments financed through the special programs. Assume that provider revenues for New York for 1994 were the same as in 1993. NA is not available.

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

program features (e.g., types of provider taxes, IGT and State transfers, highly differentiated DSH programs, taxation of nursing homes or ICFs/MR, and changing program size). We interviewed State Medicaid officials, hospital executives, hospital association representatives, and other key stakeholders (e.g., legislative staff, budget staff, State mental health officials, nursing home or ICF/MR association representatives, and lawyers).

RESULTS

This section begins by addressing overall trends for States, then continues to discuss the various structural aspects of the programs. Next, it examines the use of DSH payments by county and private hospitals, then by State hospitals. Finally, it compares State special financing programs. Unless otherwise stated, all results pertain to the 39 survey States or to the 6 case-study States.

Aggregate Trends for 39 States

Table 1 reviews aggregate trends for special financing programs from 1991 to 1994. Provider donations fell from almost $900 million in 1991 to about $4 million by 1994. The rapid decline is due to the restrictions on provider donations imposed by the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991.

Provider taxes rose from $2.4 billion in 1991 to $4.0 billion by 1992, but were projected to decline to $3.1 billion by 1994. Because the 1991 amendments required provider taxes be broad-based and prohibited hold-harmless arrangements, most States had to restructure their provider tax programs to become redistributive among providers. This redistribution created great political tension, making it difficult for State legislatures to pass hospital tax programs (Verdier, 1993).

Even so, the level of provider taxes remained surprisingly high. In some interviews, we were informed that tax programs continued, at least on a short-term basis, because the States had no simple alternatives to replace the revenues. In other cases, States were able to carefully stay within the letter of the law, but skirt the intent. For example, New Hampshire redesigned its tax program so that it fell outside the technical scope of the 1991 legislation. Among other things, the State transformed part of its hospital tax into a room-and-meals tax. The Federal rules had defined a "provider tax" as one in which health care providers were at least 75 percent of the tax base. By transferring its provider tax program into a broader tax base (the room-and-meals tax), New Hampshire fell below the 75-percent threshold and avoided the broad-based and hold-harmless provisions of the law.

Provider taxes, however, may further decline over time because of continuing tensions created by the broad-based tax requirements. For example, Illinois, which retained taxes on nursing homes and ICFs/MR in 1993, was forced to reduce these taxes for 1994 after a letter-writing campaign from senior citizens protested the taxes. These revenues were partly replaced by a cigarette tax.

To compensate for the loss of provider donations and taxes, States revised their programs to increase IGTs and transfers from other State agencies.[8] By 1993, IGTs and State transfers had become the dominant revenue source for special financing programs. From a strategic perspective, the advantage of IGTs and State transfers is that it is politically easier to negotiate revenues from a small set of governmental agencies than to enact a tax on a large number of hospitals or other providers. Further, there are no requirements that IGTs be broad-based, so DSH programs can be designed to guarantee that revenue donors will at least be returned their contributions.

On the expenditure side, DSH payments rose between 1991 and 1992, fell slightly in 1993, and were estimated to rise again by 1994. Current rules permit modest growth in total DSH payments in future years, as "low-DSH" States are allowed to gradually increase their programs.

Our survey also asked about the extent to which provider taxes were also used to increase other provider payments. For example, nursing home taxes could be used to increase regular nursing home payments, an approach that is outside the scope of the DSH programs, or hospital taxes could be used to fund increases in regular hospital payments. The level of activity in this area was relatively small ($274 million in 1993).

Variation in and Complexity of Special Financing Programs

These aggregate trends belie the complexity and variety of State special financing programs. Working closely with legislative staff, State budget officials, hospital associations, and outside consultants, State Medicaid officials designed elaborate programs that were periodically modified. They often designed multiple programs to target DSH payments to specific types of hospitals, because they contributed different levels of revenue or were perceived to have special needs (for example, rural or teaching hospitals).

Of the 39 States in our survey, 22 generated revenue from provider taxes or donations in 1993, 13 had revenue from IGTs, and 18 had revenue from State transfers or

[8] It seems likely that the 1992 data include some transfers from State agencies, so that the 1992 IGT data can be roughly compared with the sum of IGTs and State transfers for 1993 and 1994.

special State appropriations (Table 2).[9] Alabama, Colorado, Florida, Massachusetts, Missouri, Texas, and Washington had complex revenue programs that drew from all three types of revenue.

Table 3 summarizes the DSH and related payments financed by the special revenues in 1993. All 39 States made DSH payments to private and county public hospitals and all but 7 made payments to State hospitals.[10] Only six States reported increasing other types of provider payments, such as nursing home, ICF/MR, or regular hospital payments.[11]

Most DSH programs included indigent-care levels (as well as Medicaid volume) in the formulas that designate DSH hospitals and determine DSH payment levels. That is, DSH funds were normally designed to help pay for uncompensated care. States often created multiple DSH programs to target funds to different groups of hospitals within the State. For example, Florida had DSH programs for regular acute-care hospitals, mental health hospitals, teaching hospitals, and those with regional perinatal intensive-care centers, and was contemplating additional programs for rural hospitals and for hospitals providing primary care.

DSH Payments Help Needy Private and County Hospitals

The original intent of the Medicaid DSH programs was to assist hospitals that provide disproportionate levels of care to low-income clients, such as Medicaid and uninsured patients. The bulk of provider-based revenues comes from private and county hospitals (including non-profit, local, and metropolitan public hospitals), and the bulk of DSH payments are made to these hospitals.[12] This is understandable, because they provide most of the care to needy patients. In 1992, private and county hospitals accounted for 83 percent of hospital days for Medicaid clients.

Combined data from Tables 2 and 3 show that private and county providers paid $5.8 billion in provider taxes, donations, and IGTs, and received $8.2 billion in DSH payments, as well as $0.3 billion in other provider-payment increases. Thus, as shown in Table 4, private and local providers had a net gain of $2.4 billion from DSH alone and a total gain, including the other payments, of $2.7 billion in 1993.

These findings are consistent with recent analyses by the Prospective Payment Assessment Commission (ProPAC) (1994) indicating that Medicaid DSH payments helped to reduce losses resulting from uncompensated care or low regular Medicaid reimbursement. ProPAC estimated that Medicaid payments, including DSH, equalled 89 percent of the costs of treating Medicaid patients in its sample of hospitals for 1992. They also reported that payment-to-cost ratios were more favorable for hospitals with the highest proportions of Medicaid or indigent volume and were also higher for publicly owned hospitals than for privately owned hospitals.

The extent to which private and county hospitals obtain extra funding through

[9]The numbers total to more than 39 because some States had multiple responses. Nine States had no explicit provider-revenue sources.

[10]Private hospitals include non-profit and for-profit privately owned hospitals. Our impression is that the bulk of private DSH payments go to non-profit hospitals. County hospitals include publicly owned county, city, metropolitan, or district hospitals. State hospitals include any State-owned hospitals, such as State university, psychiatric, or rehabilitation hospitals.

[11]During interviews, Illinois staff acknowledged that the provider taxes had subsidized regular payments to hospitals, nursing homes, and intermediate care facilities at a level greater than they reported in the survey, although they could not estimate how much, because these amounts were now incorporated into their budget baseline. A similar problem may affect other States.

[12]For county hospitals, the funds often come from IGTs from the county (or city or hospital district) on behalf of the hospital. For example, the county may transfer some of the funds that it would normally give the hospital to the State in exchange for higher DSH payment from the State.

Table 2

Summary of Sources of Revenues for State Special Financing Programs: State Fiscal Year 1993

Survey State	Private/County Funds		Inter-governmental Transfers	State Funds (State Transfers and Special Appropriations)	Federal Matching Funds
	Total Revenues	Provider Taxes and Donations			
			In Millions of Dollars		
Total	$15,266.06	$3,946.40	$1,857.71	$1,886.23	$7,575.72
Alabama	576.27	91.70	24.90	161.40	298.27
Alaska	8.68	0.00	0.00	0.00	8.68
Arkansas	67.34	34.50	0.00	0.00	32.84
California	2,205.25	0.00	1,172.31	0.00	1,032.94
Colorado	244.17	15.40	84.70	36.70	107.37
Florida	464.03	221.80	88.00	33.66	120.57
Hawaii	66.00	44.00	0.00	0.00	22.00
Idaho	1.23	0.09	0.00	0.00	1.14
Illinois	912.85	476.40	176.00	0.00	260.45
Indiana	81.03	0.00	35.00	21.00	25.03
Iowa	4.62	0.00	0.00	1.71	2.91
Kansas	186.66	0.00	0.00	76.74	109.92
Louisiana	1,541.56	165.91	0.00	478.13	897.52
Maine	202.73	100.55	0.00	0.00	102.18
Maryland	139.99	26.80	0.00	53.50	59.69
Massachusetts	735.40	300.00	38.40	160.40	236.60
Michigan	763.91	0.00	0.00	451.60	312.31
Minnesota	81.97	62.80	1.45	0.00	17.72
Missouri	838.86	297.06	12.71	68.62	460.47
Montana	12.10	3.28	7.90	0.54	0.38
Nebraska	2.13	0.00	0.00	0.00	2.13
Nevada	164.84	110.07	0.00	11.64	43.12
New Hampshire	574.18	346.00	0.00	22.40	205.78
New Mexico	6.48	0.00	0.00	0.00	6.48
New York	2,585.00	1,193.00	0.00	0.00	1,392.00
North Dakota	0.32	0.00	0.00	0.00	0.32
Ohio	424.51	153.98	0.00	0.00	270.53
Oklahoma	34.45	0.00	0.00	0.59	33.86
Oregon	12.59	0.00	0.00	0.00	12.59
Rhode Island	52.12	0.00	0.00	0.00	52.12
South Carolina	444.60	21.50	120.66	0.00	302.43
South Dakota	0.01	0.00	0.00	0.00	0.01
Texas	1,418.14	244.00	29.00	231.86	913.28
Utah	4.13	0.00	0.00	0.57	3.56
Vermont	22.58	11.85	0.00	0.00	10.74
Virginia	70.27	0.00	0.00	0.00	70.27
Washington	310.43	25.70	66.68	75.17	142.88
Wisconsin	4.53	0.00	0.00	0.00	4.53
Wyoming	0.10	0.00	0.00	0.00	0.10
Percent of Total Revenue	100.0	25.9	12.2	12.4	49.6

NOTES: To the extent that State hospitals contribute to provider taxes, donations, or intergovernmental transfers, the private and local funds are overstated and the special State funds are understated. Special appropriations do not include regular Medicaid appropriations; these are funds appropriated specifically for these purposes. Federal matching funds are based on the Federal match rate times the disproportionate share hospital payments and other provider payment increases.

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

Table 3

Disproportionate Share Hospital (DSH) and Related Payments and State Gains From Leveraging: State Fiscal Year 1993

Survey State	Payments to Providers				Residual Funds[1]
	DSH Payments to:		Other Types of Provider Payment Increases	Total Provider Payments	
	Private and County Hospitals	State Hospitals			
	In Millions of Dollars				
Total	$8,228.99	$4,788.66	$274.27	$13,291.91	$1,974.15
Alabama	199.54	217.91	0.00	417.46	158.82
Alaska	1.98	15.37	0.00	17.35	-8.68
Arkansas	2.54	0.00	41.59	44.13	23.21
California	1,924.98	140.89	0.00	2,065.87	139.37
Colorado	137.12	60.18	0.00	197.30	46.87
Florida	172.75	66.95	0.00	239.69	224.34
Hawaii	25.52	18.48	0.00	44.00	22.00
Idaho	1.60	0.00	0.00	1.60	-0.37
Illinois	246.62	93.08	181.20	520.90	391.95
Indiana	19.80	19.80	0.00	39.60	41.43
Iowa	1.54	3.09	0.00	4.63	-0.02
Kansas	6.61	182.32	0.00	188.94	-2.27
Louisiana	328.76	888.87	0.00	1,217.64	323.92
Maine	117.37	47.94	0.00	165.32	37.42
Maryland	14.33	105.06	0.00	119.38	20.61
Massachusetts	310.89	162.31	0.00	473.20	262.20
Michigan	40.16	519.14	0.00	559.30	204.61
Minnesota	25.49	6.77	0.00	32.26	49.71
Missouri	540.17	223.64	0.34	764.15	74.72
Montana	0.54	0.00	0.00	0.54	11.56
Nebraska	2.84	0.62	0.00	3.47	-1.34
Nevada	80.51	0.00	1.98	82.49	82.35
New Hampshire	366.76	44.80	0.00	411.56	162.62
New Mexico	0.28	8.50	0.00	8.78	-2.30
New York	2,152.03	631.97	0.00	2,784.00	-199.00
North Dakota	0.44	0.00	0.00	0.44	-0.12
Ohio	374.93	74.09	0.00	449.02	-24.51
Oklahoma	1.46	19.74	27.40	48.60	-14.15
Oregon	11.30	8.88	0.00	20.18	-7.59
Rhode Island	1.90	95.26	0.00	97.16	-45.04
South Carolina	72.13	352.16	0.00	424.29	20.31
South Dakota	0.01	0.00	0.00	0.01	-0.00
Texas	808.34	609.80	0.00	1,418.14	0.00
Utah	2.24	2.48	0.00	4.73	-0.60
Vermont	9.50	8.43	0.00	17.93	4.65
Virginia	23.89	116.65	0.00	140.55	-70.27
Washington	194.74	43.18	21.76	259.68	50.75
Wisconsin	7.21	0.29	0.00	7.50	-2.97
Wyoming	0.15	0.00	0.00	0.15	-0.05
Percent of Total Expenditures	53.9	31.4	1.8	87.1	12.9

[1]Total revenues minus total provider payments.

NOTES: Other provider payment increases include in rates paid to nursing homes, intermediate care facilities for the mentally retarded or regular hospital reimbursement rates that were financed through the special financing programs. These are probably underestimated. Payments to hospitals include payment to acute inpatient hospitals, as well as to psychiatric hospitals. State leveraging is the amount gained by the State because the total revenues (provider taxes, donations and intergovernmental transfers, and Federal match) exceed the total expenditures (DSH and other provider payment increases).

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

Table 4

Net Gains by Private and Local Providers and by Survey State: State Fiscal Year 1993

Survey State	Net Gains by Private and County Hospitals and Providers		Net Gains by State	
	Through DSH Payments Only	Through DSH and Other Types of Provider Payments	Gains Through DSH Payments to State Hospitals	Residual Funds for State Use (See Table 3)
	In Millions of Dollars			
Total	$2,424.88	$2,699.14	$2,902.43	$1,974.15
Alabama	82.94	82.94	56.51	158.82
Alaska	1.98	1.98	15.37	-8.68
Arkansas	-31.96	9.63	0.00	23.21
California	752.67	752.67	140.89	139.37
Colorado	37.02	37.02	23.48	46.87
Florida	-137.06	-137.06	33.29	224.34
Hawaii	-18.48	-18.48	18.48	22.00
Idaho	1.51	1.51	0.00	-0.37
Illinois	-405.78	-224.58	93.08	391.95
Indiana	-15.20	-15.20	-1.20	41.43
Iowa	1.54	1.54	1.38	-0.02
Kansas	6.61	6.61	105.58	-2.27
Louisiana	162.85	162.85	410.74	323.92
Maine	16.82	16.82	47.94	37.42
Maryland	-12.47	-12.47	51.56	20.61
Massachusetts	-27.51	-27.51	1.91	262.20
Michigan	40.16	40.16	67.54	204.61
Minnesota	-38.76	-38.76	6.77	49.71
Missouri	230.39	230.73	155.02	74.72
Montana	-10.64	-10.64	-0.54	11.56
Nebraska	2.84	2.84	0.62	-1.34
Nevada	-29.57	-27.59	-11.64	82.35
New Hampshire	20.76	20.76	22.40	162.62
New Mexico	0.28	0.28	8.50	-2.30
New York	959.03	959.03	631.97	-199.00
North Dakota	0.44	0.44	0.00	-0.12
Ohio	220.95	220.95	74.09	-24.51
Oklahoma	1.46	28.86	19.15	-14.15
Oregon	11.30	11.30	8.88	-7.59
Rhode Island	1.90	1.90	95.26	-45.04
South Carolina	-70.03	-70.03	352.16	20.31
South Dakota	0.01	0.01	0.00	-0.00
Texas	535.34	535.34	377.94	0.00
Utah	2.24	2.24	1.91	-0.60
Vermont	-2.34	-2.34	8.43	4.65
Virginia	23.89	23.89	116.65	-70.27
Washington	102.36	124.12	-31.99	50.75
Wisconsin	7.21	7.21	0.29	-2.97
Wyoming	0.15	0.15	0.00	-0.05

NOTES: DSH is disproportionate share hospital. IGT is intergovernmental transfer. Amounts in parentheses are negative values. Gains are the funds received by the provider (or State) less the funds paid out by the provider (or State). To the extent that State hospitals contribute to provider taxes, donations, or IGTs, the private and local gains are understated, and the gains by the State are overstated. Further, it is likely that some of the other provider-payment increases are underreported by States, in which case, the private and local gains are understated.

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

DSH varied from State to State (Table 4). For example, in California, Louisiana, Missouri, New York, Ohio, Texas, and Washington, hospitals gained totals between $124 million and $959 million in extra revenue through these programs. In a few States, private and county hospitals appeared to lose some funds overall.[13] However, as discussed earlier, the broad-based/no-hold-harmless provisions mean that individual hospitals may lose or gain funds through these programs regardless of the overall trend. In general, hospitals that serve more low-income patients will have higher DSH gains than hospitals with few low-income patients.

In our interviews with hospital representatives in several States, we discussed how hospitals that gained funds were using them. The reported uses were quite varied. The funds received usually went into hospitals' general accounts and covered overall hospital operations and debt, including uncompensated care or Medicaid underpayment. Sometimes hospitals could identify specific uses of the new funds, such as providing services to persons with acquired immunodeficiency syndrome or opening new outpatient clinics. It was noted that large hospitals often serve not just as inpatient facilities but as hubs for outpatient clinics and health centers that offer primary care to low-income people. In some cases, hospitals decided to treat the additional funds as short-term windfalls and used them for capital expenditures (such as developing a new clinic, purchasing an ambulance, or replacing old X-ray equipment). In Colorado, DSH funds enabled one public hospital to secure a commercial loan from a bank, something it had been unable to do for several years. In Texas and New Hampshire, some hospitals placed the funds in interest-bearing "trusts" that could generate income for a longer period or be used for special purposes. In one State, hospitals emphasized the importance of DSH funds in cash flow: Regular Medicaid payments were often months in arrears, and DSH funds were needed to maintain day-to-day operations.

In general, hospital representatives emphasized the importance of DSH payments as a source of revenue that helped them continue to provide care to low-income individuals in their communities. In addition, many stated that even though the recent infusion of DSH payments provided welcome relief, their hospitals still fell short of covering their total uncompensated care losses.

When we spoke with county hospitals, we asked whether county (or other local) subsidies were being reduced to offset the gains in DSH funds.[14] This did not appear to be the case for the hospitals we talked with, although sometimes the county subsidies were not being increased for inflation. In Texas, for example, the State had issued rules that required counties to at least maintain their prior subsidy levels. In Florida, we were informed that there was an agreement of a similar nature.[15] ProPAC (1994) found some reduction in State or local subsidies to hospitals that may have

[13]The two States with large losses were Florida and Illinois. Florida has had a hospital tax since 1984 that is used to subsidize the general Medicaid program, not just hospitals. Illinois Medicaid and hospital association staff claimed that hospitals gain through DSH as well as through general hospital reimbursement increases, so that the apparent loss is an artifact of problems in completing the survey.

[14]For example, if a county transfers $10 million to the State and the county hospital gets back $20 million in DSH, our calculations would report that the hospital gained $10 million. However, the county could further reduce the subsidy to the hospital by $10 million, so that the hospital actually had no net gain, but the county saved $10 million from its general budget.

[15]On the other hand, in at least two States other than those in our case studies, DSH payments were used to offset general local subsidies to the hospitals, indirectly subsidizing the rest of the local area.

occurred because of DSH payments, but it was not clear whether these subsidies were reduced by the level of the IGTs or by larger subsidy reductions.

Overall, our impression was that DSH funds paid to private or county hospitals were adding revenue to needy hospitals. Although we cannot be certain of the quality or efficiency of care being provided, our data, in conjunction with the analyses of ProPAC, indicate that DSH payments are helping hospitals that would otherwise have had financial difficulties in continuing to provide care to low-income-patients.

Primary Beneficiaries of Special Financing Programs Are State Governments

Private and county hospitals netted $2.7 billion in additional revenues through DSH programs in 1993 among the 39 States. State governments, however, netted almost double that amount. In 1993, we estimate that the 39 State governments received $4.9 billion in extra funds through special financing programs.

The States employed two primary mechanisms to make money through special financing programs: residual funds for State use and paying State hospitals.

Residual Funds for State Use

If revenues from a program, including provider-related and Federal revenues, exceed provider payments, then States can keep the difference. We call this amount "residual funds." For example, a State with a 50-percent Federal match rate receives $100 million in provider taxes and makes $110 million in DSH payments (so that hospitals gain $10 million). Only $55 million in provider funds (now counted as State funds) are required to earn $55 million in Federal matching, so that the State has $45 million in residuum. These residual funds could be used for other purposes, such as paying for other Medicaid, health or welfare expenses. For this mechanism, it does not matter whether the revenue sources or expenditure outlets are private, county, or State hospitals. The State Medicaid agency earns residual funds whenever there is a discrepancy between revenues contributed and funds paid out. As shown in Table 4, the total value of residual funds gained by the States was $2.0 billion in 1993.

Paying State Hospitals

States can also gain by providing DSH payments to State-owned hospitals. The gain here is the difference between the DSH payment and the amount of revenue provided by the State. DSH programs were often structured to pay large amounts to State hospitals. The great majority of payments to State hospitals were to acute-care hospitals, such as university hospitals, not to State psychiatric hospitals, although the pattern varied in every State. Survey data indicate there were $3.0 billion in DSH payments to State acute-care hospitals and $1.8 billion in DSH payments for State psychiatric hospitals. Because there were $1.9 billion in State transfers and appropriations, State hospitals appeared to gain $2.9 billion in 1993.[16]

DSH programs were often designed to make larger DSH payments to State hospitals. State transfers and special State appropriations constituted 24 percent of the provider-related revenues (Table 1), and State hospitals received 37 percent of the DSH funds (Table 2). By contrast, State hospitals provided only 17 percent of all Medicaid inpatient days in 1992.

[16]Although these two mechanisms differ, the relationship of residual funds for State use and State hospital gains is actually somewhat more complicated. This is further discussed in the Technical Note.

However, in our interviews with State officials, it appeared that only a small share of the gains by State hospitals was actually retained by the hospitals. Instead, most of the gains were transferred back to overall State accounts. For example, Michigan has a very large transfer program with the University of Michigan Hospital. In 1994, the State pays the hospital $489 million in DSH and claims $270 million in Federal matching from the Federal Government. The hospital returns all of the $489 million to the State. Thus, the hospital gains nothing, but the State gains $270 million which is used to pay for the State's share of other portions of the Medicaid budget.

A similar transaction occurs in New Hampshire: The State's psychiatric hospital receives a very large DSH payment, but all of the gain is transferred back to the general State budget. In Florida, general State appropriations to State mental health hospitals (the primary source of DSH payments to State hospitals) were offset by the amount of extra DSH funds gained. The mental health hospitals were permitted to keep a small share of the money the first year, but not in subsequent years. In Texas, the State hospitals retain a small share of the net gain in DSH funds earned, but the great majority of the extra funds are transferred back to the State. In Colorado, the situation is more complex. State hospitals earned funds through general DSH programs (also used for private or county hospitals) as well as special programs established for the State hospitals. In Colorado, State hospitals kept some of the DSH funds and returned some back to the State.

Although State hospitals received little or no extra funds through participation in DSH programs, their staff usually believed that their general funding would have been cut if the programs did not exist. That is, because their States had experienced broad fiscal stresses, regular State funding to these hospitals may have fallen otherwise. They felt that, to the extent that the DSH programs helped the overall State budget, they indirectly helped the State hospitals' budgets.

Although the limited nature of our case studies does not allow us to draw reliable generalizations for all States, the consistency of responses suggests that DSH programs for State hospitals are usually created to generate extra revenues for the overall State budget and provide only modest financial benefit for the State hospitals themselves.

How did the States use the additional $4.9 billion gained through these mechanisms? When we asked this question in our interviews in the case-study States, the common reply was that "money is fungible." The additional funds generally flowed into State general-fund coffers, were mixed with other State funds, and were then used to help balance overall State budgets. In some cases, the extra funds were used to support specific parts of the State budgets, such as Medicaid, mental health, or general health and welfare spending, but savings in these areas decrease the budgetary pressure on other components of the State budgets. State officials normally justified the programs by stating that States were under serious fiscal stress in the early 1990s and that Medicaid was a fast growing part of their budgets. (Gold, 1994a; Coughlin, Ku, and Holahan, 1994).

State officials felt that the Medicaid budgets (as well as budgets for other health and welfare programs) might have been cut much more if they had not been able to generate these extra funds. Although this argument may hold true for the period 1990-92, it is less clear that this justification is still valid. By 1993, State economies had improved significantly and their fiscal crises had greatly eased, except for

New England and California (National Association of State Budget Officers, 1994). A number of States are now even proposing to cut State taxes.

Although $4.9 billion in extra funds may appear to be a windfall for State governments, it was a modest amount compared with the size of overall State budgets. For example, in State fiscal year (SFY) 1993, the $4.9 billion in extra State funds was equal to an average of 2.1 percent of State general-fund expenditures for the 39 States (based on data in National Association of State Budget Officers, 1994). In some States, though, special financing was far more important. In New Hampshire, the total State gain was equivalent to 25 percent of the State general fund; in Louisiana, it was 17 percent; and in South Carolina, it was 10 percent. Another way to view the impact of these special financing policies is to examine the extent to which States passed tax increases. Estimates of State tax increases legislated in recent years were $14.4 billion in tax increases implemented for 1992, $1.4 billion for 1993, and $1.2 billion for 1994 (Gold, 1994b).[17] By this measure, State gains were relatively large.

How States Compare With Each Other

There has been a great deal of negative publicity about special financing programs for States (Morgan, 1994). For better or worse, the issues have become so blurred that all States are perceived as having similar programs. However, this is not the case.

In observing the differences among States, we noted two distinguishing criteria. The first criterion is the "overall size of the State DSH programs," which reflects the overall aggressiveness of States in creating large programs (that in turn result in more Federal matching funds). Some States were very aggressive, whereas others used these programs sparingly. For example, although Iowa has a more costly overall Medicaid program than New Hampshire has, New Hampshire's DSH payments are about 90 times larger than Iowa's. The second criterion was the "extent to which State governments kept new funds generated by these programs." This measures the degree to which programs were designed to help balance State budgets versus helping hospitals that provide care for low-income patients.[18]

Table 5 categorizes State programs based on these two criteria. Size of the DSH program is expressed as a share of total Medicaid expenditures. Using a threshold of 12 percent of 1993 expenditures to designate "high-DSH" and "low-DSH" States, 14 of the 39 States are high-DSH States.[19] States for which the DSH programs were more than 25 percent of their total Medicaid expenditures included New Hampshire, Louisiana, Missouri, Alabama, and South Carolina.

The second criterion accounts for the percent of provider (private and county) and Federal funds kept by the State government. Seventeen of the 39 States kept more than 50 percent of the provider and Federal funds. These States, however, were not always high-DSH States: Five of the 14 high-DSH States kept more than one-half of the funds, whereas 12 of the 25 low-DSH States kept more than one-half of the funds. For example, though Texas, New York, and California had large DSH programs, they

[17]These are the estimated revenues from the new taxes, not including hospital or related taxes. This does not include normal growth in existing State taxes.

[18]State gains might decline over time because of changes enacted in OBRA 1993. DSH payments to some State hospitals may decline because of new limits on DSH payments. Some psychiatric facilities may lose DSH payments because they do not have 1-percent Medicaid volume.

[19]Our designations are not synonymous with the criteria used by HCFA to designate high- versus low-DSH States. HCFA rules were based on 1992 performance, whereas Table 5 uses 1993 funding levels.

Table 5

Categories of States by Size and Use of Special Financing Programs: State Fiscal Year 1993

Item and State	DSH as Percent of Medicaid	Percent of New Funds Kept by State Government	Total Net Gain by State Government
			In Millions of Dollars
Mean/Total	13.3	36.4	4,876.35
High DSH and State Kept More Than One-Half of New Funds			
Louisiana	31.2	69.1	734.66
Alabama	25.5	51.9	215.33
South Carolina	25.9	83.8	372.47
Kansas	17.6	94.0	103.31
Michigan	12.7	87.1	272.16
High DSH but State Kept Less Than One-Half of New Funds			
New Hampshire	54.2	33.5	185.02
Missouri	34.0	29.8	229.74
Nevada	20.7	46.2	70.71
Texas	20.2	31.9	377.94
Maine	20.1	42.1	85.36
New York	15.5	16.7	432.97
Colorado	15.4	33.9	70.35
California	14.7	12.7	280.27
Massachusetts	12.2	45.9	264.11
Low DSH but State Kept More Than One-Half of New Funds			
Rhode Island	11.8	96.3	50.21
Hawaii	11.4	61.3	40.48
Virginia	7.9	66.0	46.38
Illinois	6.9	53.1	485.03
Vermont	6.9	57.9	13.08
Maryland	6.1	83.4	72.16
Alaska	5.8	77.2	6.70
Florida	4.9	59.9	257.62
New Mexico	1.5	95.7	6.20
Indiana	1.4	67.0	40.23
Minnesota	1.5	68.9	56.48
Montana	0.2	95.3	11.03
Low DSH and State Kept Less Than One-Half of New Funds			
Washington	10.5	8.0	18.76
Ohio	8.7	11.6	49.35
Oregon	2.1	10.2	1.29
Oklahoma	2.0	14.8	5.00
Utah	1.0	36.9	1.31
Wisconsin	0.4	-59.1	-2.68
Nebraska	0.6	-33.7	-0.72
Idaho	0.5	-30.0	-0.37
Iowa	0.5	46.9	1.36
Arkansas	0.2	34.5	23.21
North Dakota	0.2	-38.5	-0.12
Wyoming	0.1	-49.0	-0.05
South Dakota	0.0	-42.3	0.00

NOTES: DSH is disproportionate share hospital. Amounts in parentheses are negative values. High DSH means DSH payments (reported here) are 12 percent or more of total Medicaid expenditures; low DSH means below 12 percent. Total Medicaid expenditures are from edited HCFA Form-64 data. Negative State gains mean that the State used regular Medicaid funds to pay for DSH. New funds are the sum of provider taxes, donations, intergovernmental transfers (IGTs), and Federal matching funds, i.e., the funds provided by county and Federal sources. These are overestimated if State hospitals contribute to provider taxes, donations, or IGTs.

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

redistributed most of the funds to private and county hospitals. Some States, such as Montana and New Mexico, had relatively small DSH programs but kept almost all the extra funds at the State level. Several States with small DSH programs (Wisconsin, Nebraska, Idaho, North Dakota, Wyoming, and South Dakota) registered net losses. These States actually used regular Medicaid funds (i.e., from the State general fund) to provide DSH funds to hospitals with relatively little support from provider revenues.

Another method of comparing State programs is to look at their relative size. Table 6 compares the size of the 1993 State DSH payments (as reported in HCFA Form-64 data) in various ways: as a share of their total Medicaid expenditures, as payments per State resident, as payments per person under 200 percent of the Federal poverty level, and as payments per uninsured person. Need is not the major factor affecting the size of DSH programs. In fact, when we factor in need on the basis of low-income population or the number of uninsured, the level of variation across States increases. The current distribution of DSH funds is highly inequitable and is not based on States' needs.[20]

Summary of Results

Figure 3 provides a summary of special financing programs in our 39 States: both their sources of revenues and how these funds were spent. On the revenue side, of the total $15.3 billion collected, about one-third ($5.8 billion) is contributed by private and county providers in the form of provider taxes, donations, and IGTs. About one-sixth ($1.9 billion) of the revenues comes from State funds, including State transfers and special appropriations. The remaining one-half ($7.6 billion) of the revenue comes from Federal matching payments.

On the expenditure side, expenditures include $13.0 billion in DSH payments, $0.3 billion in other provider-payment increases, and $2.0 billion in residual funds that are available for other State use. Private and county hospitals get about $8.5 billion in DSH and other provider payments. If we maintain that funds are first used to "pay back" the $5.8 billion in revenues contributed, then private and county providers have an aggregate gain of $2.7 billion.[21] This $2.7 billion is the "new funds" that could be used by private and county hospitals to help cover the costs of uncompensated care. State hospitals receive $4.8 billion in DSH payments, so that they apparently gain $2.9 billion. In addition, the States gain $2.0 billion in "residual" revenue; these funds are available for other purposes, such as paying for other Medicaid expenditures (aside from DSH) or even other health or welfare expenditures. The case studies suggest that most of the combined $4.9 billion in State gains are mixed with other funds and are used broadly throughout the State budgets.

Some people mistakenly believe that DSH funds are all used to pay for uncompensated care. Although this is one important use of these funds, the net "new" funds received by private and county providers was only $2.7 billion or about one-sixth of the total expenditures (or one-fifth of the total provider payments, most of which are DSH). About one-half of the funds are used to pay back providers (private, county,

[20]Although Cromwell et al. (1994) found that State fiscal stress is correlated with DSH payment levels, this is not an unbiased measure of State economic needs. Fiscal stress is more related to State choices about their levels of taxation and expenditures.

[21]This is somewhat simplified because some providers pay taxes but never receive DSH funds in return, so they are never "paid back" at all.

Table 6

Comparisons of 1993 Disproportionate Share Hospital (DSH) Payments by Alternative Standards, Based on HCFA Form-64 Data for 50 States

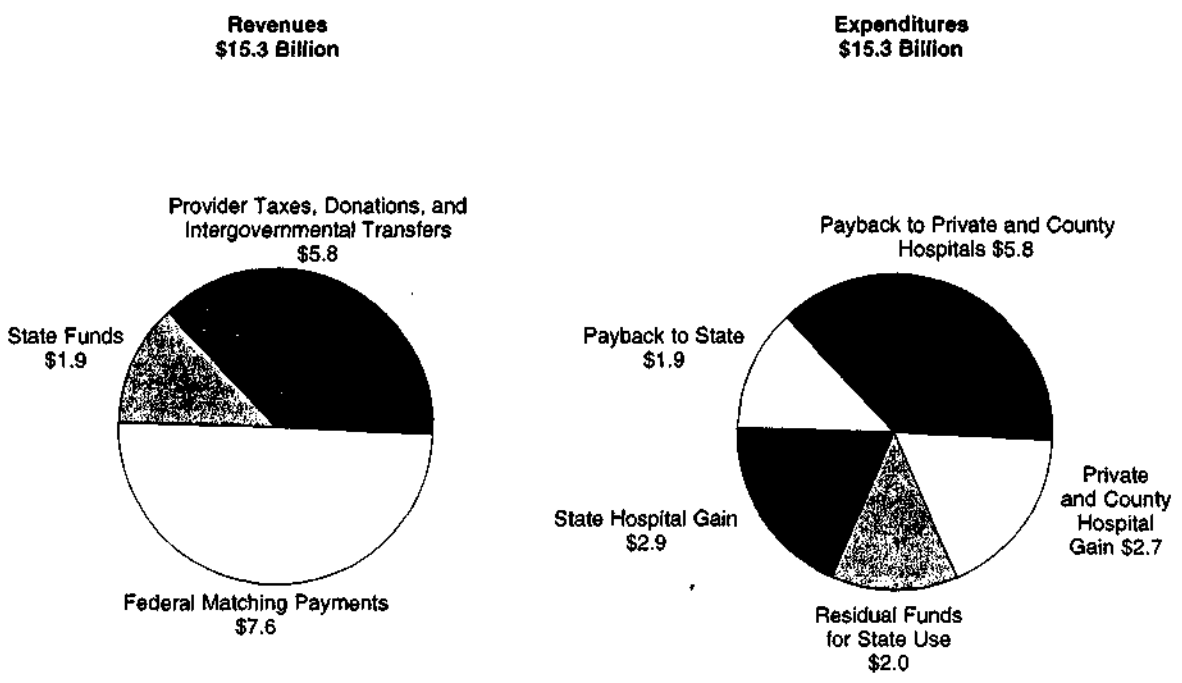
State	DSH Payments (Millions)	DSH as a Percent of Total Medicaid Expenditures	DSH Expenditures per State Resident	DSH Expenditures per Person Under 200 Percent of Federal Poverty Level	DSH Expenditures per Uninsured Person
Total	$16,953.1	13.5	$68	$205	$491
Alabama	419.1	25.6	102	247	589
Alaska	14.2	5.7	29	86	144
Arkansas	2.5	0.2	1	2	6
California	2,542.5	18.8	83	238	483
Colorado	130.5	12.0	40	136	326
Connecticut	417.3	18.3	128	729	1,720
Delaware	5.2	2.1	7	27	57
District of Columbia	46.1	6.7	85	205	409
Florida	239.7	4.8	18	49	93
Georgia	309.4	11.1	48	129	289
Hawaii	43.9	11.5	42	143	570
Idaho	1.0	0.3	1	2	6
Illinois	240.1	4.8	20	65	178
Indiana	33.8	1.2	6	18	53
Iowa	4.0	0.4	1	4	15
Kansas	184.4	20.7	73	236	688
Kentucky	137.0	7.4	38	94	306
Louisiana	1,217.6	32.6	292	681	1,506
Maine	164.1	19.3	131	380	1,186
Maryland	77.8	4.0	17	65	146
Massachusetts	484.5	12.0	83	336	835
Michigan	544.7	12.5	58	190	620
Minnesota	32.3	1.5	7	25	68
Mississippi	152.3	12.7	57	114	302
Missouri	703.1	31.2	135	361	1,046
Montana	0.5	0.2	1	2	5
Nebraska	3.3	0.6	2	7	24
Nevada	80.3	19.0	63	201	332
New Hampshire	392.1	51.5	327	1,420	2,670
New Jersey	1,088.2	23.1	139	606	1,253
New Mexico	8.8	1.5	6	13	27
New York	2,558.7	13.0	143	430	1,113
North Carolina	345.5	11.9	53	149	391
North Dakota	0.0	0.0	0	0	0
Ohio	449.0	8.7	40	132	421
Oklahoma	23.5	2.2	7	18	40
Oregon	20.6	2.2	7	21	55
Pennsylvania	811.1	14.5	66	226	742
Rhode Island	97.2	11.7	101	373	1,084
South Carolina	440.7	26.2	125	324	760
South Dakota	0.0	0.0	0	0	0
Tennessee	430.2	16.1	87	219	630
Texas	1,513.0	21.3	89	228	417
Utah	4.5	0.9	3	7	23
Vermont	18.6	7.3	31	111	328
Virginia	130.8	7.3	22	78	134
Washington	257.0	11.1	53	226	484
West Virginia	105.3	8.8	58	132	460
Wisconsin	7.6	0.4	2	5	20
Wyoming	0.1	0.1	0	1	2

NOTES: The DSH payments here differ slightly from those in Table 5. This table is based on edited HCFA Form-64 data. Arizona is excluded from this table. Data on State residents, persons under 200 percent of Federal poverty level, and uninsured people are from a 3-year pooled sample of the Current Population Surveys for 1991-93 (Winterbottom, Liska, Obermaier, 1995).

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

Figure 3

Survey State Special Financing Programs: Where the Funds Come From and Where They Go, State Fiscal Year 1993



NOTE: Total State Gain ($4.9 billion) = State Hospital Gain and Residual Funds.
SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

and State) who contributed funds. The remaining one-third is retained by State governments, either through gains by State hospitals or residual funds, and used for a variety of purposes, such as general Medicaid, health, welfare, and other State expenditures. Though some of these State gains could be used for uncompensated care by State hospitals, the discussions with the case-study States suggest that this is the exception, not the norm. The share of funds that are actually available for supporting uncompensated care is only a small fraction of the total.

DISCUSSION

DSH and related special financing programs have strengths and weaknesses. There are at least three benefits. First, these programs helped many needy hospitals, especially private (non-profit) and public hospitals that provide care to the low-income and uninsured. Second, the programs helped States "weather" a period of fiscal stress. Third, States cited the importance of these funds in underwriting Medicaid growth during the early 1990s, including the costs of federally mandated expansions. Medicaid budgets in many States might have been quite different if these special programs were not available.

The special financing programs have four significant disadvantages. First, the Federal Government bears additional costs. Effectively, this transfers costs to taxpayers in other States. Shifting costs to the Federal

Government also moves burdens away from revenue sources used by the States, such as sales taxes, and toward revenue sources used by the Federal Government, such as income taxes and borrowing.

Second, the current program is not equitable. The level of funding is very uneven across the country and is related neither to a State's needs nor to the breadth of its Medicaid program. Instead, the current allocation is dictated by how aggressive a State was in creating programs by 1992. The current Medicaid matching formula is designed to allocate State-Federal costs equitably, although there have been a number of criticisms of the current formula (Blumberg, Holahan, and Moon, 1993; Cromwell et al., 1994). DSH payments essentially short-circuit the funding formulas.

Third, the complex flow of funds makes it difficult to determine the proportion of Medicaid expenditures that are used for health care at needy hospitals and the proportion used for other purposes. Analyzing Medicaid budgets and expenditures has become much more confusing.

Finally, a large share of the funds are being diverted from direct health care to general State coffers. It is reasonable to ask if Medicaid is an appropriate vehicle for general revenue sharing between the Federal Government and the States.

In the near term, an issue confronting many States is the implementation of OBRA 1993 rules. These amendments limited excessive DSH payments to State hospitals and would keep DSH payments from exceeding the volume of uncompensated care or Medicaid loss and would require at least 1-percent Medicaid volume. It seems likely that many States will be able to restructure their DSH and transfer programs to be able to maintain their programs at the level of the DSH cap. Another option being considered by some States is to develop section 1115 waiver programs that help "lock-in" the Federal matching funds.[22]

On a longer term basis, the prognosis of these programs is unclear. The final part of this article discusses two ways to reform Medicaid special financing programs. One is to use DSH funds to pay for health reform at the national or the State level. The other is incremental reform of the DSH program to make it more equitable and effective.

Reprogramming DSH Payments for Health Reform

Because Medicaid DSH payments are intended to help defray the costs of uncompensated care, many view the nearly $17 billion spent on DSH in 1993 as a large "downpayment" on health reform. Most health reform proposals, at both national and State levels, called for eliminating or greatly limiting DSH payments and reprogramming them to extend health insurance to uninsured people. For example, the Clinton Administration's Health Security Act would have eliminated Medicaid, including DSH payments, and replaced it with another insurance program for the low income including smaller "vulnerable population adjustments." Although the national health reform debate has largely ended, it is possible that elimination or reduction of DSH could resurface in the context of scaled-back health reform proposals or general deficit reduction.

A number of State health reform proposals would use Medicaid as the basis for health care expansion (Holahan et al., 1994; Rajan et al., 1994). Medicaid section 1115 demonstration waivers have been approved in Tennessee, Oregon, and

[22]For section 1115 waivers, the level of DSH funds cannot exceed published DSH allotments and must be consistent with OBRA 1993 rules.

Hawaii, permitting States to reduce the level of funds spent as DSH payments and use them to pay for eligibility expansions. HCFA has also approved similar plans for Florida, Ohio, and Kentucky, although their waiver programs have been delayed pending State legislative action. HCFA recently approved planning milestones for South Carolina's proposal that permit use of DSH funds; this proposal may eventually lead to a full waiver. Other States (such as New Hampshire and Massachusetts) have proposed Medicaid waiver programs and contemplate similar reallocations of DSH funds.

The basic rationale for redirecting DSH funds to health reform efforts is that if more people are insured and reimbursement rates to providers are "fair," there is less need for extra funding for uncompensated care. However, our estimates suggest that only a small share of the funds currently generated by DSH programs are actually used to cover uncompensated care. Only about one-sixth of the total funds of private or county hospitals are gains that could be used for uncompensated care. The bulk of DSH funds are used to either pay back providers who contributed revenues or to help the States balance their budgets. Changes to the DSH program would not only affect the flow of funds to hospitals but, perhaps more important, would affect the States' overall budgets.

We asked State and hospital officials how they viewed a scenario in which there was universal insurance coverage, but no DSH payments. Reactions were mixed. Some, including both State and hospital representatives, agreed that DSH would no longer be needed, provided that: everyone had health insurance (so there are few or no uncompensated care burdens), payments to hospitals were fair (so that the costs of Medicaid are adequately covered), and there was a reasonable implementation schedule. Even under this scenario, an adjustment might still be needed to help pay for residual uncompensated care (e.g., for undocumented aliens).

Other interviewees said that the end of DSH would cause serious hardships to States and to hospitals. Some State officials commented that funds gained through DSH programs were supporting large parts of the State budget, especially Medicaid and mental health. Elimination of DSH could make it much harder to balance State budgets and would probably lead to some serious budget cutbacks in health or welfare programs, including Medicaid. Some hospital officials still had doubts that the health reforms would be broad enough or that State payments would be sufficient without DSH adjustments.

Although it is reasonable for health reform proposals to reallocate DSH funds to pay for health reform, people should not think of these as "free money." They are now being used by States and hospitals, and the loss of funds would have some negative repercussions. Whether the overall impacts of health reform restructuring are good or bad for States or hospitals depends on the other parts of the health reform packages.

Incremental Reforms to the Special Financing Programs

This final section addresses the possibility of incremental changes to these programs, short of broader health system reform. Because DSH payments have done some good for hospitals and for States, the current system is highly inequitable. If Congress does not pass broad health reforms, policymakers may want to consider more focused changes to Medicaid's special financing programs. If it is not possible to use DSH funds to subsidize health insurance, these funds could be used to

more directly and equitably underwrite uncompensated care for the uninsured.

A number of alternatives exist. For example, it would be possible to eliminate the current Medicaid DSH program and replace it with a new Federal grant program that directly supports uncompensated care. Table 7 presents a simulation of one possible means of allocating grant funds. The number of uninsured people in each State is multiplied by the FMAP, forming an index for each State. The current Federal DSH expenditures of $9.7 billion would be allocated among States, based on their indexes. This approach uses simple measures of State health needs (number of uninsured) and economic capacity (FMAP). This alternative distributes Federal funds more equitably than does the current system.

There are alternative methods to measure health needs other than the number of uninsured persons, such as the number of low-income people in each State or the level of uncompensated care. A conceptual disadvantage of using the uninsured is that States with generous Medicaid programs, which thereby have fewer uninsured people, would get smaller allocations. This might be viewed as penalizing States with broader Medicaid coverage. On the other hand, it does target funds to areas that are more at risk for uncompensated care because of no insurance (which is also caused by a lack of employer-based insurance as well as by a lack of Medicaid). Using the number of low-income persons (e.g., persons below 200 percent of the Federal poverty level) in each State avoids penalizing States with generous Medicaid programs, but this measure is not directly related to health care needs. Using uncompensated care (including both charity care for the uninsured and the gap between Medicaid costs and payments) most carefully measures actual uncompensated care burdens, but this measure penalizes States with better Medicaid hospital payment rates.[23]

Alternative measures of economic capacity other than the current FMAP also exist. The current FMAP formula does not perfectly measure State economic capacity or need. Alternatives, such as tax or revenue capacity, have been proposed for computing the Federal share of Medicaid (Blumberg, Holahan, and Moon, 1993; Cromwell et al., 1994). The simulation uses the current FMAP because it is already used in Medicaid; alternative measures of economic capacity are plausible and would yield slightly different results.

Once a grant level for each State is determined, States would allocate funds to needy hospitals. The Federal funds could be used for uncompensated-care pools. Some States are already using DSH funds to underwrite their uncompensated-care pools; this would permit such a change on a broader basis. Alternatively, States could use the funds to target special payments to hospitals that provide high levels of charity care. To level the "playing field" with respect to gains that can be made by paying State hospitals, national guidelines could be developed to regulate payments to State acute care or psychiatric hospitals. In any event, it would be important to develop an accountable reporting system to demonstrate how funds received are used.[24]

[23] In addition to conceptual concerns, there are also technical issues. These three measures of need are not readily available for any State. The data used for the uninsured are the number of uninsured non-elderly civilians, based on a special 3-year pooled sample of the 1991-93 Current Population Surveys, corresponding to insurance levels between 1990 and 1992 (Winterbottom, Liska, and Obermaier, 1994).

[24] A variant of this proposal would be to allocate DSH funds to help with uncompensated-care costs of both hospitals and primary care providers. That is, within a State, formulas could be developed to allocate funds not only to hospitals but to community health centers, outpatient clinics, local health departments, and other groups that provide medical services to the uninsured. This would support primary care, although developing an accounting system would be a major undertaking.

Table 7

Comparison of Actual Federal Funds Received for Disproportionate Share Hospitals (DSH) in Federal Fiscal Year (FFY) 1993 With an Allocation Based on the Number of Uninsured Times the Federal Matching Rate

State	Percent of Population Uninsured	New Allocation Based on Federal Matching Rate Times Number of Uninsured	Actual Federal Share of FFY 1993 DSH Payments	Percent Difference
		In Millions of Dollars		
Total	16	$9,701.4	$9,701.4	0
Alabama	20	248.1	299.5	-17
Alaska	22	23.8	7.1	237
Arkansas	20	150.7	1.9	>1,000
California	19	1,275.6	1,271.3	0
Colorado	14	105.8	71.0	49
Connecticut	8	58.4	208.7	-72
Delaware	15	22.3	2.6	757
District of Columbia	23	26.9	23.0	17
Florida	23	628.7	120.6	421
Georgia	19	320.4	192.1	67
Hawaii	8	18.4	22.0	-16
Idaho	18	58.5	0.7	>1,000
Illinois	13	326.3	120.0	172
Indiana	13	196.0	21.3	818
Iowa	10	79.7	2.5	>1,000
Kansas	12	75.4	107.3	-30
Kentucky	14	156.0	98.2	59
Louisiana	22	290.3	897.5	-68
Maine	12	41.7	101.4	-59
Maryland	13	129.5	38.9	233
Massachusetts	11	139.7	242.2	-42
Michigan	11	238.1	304.2	-22
Minnesota	12	127.3	17.7	619
Mississippi	21	193.3	120.4	61
Missouri	14	196.0	423.7	-54
Montana	16	40.7	0.4	>1,000
Nebraska	10	41.2	2.0	>1,000
Nevada	21	61.1	42.0	46
New Hampshire	14	34.1	196.0	-83
New Jersey	13	210.9	544.1	-61
New Mexico	24	116.0	6.5	>1,000
New York	15	554.8	1,279.4	-57
North Carolina	15	281.8	227.8	24
North Dakota	10	18.3	0.0	>1,000
Ohio	11	311.3	270.5	15
Oklahoma	22	200.7	16.4	>1,000
Oregon	14	113.6	12.9	784
Pennsylvania	10	294.0	450.0	-35
Rhode Island	11	23.4	52.1	-55
South Carolina	18	200.4	314.1	-36
South Dakota	17	34.0	0.0	>1,000
Tennessee	16	224.3	290.7	-23
Texas	24	1,132.3	974.4	16
Utah	12	71.4	3.4	>1,000
Vermont	11	16.3	11.1	46
Virginia	18	237.0	65.4	262
Washington	12	141.1	141.4	0
West Virginia	15	85.1	80.3	6
Wisconsin	9	112.8	4.6	>1,000
Wyoming	13	18.1	0.1	>1,000

NOTES: The number of uninsured is for persons under 65 years of age based on a 3-year pooled sample of the Current Population Surveys from 1991 to 1993 (Winterbottom, Liska, Obermaier, 1995). The DSH payments are based on edited HCFA Form-64. Arizona is excluded.

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

Targeting DSH payments to States on the basis of the number of uninsured and State economic capacity could be simpler and more equitable than the current system. It could also be a more effective means of helping hospitals that provide high levels of charity care because it would reduce the ability of States to manipulate the flow of funds. Table 7 compares a simulation of this hypothetical system with actual Federal DSH levels for Federal fiscal year (FFY) 1993. About one-third of the States (16) would receive fewer Federal funds than they do under the current DSH program (including New Hampshire, Connecticut, Louisiana, New Jersey, New York, Maine, Missouri, and Michigan). About two-thirds (33) would get more under this hypothetical system (including Texas, North Carolina, Colorado, Florida, and Illinois). Two (California and Washington) would essentially break even (they register very small losses). In general, States that currently have very large DSH programs would get less money than they do currently, and States with smaller DSH programs would gain money.

We are not endorsing the creation of such a program. However, this alternative illustrates how Federal resources now spent on DSH could be redirected in a more equitable fashion across States and more in keeping with the original intent of the DSH legislation. The Medicaid amendments passed by Congress in 1991 and in 1993 yielded some needed reforms to the special financing programs but also perpetuated the basic structure of the current system. Redesigning the special financing policies in Medicaid, whether through broad health system reforms or incremental changes, could permit these funds to be spent in a fashion that is simpler to understand, fairer across States, and more effective in increasing the delivery of health services to the uninsured.

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TECHNICAL NOTE

Data Quality

The survey responses from the 39 States are imperfect. The accounting for these programs is complex, and terminology is not consistent across States. In addition, in some States, completing the survey required input from several different offices and, occasionally, even different agencies within a State. As a result of these problems, some States may have misreported despite our efforts to contact States when we were aware of problems. Table 8 compares the estimated DSH payments from our survey respondents and from HCFA Form-64 expenditure reports submitted by all States for FFY 1993. HCFA Form-64 data are the financial reports that are the basis for Federal matching payments to States. For the 39 States, the two sources are within 0.5 percent, although individual State discrepancies are often larger. Comparisons between the two sources must be made with caution because of the difference in SFYs (reported in our survey) and FFYs (reported in HCFA Form-64 data). Because DSH payments are often made as large lump sums,

Table 8

Comparison of DSH Payments Reported in Urban Institute Survey and on HCFA Form-64: 1993

State	DSH Payments HCFA Form-64 FFY 93	Survey FFY 93	Difference
		In Millions of Dollars	
Total	$17,025.04	—	—
Responding to Urban Institute Survey			
Total	13,086.09	$13,017.64	$68.45
Alabama	419.14	417.46	1.68
Alaska	14.15	17.35	-3.20
Arkansas	2.54	2.54	0.00
California	2,542.50	2,065.87	476.63
Colorado	130.55	197.30	-66.75
Florida	239.69	239.69	0.00
Hawaii	43.93	44.00	-0.07
Idaho	0.98	1.60	-0.62
Illinois	240.09	339.70	-99.61
Indiana	33.78	39.60	-5.83
Iowa	3.99	4.63	-0.64
Kansas	184.42	186.94	-4.52
Louisiana[1]	1,217.64	1,217.64	0.00
Maine	164.08	165.32	-1.24
Maryland	77.82	119.38	-41.56
Massachusetts	484.48	473.20	11.28
Michigan	544.75	559.30	-14.55
Minnesota	32.26	32.26	0.00
Missouri	703.09	763.81	-60.72
Montana	0.54	0.54	0.00
Nebraska	3.34	3.47	-0.13
Nevada	80.27	80.51	-0.24
New Hampshire[1]	392.01	411.56	-19.55
New Mexico	8.78	8.78	0.00
New York	2,558.72	2,784.00	-225.28
North Dakota	0.01	0.44	-0.43
Ohio	449.02	449.02	0.00
Oklahoma	23.47	21.20	2.27
Oregon	20.60	20.18	0.42
Rhode Island	97.16	97.16	0.00
South Carolina	440.72	424.29	16.43
South Dakota	0.01	0.01	0.00
Texas	1,513.03	1,418.14	94.89
Utah	4.45	4.73	-0.27
Vermont	18.59	17.93	0.66
Virginia	130.76	140.55	-9.79
Washington	257.04	237.92	19.12
Wisconsin	7.60	7.50	0.10
Wyoming	0.09	0.15	-0.05
Not Responding to Urban Institute Survey			
Arizona	91.11	—	—
Connecticut	417.34	—	—
Delaware	5.19	—	—
District of Columbia	46.08	—	—
Georgia	309.43	—	—
Kentucky	136.99	—	—
Mississippi	152.34	—	—
New Jersey	1,088.21	—	—
North Carolina	345.55	—	—
Pennsylvania	811.14	—	—
Tennessee	430.25	—	—
West Virginia	105.32	—	—

[1]DSH payments on the HCFA Form-64 for Louisiana and New Hampshire were edited to correspond with other information provided by the States.

NOTES: DSH is disproportionate share hospital. FFY is Federal fiscal year. SFY is State fiscal year.

SOURCE: Ku, L. and Coughlin, T.A., The Urban Institute, 1994.

a few months can shift large amounts of money. Payments made by the 39 sample States comprise 77 percent of the DSH payments reported in the adjusted HCFA Form-64 data for 1993.

Both our survey and the HCFA-Form 64 data probably contain some errors. In completing the survey, States may have reported DSH payments that were not subsequently approved by HCFA (in which case, the survey estimates may be high). HCFA Form-64 data are incomplete because States may make retroactive DSH payments that are not yet posted in the HCFA accounts. For example, we edited New Hampshire's HCFA Form-64 estimate of $37.6 million for DSH payments in FFY 1993 to $392.0 million, based on information from the State. The State assured us that they were making retroactive payments that had not yet been posted in the HCFA accounts and that the State would claim its maximum allowable level of DSH payments. We also edited Louisiana's HCFA Form-64 estimate of $981.4 million to the level of $1,217.6 million to ensure internal consistency of data; the higher level also corresponds with Louisiana's DSH cap level.

Accounting for State Funds: The Interaction of Residual Funds and State Hospital Gains

One complicated issue is how States report the use of State funds as revenue sources. For example, some States have explicit transfers from the mental health agency to the Medicaid agency, whereas others do not, yet operate similar programs. This affects the distribution of funds on the books but does not affect overall State gains or losses.

An example is illustrative. Consider a State with a 50-percent match that pays $10 million in Medicaid DSH payments to a State psychiatric hospital. The State earns a $5 million Federal matching payment. Two potential scenarios emerge.

Scenario A

If the State mental health agency had transferred $7 million to the Medicaid agency, then the Medicaid agency would have "residual funds" of $2 million, because it had $12 million in revenue but only $10 million in expenditures. The State hospital gain would have been $3 million, because it contributed $7 million but got back $10 million. The total State gain would be $5 million.

Scenario B

If the State mental health agency did not transfer any funds to the Medicaid agency, then the Medicaid agency would have negative residual funds of -$5 million. But the State hospital would have gained $10 million. The total State gain would still be $5 million.

The mechanism of State transfers or other special appropriations affects the distribution of funds within the State government but not the overall level of funds gained by the State. Although residual funds and State hospital gains are different mechanisms through which States can earn Federal funds, the lines are actually somewhat blurred because of inconsistencies in how States handle these transactions. Thus, the overall net gain by States (Table 5) is more important and more reliable than the apparent distribution in gains to State hospitals and residual funds (Table 4).

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