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Medicaid Disproportionate Share Payments

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Summary

The Medicaid statute requires that states make disproportionate share (DSH) adjustments to the payment rates of certain hospitals treating large numbers of low-income and Medicaid patients — recognizing the disadvantaged situation of those hospitals. Although the requirement was established in 1981, DSH payments did not become a significant part of the program until after 1989 when they grew from just under $1 billion to almost $17 billion by 1992. During that time states' Medicaid budgets were facing a number of upward pressures while states were learning about financing techniques that made it easier to collect increased DSH payments from the federal government.

In 1991 Congress intervened to control the growth of DSH payments by limiting the amounts available to each state and setting national limits. The new law was successful. After 1992 DSH payment growth slowed considerably, although the level of national DSH payments remains high — just over $15.9 billion in 2002.

Today, as a result of amendments contained in the Balanced Budget Act of 1997 (BBA-1997) and further changes in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), a state's DSH payments may not exceed an allotment amount set in the law for that state. States must define, in their state Medicaid plan, hospitals qualifying as DSH hospitals and DSH payment formulas. DSH hospitals must include *at least* all hospitals meeting minimum criteria and may not include hospitals that have a Medicaid utilization rate below 1%. The DSH payment formula also must meet minimum criteria and DSH payments for any specific hospital cannot exceed a hospital-specific cap based on the unreimbursed costs of providing hospital services to Medicaid and uninsured patients. DSH payments for mental hospitals cannot exceed a facility-specific cap based on a percentage of such payments in 1995. However, within these broad guidelines states also have a great deal of discretion in designating DSH hospitals and calculating adjustments for them. For this reason, Congress has required states to report the methods used to identify and pay DSH hospitals and the payments made to each of the identified hospitals.

Congress provided relief to states from the 1997 DSH cuts. The reductions in states' allotments that were to take place in 2000, 2001, and 2002 were eliminated but the temporary reprieve did not extend beyond 2002. In 2003 states faced significant reductions in their DSH allotments. In P.L. 108-173, Congress again stepped in to raise DSH payments. Beginning in FY2004 and for certain subsequent fiscal years, states will be allotted 16% more than the amounts previously available. In addition, the number of states able to qualify for low DSH payments and the allotments for those low DSH states were raised.

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Background: The Medicaid Program

Medicaid is a federal-state program providing medical assistance for specified groups of low-income persons who are aged, blind, disabled, or members of families with children. Within federal guidelines, each state designs and administers its own program. Thus there is substantial variation among the states in terms of persons covered, types of benefits provided, and payment rates for covered services.

The federal government shares in the cost of Medicaid services through a variable matching formula. After a state pays for a Medicaid-covered service, it makes a claim for the federal share of the payment and is reimbursed at the federal matching rate for that state. The federal matching rate, known as the federal medical assistance percentage (FMAP), is inversely related to a state's per capita income and may range from 50% to 83%. In FY2004, 13 states, and all of the territories received the minimum of 50% federal matching on Medicaid payments. Mississippi had the highest FMAP in FY2004, 77.08%. The federal share of most state administrative expenditures is 50% in all states; higher matching is allowed for certain administrative activities. Overall, the federal share of Medicaid spending was approximately 57% in FY2002.[1]

When Medicaid was enacted in 1965, it was targeted at persons receiving cash welfare: Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) for the aged, blind, and disabled. Over time, the program has moved away from its explicit link to the cash assistance programs especially for low-income families. It now covers many pregnant women and children with no ties to the welfare system; it pays Medicare's cost-sharing and premiums for certain low-income Medicare beneficiaries; and it is the major source of funding for nursing facilities (NFs) and other long-term care needed by the elderly and other disabled populations who are not literally poor.

In FY2002, 49.5 million people were enrolled in Medicaid, at a combined federal and state cost of $246.3 billion[2]. As **Table 1** indicates, Medicaid spending growth slowed considerably after a period of sharp increases in the early 1990s. The pattern of rapid spending growth during 1989 to 1993, followed by much slower

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[1] CRS tabulations of CMS-64 data available at [http://www.cms.gov/medicaid/mbes/ofs-64.asp].

[2] Enrollment figures from [http://www.cms.gov/medicaid/msis/msis99sr.asp]. Expenditure figures are CRS tabulations of CMS-64 data summarized by CMS and downloaded at [http://www.cms.gov/medicaid/mbes/sttotal.pdf].

spending growth through 1998 is echoed in spending for Medicaid disproportionate share (DSH) payments during the same periods.

Table 1. Medicaid Outlays, FY1988-FY2001
($ in billions)

Fiscal year	Federal	State[a]	Total	Percentage change in federal outlays
1988	30.5	23.7	54.1	-
1989	34.6	26.6	61.2	13.2%
1990	41.1	31.4	72.5	18.4%
1991	52.5	39	91.5	26.2%
1992	67.8	50.3	118.1	29.1%
1993	75.8	56.2	132	11.7%
1994	82	61.9	143.9	9.0%
1995	89.1	67.2	156.3	8.6%
1996	91.9	69.3	161.2	3.1%
1997	94.4	72.5	166.9	3.5%
1998	99.4	76.5	175.9	5.4%
1999	107.7	82.7	190.4	8.3%
2000	116.9	89.2	206.1	8.5%
2001	129.8	98.2	228.0	11.0%
2002	140.0	106.2	246.3	8.0%

Sources: Office of Management and Budget, 2000 Budget of the United States; Medicaid Statistics HCFA pub. N. 10129; for 2000-2002 at [http://www.cms.hhs.gov/medicaid/mbes/ofs-64.asp].

Note: Totals may not add due to rounding.

a. State outlays for 1988 to 1996 are based on percentage estimates furnished by the Health Care Financing Administration, OA. State outlays for 1997 to 2001 are equal to reported total spending minus reported federal spending.

Disproportionate Share Adjustments

The disproportionate share hospital adjustment (DSH adjustment) was established by Congress in 1981. The DSH provision was included in a package of provisions referred to as the "Boren amendment" after its sponsor, David Boren, who was a Democratic Senator from Oklahoma. Prior to 1981, state Medicaid programs were required to follow Medicare reimbursement principles in paying for inpatient hospital services. Under the Medicare rules in effect at that time, this meant that every state used a reasonable cost system. The Boren amendment was intended to give states greater flexibility to use other payment methods and, at the same time, provide protections for hospitals, specifically hospitals with large caseloads of low-income and uninsured patients. The protections included a requirement that states make assurances to the Secretary that payment rates were "reasonable and adequate" and that states "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" by raising payment rates (DSH adjustments) for those hospitals. The requirement to make DSH adjustments implicitly recognized the disadvantaged situation of hospitals which treated large numbers of Medicaid and other low-income patients and which had to

depend on the relatively low payment rates of most Medicaid programs at the time. The provisions did not place any upper limits on DSH adjustments and later, in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Congress clarified that the Health Care Financing Administration (HCFA)[3] had no authority to limit in any way the amount of payment adjustments made to DSH hospitals.

Concerned by reports that many of the states were not implementing this mandate, Congress in 1987 amended the DSH provisions to require states to submit a Medicaid plan amendment describing their DSH policy.[4] Specifically, Congress required that each state describe the criteria used to designate hospitals as DSH hospitals and define the formulas used to calculate the increase in the payment rate (the DSH adjustment) for inpatient services provided by these hospitals. The law, passed as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), included minimum criteria for defining a hospital as a DSH hospital and minimum criteria for calculating DSH adjustments.

For purposes of designating hospitals as DSH, OBRA 87 required that at least those hospitals with (a) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state; or (b) a low-income utilization rate of 25% be included.[5] All hospitals qualifying as DSH hospitals must also retain at least two obstetricians with staff privileges. A state plan could include other hospitals under its definition of DSH as long as those hospitals meeting the minimum criteria were classified as DSH hospitals.

OBRA 87 required states' Medicaid plans specify the increase in payment to be made to DSH hospitals and gave states two options for determining DSH payment amounts. States were allowed to make minimum payments to DSH hospitals using either the Medicare methodology[6] or a formula providing payments that increase as

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[3] The former name of what is now the Centers for Medicare and Medicaid Services (CMS).

[4] A state qualifies for federal matching payments for Medicaid as long as the state has submitted and the Secretary of Health and Human Services (HHS) has approved a state plan for medical assistance. The plan describes who is eligible for the program, what services are covered, and how payments are made. Amendments to a state's plan describe changes to the program and must also be approved by the Secretary of HHS.

[5] The Medicaid utilization rate is defined as the number of days of care furnished to Medicaid beneficiaries during a given period divided by the total number of days of care provided during the period. The "standard deviation" is a statistical measure of the dispersion of hospitals' utilization rates around the average; the use of this measure identifies hospitals whose Medicaid utilization is unusually high. The low-income utilization rate is the sum of two fractions: Medicaid payments plus state and local subsidies divided by total patient care revenues, and inpatient charges attributable to charity care (other than charity care subsidized by state or local government) divided by total inpatient charges.

[6] To qualify for Medicare DSH, a hospital must have a share of low-income patients that equals or exceeds 15%. The low income share is determined by summing (a) the number of Medicare inpatient days provided to SSI recipients divided by total Medicare patient days, and (b) the number of inpatient days provided to Medicaid beneficiaries divided by

(continued...)

the hospital's Medicaid inpatient utilization rate increases over the state's average. Under the second option, a state's formula could vary payments to different types of hospitals, as long as all hospitals of each type were treated equally and adjustments were reasonably related to the hospital's Medicaid or low-income patient volume. Again, no upper payments limits were established.

Following the passage of OBRA 87 and until 1990, total payments for DSH adjustments remained relatively low until a combination of events occurred that resulted in a rise in DSH adjustments from just under $1 billion in FY1990 to $17.4 billion two fiscal years later.[7] In the late 1980s, states were experiencing a number of upward pressures on their Medicaid budgets. General health care inflation was rising at unprecedented high rates. National health spending estimated by the Centers for Medicare and Medicaid Services (CMS), then known as HCFA, rose by over 20% during the 1990 to 1992 period.[8] The medical component of the consumer price index, a common measure of health care prices, rose by almost 17%. At the same time a recession was increasing the rolls of eligible Medicaid beneficiaries while states were being required to phase in a number of mandatory eligibility expansions. These combined factors led to an enrollment increase of over 24% or 6 million new people on the Medicaid rolls between 1990 and 1992. In addition, the recession shrunk the tax base from which states could fund increasing program costs. In response to these pressures, states turned to funds donated by health care providers or taxes paid by those providers to leverage federal matching payments. These funding mechanisms helped drive DSH payments to their high levels.

Donations, Provider Taxes and Intergovernmental Transfers

In response to those pressures, three special funding techniques began to spread among the states to leverage federal Medicaid funds. The three approaches were collecting donations, collecting provider-specific taxes, and transferring funds from different levels of governments or governmental entities to the state government. The funds collected through one or more of the three mechanisms were aggregated at the state-level and used for the state share of Medicaid spending. Once used as a state share of Medicaid spending, the donated, taxed, or transferred funds would be matched with federal Medicaid matching dollars and then returned to the donors or taxpayers through higher DSH adjustments or higher provider payment rates.

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[6] (...continued)
total inpatient days. Payment adjustments are specified by statute as a percentage increase to the hospital payment rate depending upon the hospital's size, urban/rural location, and status as a rural referral center or sole community hospital.

[7] Holahan, J., D. Liska, and K. Obermaier. *Medicaid Expenditures and Beneficiary Trends, 1988-1993*. Urban Institute, September 1994.

[8] Levit, K.R., H.C. Lazenby, B.R. Braden, C.A. Cowan, P.A. McDonnell, L. Sivarajan, J.M. Stiller, D.K. Won, C.S. Donham, A.M. Long, and M.W. Stewart. National Health Expenditures, 1995. *Health Care Financing Review*, 1996.

Before 1990, these techniques did not appear to be widespread and few were aware of the potential for misuse. In 1985, for example, before HCFA became aware of problems, it issued a regulation declaring that donated funds were a legitimate source of state Medicaid matching payments. The regulation (42 CFR 433.45(b)) established that donated funds could be used to finance the state share of any Medicaid service or administrative spending as long as two conditions were met: the funds were under control of the Medicaid agency, and the funds could not revert to the donor unless the donor was a non-profit organization and the Medicaid agency decided on its own to use the donor's facility. Originally, two states, Tennessee and West Virginia, developed programs to collect donations from hospitals, claim those funds as a state share, and collect a federal match. A portion of the donations and their federal match were subsequently returned to the donors through higher Medicaid hospital payments than they would have received including higher DSH adjustments. HCFA at first approved the two state plans but later took steps to deny federal matching for the spending funded by the programs. By 1988, HCFA indicated that it planned to issue regulations limiting the use of donations as the state's share of Medicaid.

Similar issues were raised with respect to the treatment of taxes imposed by states on health care providers. A set of instructions issued to state Medicaid programs in 1987 distinguished between taxes of general applicability and provider-specific taxes. Taxes of general applicability were those imposed on all kinds of goods and services while provider specific taxes were those that applied only to health care providers or services. The instruction allowed for states to reimburse providers for general taxes, such as sales or excise taxes applicable to all businesses, and to receive federal matching for those reimbursements. However no federal matching was allowed for provider-specific taxes, such as a tax on each day of care or each hospital bed. In HCFA's view, provider-specific tax arrangements could potentially work in the same way as voluntary contribution programs. A state could impose a tax on providers, use the tax to claim federal matching, then repay the tax to the providers along with some or all of the federal funds without having spent state general revenue. Because HCFA instructions do not have the same legal force as regulations and because many states' provider payment systems did not allow for a clear connection between the tax paid by the provider and the reimbursement received from the state, the use of this technique began to spread among the states. Up to this point, intergovernmental transfers had not been addressed.

Before HCFA could issue final regulations defining its position, Congress intervened. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) included a provision prohibiting the Secretary from issuing final rules that would change the treatment of voluntary contributions or provider-specific taxes before May 1, 1989. The prohibition was twice extended by Congress, first in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) through the end of 1990, and then later OBRA 90 extended it through the end of 1991 for voluntary contributions only. OBRA 90 prohibited altogether regulation of provider-specific taxes although the law was not clear.[9]

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[9] OBRA 90 included two provisions addressing provider specific taxes that were interpreted (continued...)

After OBRA 90 was enacted, states' use of donations and taxes continued to rise. By July of 1991, the Inspector General of HHS had issued three reports on the rise in the use of provider donations and taxes, characterizing the programs as an "uncontrollable virus" and "egregious."[10] The Inspector General asserted that the schemes were used by states to reduce the effective state share of the program, forcing the federal government to pay more for Medicaid.

DSH adjustments rose, coinciding with the taxes and donations. DSH had become the most popular mechanism for returning targeted taxes or donations back to the hospitals since DSH adjustments were uncapped and did not need to be tied to particular beneficiaries or services. Some providers shared in the proceeds that states generated by the federal matching payments on the donation and tax programs; states returned DSH payments to those donors in excess of their contribution, or increased their payment rates.[11]

Finally, after intense negotiations between the White House, the Governors, and the Congress, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) was passed in November of that year. The law established the first upper bounds on DSH payments and prohibited the use of donated funds and health care related taxes that were not broad based for the purpose of claiming federal matching payments. It established a cap on the portion of the state share of Medicaid spending that could be raised through provider-specific taxes and established aggregate national and state limits on DSH payments. The national limit on DSH adjustments was set at 12% of Medicaid costs in any year, and beginning in 1993, state DSH adjustments would be limited to published amounts above which federal matching payments would not be available.

Under the law, each state would be eligible to receive the DSH adjustment amount published in the *Federal Register* for that year and no more than that amount. The published amount for each fiscal year would be based on 1992 payments. States with 1992 DSH adjustments exceeding 12% of their 1992 Medicaid costs would continue to receive allotments at their 1992 level until those payments became 12% of total Medicaid spending in that state. These states were classified as "high" DSH states. States with 1992 DSH payments below 12% could receive allotments increasing their DSH adjustments (subject to a formula) up to a limit of 12%.

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[9] (...continued)
as conflicting. The first provision stated that "... nothing in this title ... shall be construed as authorizing the Secretary to deny or limit payments to a state for expenditures ... attributable to taxes (whether or not of general applicability) imposed with respect to the provisions of such [health care] items or services." A second provision excluded provider-specific taxes from the cost base of a provider for purposes of computing Medicaid reimbursement to the provider. Congress focused on the first provision, while the Administration focused on the second, fueling a debate.

[10] U.S. Dept. of Health and Human Services. Memoranda dated July 25, 1991, May 10, 1991, October 11, 1990. Prepared by Richard Kusserow, Inspector General. Washington. (Hereafter cited as Inspector General memorandum)

[11] Inspector General memorandum data, July 25, 1991.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments specifically protected intergovernmental transfers while restricting the use of the other two funding mechanisms. The law restricted the Secretary of HHS from limiting the use, as the non-federal share of Medicaid, of funds derived from state or local taxes or funds transferred by units of government within the state.

At the time, few states utilized intergovernmental transfers to generate federal matching payments and the 1991 law was deemed a success. Despite the remaining intergovernmental transfer loophole, the upper caps on DSH payments had a significant impact on total DSH spending — the rapid climb in DSH payments had been stopped. In the last few years, on the other hand, intergovernmental transfers have begun to grow. In the most recent incarnation, instead of claiming DSH payments with the intergovernmental funds, states have increasingly claimed grossly inflated hospital charges for certain public hospitals.

Table 2. Federal and State Medicaid Disproportionate Share Payments and Percentage Change, 1990-2001

(By fiscal year, in billions of dollars)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
$.96	4.7	17.4	16.6	16.9	19.0	15.1	15.9	15.0	15.5	15.6	15.9	15.9
	389%	270%	-4.6%	1.8%	12.4%	-20.5%	5.3%	-5.6%	3.3%	3.2%	1.6%	0%

Source: Payments estimated by Urban Institute for 1990-1992; data from CMS, 1993-2002. CRS tabulations of percentage growth.

Although the growth in DSH payments stopped after 1991, complaints about the distribution of those payments among hospitals persisted. There were anecdotal reports that some hospitals were receiving large DSH payments, even though they had few Medicaid patients and that other hospitals were receiving DSH payments so large that the amount of their DSH payments exceeded the amount of uncompensated care provided by the hospital.

In response to these concerns, Congress included in OBRA 1993 (P.L. 103-66) a number of provisions intended to better target DSH hospital payments. The policies in OBRA 1993 were different from earlier laws limiting DSH payments in that the earlier laws sought only to cap total DSH payments flowing to the states. OBRA 1993, however, set limits on the amounts of DSH payments that individual hospitals would be allowed to receive and limited states' flexibility to designate hospitals as DSH hospitals. It prohibited designation of a hospital as a DSH hospital for purposes of Medicaid reimbursement unless the hospital has a Medicaid inpatient utilization rate of at least 1%.[12] It also limited DSH adjustments to no more than the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients. This cap,

[12] Medicaid inpatient utilization means the total number of Medicaid inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in the same period.

known as the hospital-specific or facility-specific DSH cap was phased-in for certain public hospitals and later became effective for private hospitals, too. Its provisions became fully effective in 1995 and may have been the force behind the large drop in total payments seen in FY1996. Later legislation raised the hospital-specific cap on DSH payments for public hospitals in the state of California. BIPA 2000 extended California's higher hospital-specific cap (175% of a hospital's uncompensated costs) to public hospitals in the rest of the country for a period of two years, beginning with the state fiscal year that starts after September 30, 2002.

After OBRA-93 was passed, DSH payments to hospitals continued to be a focus of congressional attention despite the law's success in stopping their rapid growth. This was because DSH payments were both large and little information existed on what precisely those payments accomplished. As a result, DSH again became the target of congressional budget cutters. Provisions were included the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33), to reduce DSH spending and to address other issues affecting DSH. The formula-based DSH allotments set into law in 1991 were replaced with *specific* DSH allotments for states for 1998 through 2002. The federal share of DSH payments were set at $10.3 billion in 1998 (approximately $18 billion if matched by states at the 57% federal: 43% state matching rate) and were to decline to $8.5 billion by 2002 (approximately $15 billion if matched by a state at the 57%:43% rate). The constraints for fiscal years 2001 and 2002 were later relaxed by Congress as part of the BIPA 2000. In that bill, the state allotments for 2001 were raised to 2000 levels. For 2003, the allotments are to return to the BBA levels for 2002, increased by percentage growth of the consumer price index (CPI). Thereafter, allotments will increase annually by the percentage growth of the CPI. The result of reverting to the BBA policy in 2003 will be a significant reduction in DSH allotments for most states for that year. This drop in allotments has been referred to as the "DSH dip".

The federal share of DSH allotments under current law, taking into account amendments made by BIPA 2000 are reflected in **Table 3**. (DSH allotments are different from DSH payments in that allotments reflect the maximum amount of payments that could made to qualify for federal matching funds. Actual DSH payments in any year could be lower than the allotments for that year or could even be higher if some of those payments relate to claims for an earlier year. This difference is reflected in differences in the numbers in **Tables 3 and 4**.)

Table 3. Federal DSH Allotments for 1998-2002, Preliminary Allotments for 2003 and 2004

(in millions of dollars)

State or District	1998	1999	2000	2001	2002	2003	2004
Alabama	293	269	248	256.7	263.4	249.7	289.6
Alaska	10	10	10	10.4	10.6	9.1	10.6
Arizona	81	81	81	83.8	86.0	82.2	95.4
Arkansas	2	2	2	18.6	19.1	19.3	22.4
California	1,085	1,068	986	1,020.5	1,047.0	890.2	1,032.6
Colorado	93	85	79	81.8	83.9	75.1	87.1
Connecticut	200	194	164	169.7	174.2	162.4	188.4
Delaware	4	4	4	4.1	4.2	4.1	4.7
District of Columbia	23	23	32	33.1	34.0	32.5	37.7
Florida	207	203	197	203.9	209.2	162.4	188.4
Georgia	253	248	241	249.4	255.9	218.2	253.1
Hawaii*							
Idaho	1	1	1	7.1	7.3	7.4	8.6
Illinois	203	199	193	199.8	204.9	174.6	202.5
Indiana	201	197	191	197.7	202.8	173.6	201.3
Iowa	8	8	8	17.0	17.4	17.7	20.5
Kansas	51	49	42	43.5	44.6	33.5	38.9
Kentucky	137	134	130	134.6	138.0	117.7	136.6
Louisiana	880	795	713	713.0	713.0	631.0	732.0
Maine	103	99	84	86.9	89.2	85.3	98.9
Maryland	72	70	68	70.4	72.2	61.9	71.8
Massachusetts	288	282	273	282.6	289.9	247.7	287.3
Michigan	249	244	237	245.3	251.7	215.2	249.6
Minnesota	16	16	33	34.2	35.0	33.5	38.9
Mississippi	143	141	136	140.8	144.4	123.8	143.6
Missouri	436	423	379	392.3	402.5	384.7	446.2
Montana	.2	.2	.2	4.9	5.0	5.1	5.9
Nebraska	5	5	5	12.2	12.5	12.7	14.7

State or District	1998	1999	2000	2001	2002	2003	2004
Nevada	37	37	37	38.3	39.3	37.6	43.6
New Hampshire	140	136	130	130.0	131.8	132.0	153.1
New Jersey	600	582	515	533.0	546.9	522.7	606.4
New Mexico	5	5	9	9.3	9.6	9.1	10.6
New York	1,512	1,482	1,436	1,486.3	1,524.9	1,304.3	1513.0
North Carolina	278	272	264	273.2	280.3	239.5	277.9
North Dakota	1	1	1	4.1	4.2	4.3	5.0
Ohio	382	374	363	375.7	385.5	329.9	382.7
Oklahoma	16	16	16	16.6	17.0	16.2	18.8
Oregon	20	20	20	20.7	21.2	20.3	23.5
Pennsylvania	529	518	502	519.6	533.1	455.7	528.7
Rhode Island	62	60	58	60.0	61.6	52.8	61.2
South Carolina	313	303	262	271.2	278.2	265.9	308.5
South Dakota	1	1	1	4.8	4.9	4.9	5.7
Tennessee*							
Texas	979	950	806	834.2	855.9	776.5	900.7
Utah	3	3	3	8.4	8.7	8.8	10.2
Vermont	18	18	18	18.6	19.1	18.3	21.2
Virginia	70	68	66	68.3	70.1	71.1	82.5
Washington	174	171	166	171.8	176.3	150.2	174.3
West Virginia	64	63	61	63.1	64.8	54.8	63.6
Wisconsin	7	7	7	40.7	41.8	42.4	49.2
Wyoming	.067	.095	.1	.1	.1	.1	.1
Total (in billions of dollars)	$10.3	$9.9	$9.2	$9.7	$9.9	$8.7	$10.1

Source: Department of Health and Human Services, "Medicaid Program: Disproportionate Share Hospital Payments," 69 *Federal Register* 15850, March 26, 2004.

* Does not make DSH payments.

The BBA 1997 also imposed a hospital-specific cap on DSH payments to mental health facilities. Beginning in 2003, DSH payments to institutions for mental diseases and other mental health facilities can be no higher than 33% of DSH payments in 1995 made to such facilities.

Other provisions were included in BBA 1997, BBRA 1999, and BIPA 2000, to better target DSH payments to needy hospitals or to make other minor changes in DSH payment policy. BBA 1997 required states to submit to the Secretary a description of the methods used to identify and pay DSH hospitals, including children's hospitals, on the basis of the proportion of low-income and Medicaid patients served by such hospitals. Payments made to each of the identified DSH hospitals are required to be reported annually. The bill also requires that DSH payments be made directly by the states to DSH hospitals and not be included in capitation rates to managed care entities.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999), which was included in the Consolidated Appropriations Act for FY2000 (P.L. 106-113) by reference, increased DSH payments for the following states for FY2000 through 2002; the District of Columbia, Minnesota, New Mexico, and Wyoming. That bill also clarified that Medicaid DSH payments are not to be matched at the enhanced federal matching rate used for the State Children's Health Insurance Program.

BIPA 2000[13] clarified that certain managed care enrollees are to be included when calculating the Medicaid inpatient utilization rates and the low-income utilization rates used for computing DSH payments. The bill also earmarks new DSH funds for certain public hospitals that are owned or operated by a state (or instrumentality or unit of government within a state) that are not receiving DSH payments in October of 2000 and that have a low-income utilization rate in excess of 65%. Those funds rise from $15 million in 2002 to $375 million for FY2006 and remain at that level for each year thereafter. It also added a requirement that the Secretary implement accountability standards to ensure that DSH payments are used in accordance with statutory requirements.

Finally, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003, P. L. 108-173), passed in December of 2003, establishes a 16% increase in DSH allotments to states for FY2004 and raises allotments for certain subsequent fiscal years. The increased amounts for 2002 only are not subject to the 12% ceiling on DSH allotments as a percentage of all medical assistance payments. Allotments for years after FY2004 will be equal to FY2004 amounts unless the Secretary of HHS determines that the allotments as would have been calculated under prior law are equal to or exceed the FY2004 amounts. For such fiscal years, allotments will be equal to allotments for the prior fiscal year increased by the percentage change in the CPI-U for the prior fiscal year. The law also changes the definition of a low DSH state to those states in which total DSH payments for FY2000 are less than 3% (rather than 1% as under prior law) of the state's total Medicaid spending on benefits. In addition, P.L. 108-173 increases the floor allotment amount for low DSH states for FY2004 through FY2008 by 16% each year (over the prior year amount). For FY2009 forward, as for all other states, the allotment for low DSH states for each year equals the prior year amount increased by

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[13] BIPA 2000 was incorporated by reference into H.R. 4577, The Consolidated Appropriations Act of 2001 (P.L. 106-554). H.R. 4577 was passed by the House and Senate on December 15, 2000 and was signed into law on December 21.

inflation. Finally, as a condition of receiving federal Medicaid payments for FY2004 and beyond, states are required to submit to the Secretary of HHS a detailed annual report and an independent certified audit on their DSH payments to hospitals.

Disproportionate Share Payments Today

To summarize the current law with respect to Medicaid DSH adjustments, states:

- must pay DSH adjustments to hospitals serving a disproportionate share of Medicaid patients and patients with special needs.
- must define which hospitals qualify as DSH hospitals and provide for an adjustment in the payment rate for those hospitals in the state's Medicaid plan.
- have flexibility in establishing the designation of DSH hospitals but must include in their definition *at least* all hospitals meeting minimum criteria: (a) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state; or (b) a low-income utilization rate of 25%. States may not include hospitals that do not have a Medicaid utilization rate of at least 1% as DSH hospitals.
- have flexibility in calculating DSH payment amounts to hospitals but must pay DSH hospitals at least: (a) an amount calculated using the Medicare DSH payment methodology, or (b) an amount calculated using a payment methodology that increases each hospital's adjustment as the hospital's Medicaid inpatient utilization rate exceeds the statewide average. DSH hospital payments cannot exceed the hospital-specific cap, set at 175% (for two years) of the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients for public hospitals, and at 100% of those costs for private hospitals.
- cannot make DSH payments in an amount that exceeds the state's DSH allotment.
- except for in 2004, cannot have total DSH payments that exceed 12% of total Medicaid benefits payments.

In 2002, according to preliminary state reports, DSH hospital adjustments totaled over $15.9 billion. The federal share of those payments was about $9.0 billion and represented 6.4% of total Medicaid payments for benefits, a significant drop from the 1992 high of about 15.3%.[14] Regular Medicaid payments for inpatient hospital services were about $31.2 billion[15]. The 2002 DSH hospital adjustments to inpatient hospitals totaled about 40% of regular Medicaid payments for inpatient hospital services. This percentage varied considerably among the states from less that 1% of regular hospital payments in a few states to several times more than

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[14] Prospective Payment Assessment Commission (PROPAC), p. 12.

[15] This figure does not include payments made to hospitals under managed care capitation payments.

regular hospital payments. There were five states in 2002 in which DSH payments to regular inpatient hospitals exceeded regular payments for inpatient hospital services as reported to CMS.

DSH payments are highly concentrated in a few states. Six states — New York, California, Texas, Louisiana, New Jersey, and Pennsylvania — accounted for over half of 2002 DSH payments. Fourteen states made three quarters of all 2002 DSH payments.

Table 4 shows FY2002 DSH allotments and payments as well as DSH payments as a percentage of total medical assistance payments in each state. DSH payments made in 2002 ranged from below than 1% of medical assistance in several states to almost 18% of medical assistance in Louisiana. Because states have up to two years to claim their DSH allotments, outlays for DSH payments can be a moving target. The numbers below reflect preliminary 2002 payments as posted on the CMS website at the time of publication.

Table 4. Disproportionate Share Payments and Payments as a Percentage of Total Medical Assistance, FY2002

(in millions of dollars)

State	DSH payments		DSH payments as a percentage of medical assistance[a]
	Total federal and state combined	Federal share	
Alabama	373.8	263.4	12.1%
Alaska	18.2	10.5	2.7%
Arizona	87.6	56.9	2.5%
Arkansas	14.5	10.6	0.6%
California	1349.5	694.4	5.0%
Colorado	161.7	80.9	7.0%
Connecticut	241.6	120.8	7.0%
Delaware	3.4	1.7	0.5%
District of Columbia	40.4	28.2	3.9%
Florida	392.0	221.2	4.0%
Georgia	433.2	255.6	6.9%
Hawaii[b]	—	—	—
Idaho	10.3	7.3	1.3%
Illinois	376.6	188.3	4.3%
Indiana	399.4	247.4	9.0%
Iowa	27.6	17.3	1.1%
Kansas	40.9	40.9	2.2%
Kentucky	197.4	138.0	5.2%
Louisiana	860.9	605.2	17.6%
Maine	51.4	34.2	3.6%
Maryland	136.9	68.5	3.8%
Massachusetts	623.2	311.6	7.7%
Michigan	405.2	228.3	5.4%
Minnesota	59.5	29.7	1.3%

State	DSH payments		DSH payments as a percentage of medical assistance[a]
	Total federal and state combined	Federal share	
Mississippi	189.4	144.1	6.6%
Missouri	536.7	327.7	10.0%
Montana	0.3	0.2	0.1%
Nebraska	11.0	6.6	0.8%
Nevada	76.4	38.2	9.4%
New Hampshire	181.5	90.7	17.9%
New Jersey	1215.5	607.8	15.7%
New Mexico	12.3	9.0	0.7%
New York	2,861.3	1,430.7	7.9%
North Carolina	460.1	282.8	6.8%
North Dakota	2.3	1.6	0.5%
Ohio	654.3	384.6	6.8%
Oklahoma	24.1	17.0	1.1%
Oregon	22.9	13.6	0.9%
Pennsylvania	779.2	425.1	6.4%
Rhode Island	88.2	46.3	6.5%
South Carolina	391.1	271.2	11.9%
South Dakota	1.1	0.7	0.2%
Tennessee[b]	—	—	—
Texas	1,423.1	856.8	10.5%
Utah	12.4	8.7	1.3%
Vermont	28.9	18.2	4.4%
Virginia	181.7	93.5	4.8%
Washington	357.9	180.3	6.9%
West Virginia	83.0	62.5	5.2%
Wisconsin	49.2	28.8	1.2%
Wyoming	0.1	0.1	0.1%
National Totals	15,949.2	8,991.4	6.5%

Source: CRS tabulations of data from CMS-64.

Notes: Payments may differ from allotments because allotments are the cap on a state's DSH obligations during the fiscal year. Payments are the outlays that occur during the year. Outlays in a fiscal period may be made for obligations made in different fiscal periods.

a. Excludes payments for administration.
b. Does not make DSH payments.

In 2002, only four states were considered "high" DSH states (states with DSH payments in excess of 12% of total Medicaid payments). This is down from the high in 1993 when 21 states were considered "high" DSH states. Since the 12% ceiling will not apply in 2004 only, the number of states exceeding that ceiling may rise for the year.

Designating Hospitals as Disproportionate Share and Calculating Adjustments

The Medicaid law provides a great deal of discretion to states in designating DSH hospitals and calculating DSH adjustments for designated hospitals. States must provide DSH adjustments to *at least* those hospitals meeting certain minimum criteria. The state may use another designation formula to define DSH hospitals; however, the definition must include the hospitals meeting the minimum criteria above. According to PROPAC, only 13 states used the minimum criteria in 1993. Most states use an expanded definition of DSH allowing additional hospitals to be designated as DSH. Because of the flexibility, there is a great amount of variation across the states in the number of hospitals that are designated as DSH. Some states designate only those hospitals that meet the minimum criteria while others designate all or almost all hospitals.[16]

Even more flexibility is available in terms of the payment methodology. The statute provides only the principles by which states should distribute the funds but does not address the amount of funds the states pay to individual DSH hospitals from their capped allotment. States must make minimum payments to DSH hospitals using either the Medicare methodology or a formula providing payments that increase as the hospital's Medicaid inpatient utilization rate increases over the state's average. If a state uses its own formula it may vary payments to different types of hospitals, as long as all hospitals of each type are treated equally and adjustments are reasonably related to the hospitals' Medicaid or low-income patient volume and the minimum payment requirement is met. Since OBRA 93, payments to individual hospitals are subject to a cap. The cap amount is equal to 100% of the cost of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients (hospital-specific cap) except for certain public hospitals in California which are capped at 175% of those costs. Beginning in FY2003, and extending for two state fiscal years, all public hospitals will be subject to the higher (175% of cost) ceiling. PROPAC found that, in 1993, no two states' payment methodologies were the same. Very few states relied on the Medicare DSH formula and those that did were the states distributing the fewest DSH dollars. Most states used a proportional payment formula but payments varied widely depending upon how low-income utilization rates were calculated and the level of funds available.[17]

Uses of Disproportionate Share Funds

A major reason for the perennial focus on DSH payments is that very little reporting information about the uses of DSH funds has, in the past, been required of states. Combined with the size of DSH payments, the inability to precisely say what the funds are used for leads to concern that the program is either unnecessary or abused. There has been some evidence, that, indeed, the program has in the past been abused and DSH payments may only tenuously be related to their original purpose.

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[16] PROPAC, p. 14.

[17] Ibid., p. 23.

Hospitals have reported receiving only a portion of reported DSH payments while an even smaller portion goes to hospitals that serve a disproportionate share of Medicaid and low-income beneficiaries relative to other hospitals.

In 1994, the Urban Institute conducted a survey of states on Medicaid DSH practices. They found that about half of the 1993 DSH payments were used to pay providers back for their contributions, about one-sixth of reported payments went to private and county providers and state hospitals, while one-third was kept by the states to "finance diverse expenditure, including general health and welfare expenditures."[18]

Several provisions in BBA-1997 are targeted at the issue of the proper use of DSH funds. A reporting requirement was added to the law. Under the new rule, states will have to report annually to the Secretary on the methods used to identify and pay DSH hospitals, including children's hospitals. The method used to identify DSH hospitals must have as its basis the proportion of low income and Medicaid patients served by such hospitals. In addition, the bill also included limitations on the amount of DSH payments that can be paid to individual mental hospitals or institutions of mental disease. The facility specific caps, described above, are also meant to ensure that more of the DSH funds are used to meet the intent of the law.

How Are Medicaid Disproportionate Share Adjustments Different from Medicare Disproportionate Share Adjustments?

Medicaid and Medicare DSH hospital adjustments are similar in that the major basis for designating hospitals to receive payments is the proportion of services provided to low-income patients. For Medicare designation, though, only hospitals meeting the Medicare criteria qualify for payments. A Medicare DSH hospital is one that has a "disproportionate patient" percentage that exceeds certain levels depending upon the type of hospital. A hospital's "disproportionate patient" percentage is defined as the hospital's total number of inpatient days attributable to federal SSI Medicare beneficiaries divided by the total number of Medicare patients days, plus the number of Medicaid patient days divided by the total patient days. For Medicaid designation, on the other hand, states are not limited to the federal minimum criteria. As long as at least those hospitals meeting the minimum criteria are classified as DSH, the state may establish a more liberal methodology of designating DSH hospitals.

Calculating payment adjustments for DSH hospitals can be different for Medicaid and Medicare DSH hospitals. Although states may use the Medicare payment methodology to calculate Medicaid DSH payments, most states do not and

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[18] Ku, L., and T. Coughlin. *Medicaid Disproportionate Share and Other Special Financing Programs: A Fiscal Dilemma for States and the Federal Government*. Urban Institute, 1994.

many of those that do use the Medicare methodology also use another methodology for different types of hospitals.

PROPAC found in 1994 that there is a "striking disparity between Medicare and Medicaid DSH expenditures, both in total amounts and as proportions of inpatient hospital spending." Then, Medicare DSH adjustments were $2.7 billion and only equal to just over 4% of Medicare hospital spending compared to Medicaid payments of well over 10 billion, equal to about one-third of Medicaid hospital payments.[19] More recently, this disparity is even more striking. Medicare DSH adjustments were estimated to be $6.8 billion in 2003, or 6.2% of Medicare hospital inpatient care.[20] Medicaid DSH payments were over $15.9 billion, or about 40% of the size of regular Medicaid payments to hospitals for general inpatient services[21]

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[19] PROPAC. Analysis of Medicaid Disproportionate Share Payment Adjustments. *Congressional Report C-94-01,* January 1, 1994. p. 26.

[20] CBO March 2004 Baseline for Medicare.

[21] Total Medicaid payments to inpatient hospitals were $31.2 billion (excluding mental hospitals) in 2002 based on preliminary CMS-64.