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Medicaid Disproportionate Share Payments

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July 30, 2007

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Medicaid Disproportionate Share Payments

Updated July 30, 2007

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Prepared for Members and Committees of Congress

Medicaid Disproportionate Share Payments

Summary

The Medicaid statute requires that states make disproportionate share (DSH) adjustments to the payment rates of hospitals treating large numbers of low-income and Medicaid patients. This provision is intended to recognize 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 law was successful. The rapid growth in DSH payments had been halted. In 2005, the most recent year for which data were available, total reported DSH payments were $17 billion.[1]

Today, a state's DSH payments cannot exceed an allotment amount, calculated based on a statutory formula, 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 an aggregate 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. Annual state reporting, however, is not yet being routinely collected by the Centers on Medicare and Medicaid Services (CMS).

Congress has intervened a number of times to change various features of the DSH allotments, sometimes to reduce payments below the levels provided for in the 1991 legislation and other times to provide additional allotment funds. Statutory changes are described in more detail below.

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[1] 2005 CMS 64 data - Net reports.

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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 FY2007, 11 states and all of the territories received the minimum of 50% federal matching on Medicaid payments. Mississippi had the highest FMAP in FY2007, 75.89%.[2] 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 FY2005.[3]

When Medicaid was enacted in 1965, it was targeted to 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 June of 2005, states reported covering a total of 42.5 million people in Medicaid, at a combined federal and state annual cost of almost $316 billion.[4] As

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[2] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2006 Through September 30, 2007," 70 *Federal Register* 71856, November 30, 2005.

[3] CRS tabulations of CMS-64 data.

[4] Enrollment figures from Ellis, E., Smith, V., Rousseau, D., Swartz, K., "Medicaid Enrollment in 50 States: June 2005 Data Update,"

(continued...)

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 spending growth through 1998 is echoed in spending for Medicaid disproportionate share (DSH) payments during the same periods. However, growth in Medicaid continues to sharply outpace general and medical inflation.

Table 1. Medicaid Outlays, FY1988-FY2005

($ 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%
2003	161.0	115.1	276.2	12.1%
2004	175.0	121.3	296.3	7.3%
2005	180.4	135.5	315.9	6.6%

Sources: Office of Management and Budget, 2000 Budget of the United States; Medicaid Statistics HCFA pub. N. 10129; for 2000-2005 from form CMS 64 state financial reporting.

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, Office of the Actuary. State outlays for 1997 to 2001 are equal to reported total spending minus reported federal spending.

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[4] (...continued)
[http://www.kff.org/medicaid/upload/7606.pdf]. Expenditure figures are CRS tabulations of CMS-64 data.

Disproportionate Share Payments

The disproportionate share hospital (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. Medicare utilized a reasonable cost system for paying for hospital services at that time. As a result, every state used a reasonable cost system to pay for Medicaid services. 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.

In the years between 1986 and 1991, however, DSH payments grew dramatically, prompting Congress to establish ceilings on each state's DSH payments, on the amounts that individual hospitals can receive, and to establish other rules regarding DSH payments.

Table 2. Total Federal and State Medicaid Disproportionate Share Payments and Percentage Change, 1990-2005

(by fiscal year, in billions of dollars)

Year	Total Medicaid DSH Payments	Percentage Change in DSH Payments
1990	$ 0.96	
1991	4.7	389%
1992	17.4	270%
1993	16.6	-4.6%
1994	16.9	1.8%
1995	19.0	12.4%
1996	15.1	-20.5%
1997	15.9	5.3%
1998	15.0	-5.6%
1999	15.5	3.3%
2000	15.6	3.2%
2001	15.9	1.6%
2002	15.9	0.0%

Year	Total Medicaid DSH Payments	Percentage Change in DSH Payments
1990	$ 0.96	
2003	14.3	-10.2%
2004	17.2	20.3%
2005	17.1	-0.5%

Sources: Payments estimated by Urban Institute for 1990-1992; data from CMS, 1993-2005. CRS tabulations of percentage growth.

Today, the federal share of DSH payments are limited to levels that are calculated based on a formula. The formula-based ceilings, referred to as "DSH allotments," are calculated by the Centers for Medicare and Medicaid Services (CMS) and promulgated in the *Federal Register*.

State Allotments

State DSH allotments are the maximum amount of federal matching payments that each state is permitted to claim for DSH payments. DSH allotments have both state and national limitations that are specified in Title XIX, Section 1923, of the Social Security Act. Total DSH payments across all 50 states may be no more than 12% of the total amount of Medicaid medical assistance spending during the fiscal year. As a result of this rule, CMS must publish preliminary DSH allotments before the start of the fiscal year that are based on estimated total Medicaid outlays. Only after the end of the fiscal year, when actual expenditure data are available, are final DSH allotments published.

State-by-state DSH allotments were specified in statute for 1998-2002. After that, each state's DSH allotment was calculated based on the prior year's amount and subjected to a set of rules defining minimum and maximum amounts. All of these rules have been modified a number of times in subsequent legislation. Current laws and allotment amounts are discussed in this section. For a more complete information on legislative activity related to DSH, see section below entitled "Legislative History."

Each state's allotment can be no more than the greater of the prior year's amount or 12% of total medical assistance payments for the prior year. This ensures that states with DSH allotments above 12% of total medical assistance spending (referred to as "high DSH" states) receive allotments that do not grow until the DSH allotments are below 12% of medical assistance spending in each state. This rule is a vestige of the original DSH allotments established in 1991, which were set based on historical DSH spending. The states that had been paying the largest DSH payments relative to other Medicaid payments received higher allotments, but those amounts did not increase over time. States making the smallest historical payments received allotments that were to increase each year until they reached the 12% cap.

In general, to arrive at each state's DSH allotment for the years after 2002, the prior year's amount is multiplied by an inflation factor, which is estimated using the

growth of the consumer price index for all urban consumers (CPI-U) for the previous year. Special rules, however, have been enacted affecting the rates of growth applicable for different states and for different years. Special allotments for 2004 and rates of growth for calculating DSH allotments for all states for the years immediately subsequent to 2004 were enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). For years after 2004,

- if a state would have had a lower allotment by using the pre-MMA 2004 amounts, then their allotment for that year will be equal to the 2004 MMA amount, otherwise,

- the allotment is equal to the prior year's amount increased by the CPI-U.

States with low DSH allotments are subject to special rules for FY2003 through 2008. Those states with DSH spending below 3% of medical assistance payments in FY2000 receive an allotment for each of years 2003 through 2008 equal to 16% more than the prior year's amount. After FY2008, allotments will increase based on the inflation rate of the CPI-U as for all other states.

Certain states have special statutory arrangements relating to their state allotments. The District of Columbia was allotted additional funds for FY2000-FY2002, raising its base for calculating subsequent DSH allotments. Other states with such adjustments in their DSH allotments for FY2000-FY2002 have included Minnesota, New Mexico, and Wyoming.

CMS calculates annual allotments and publishes them in periodic notices in the *Federal Register*. The last publication of DSH allotments was in *Federal Register*, V. 71, on October 3, 2006 (p. 58400.) This notice included final allotments for FY2004 and FY2005 and preliminary amounts for FY2006 and FY2007. The federal share of DSH allotments under current law are reflected in **Table 3**. (DSH allotments are different from DSH payments in that allotments reflect the maximum amount of federal share that are available for DSH payments. Actual DSH payments in any year are higher than the allotments because payments should include both a federal and state share.)[5]

Table 3. DSH Allotments for 2005, and Preliminary Allotments for 2006 and 2007

(in millions of dollars, rounded to the nearest tenth)

State or District	2005	2006	2007
Alabama	289.6	289.6	289.6
Alaska	12.3	14.3	16.5
Arizona	95.4	85.4	95.4

[5] Other differences between federal share of payments in a year and federal allotments for the year could be related to states making payments related to claims for an earlier year.

State or District	2005	2006	2007
Arkansas	26.0	30.2	35.0
California	1,032.6	1,032.6	1,032.6
Colorado	87.1	87.1	87.1
Connecticut	188.4	188.4	188.4
Delaware	5.5	6.3	7.4
District of Columbia	37.7	57.7	57.7
Florida	188.4	188.4	188.4
Georgia	253.1	253.1	253.1
Hawaii[a]	0.0	0.0	0.0
Idaho	9.9	11.5	13.3
Illinois	202.5	202.5	202.5
Indiana	201.3	201.3	201.3
Iowa	23.8	27.6	32.0
Kansas	38.9	38.9	38.9
Kentucky	136.6	136.6	136.6
Louisiana	732.0	732.0	732.0
Maine	98.9	98.9	98.9
Maryland	71.8	71.8	71.8
Massachusetts	287.3	287.3	287.3
Michigan	249.6	249.6	249.6
Minnesota	45.1	52.3	60.6
Mississippi	143.6	143.6	143.6
Missouri	446.2	446.2	446.2
Montana	6.8	7.9	9.2
Nebraska	17.1	19.8	23.0
Nevada	43.6	43.6	43.4
New Hampshire	150.8	150.8	150.8
New Jersey	606.4	606.4	606.4
New Mexico	12.3	14.3	16.5
New York	1,513.0	1,513.0	1,513.0
North Carolina	277.9	277.9	277.9
North Dakota	5.8	6.7	7.8
Ohio	382.7	382.7	382.7
Oklahoma	21.9	25.3	29.4
Oregon	27.3	31.7	36.8
Pennsylvania	528.7	528.7	528.7
Rhode Island	61.2	61.2	61.2

State or District	2005	2006	2007
South Carolina	308.5	308.5	308.5
South Dakota	6.7	7.7	9.0
Tennessee[a]	0.0	0.0	0.0
Texas	900.7	900.7	900.7
Utah	11.8	13.7	15.9
Vermont	21.2	21.2	21.2
Virginia	82.5	82.5	82.5
Washington	174.3	174.3	174.3
West Virginia	63.6	63.6	63.6
Wisconsin	57.0	66.2	76.8
Wyoming	0.1	0.2	0.2
Total (in billions of dollars)	10,185.2	10,185.2	10,305.3

Source: Department of Health and Human Services, "Medicaid Program: Fiscal Year Disproportionate Share Hospital Allotments and Disproportionate Share Hospital Institutions for Mental Disease Limits," 71 *Federal Register* 58395, October 3, 2006.

a. Allotment amounts for Tennessee and Hawaii do not reflect funds authorized for those states as part of the Tax Relief and Health Care Act of 2006 (P.L. 109-432). See Legislative History section below for a description of those special arrangements for Tennessee and Hawaii.

The BBA 1997 imposed separate limits on DSH payments to institutions for mental disease (IMD) and other mental health facilities. The limits are aggregated on a state-by-state basis and, when summed together with all other DSH payments to hospitals within the state, the totals are required to be below the allotments in **Table 3** above. Under the limits, known as the IMD DSH limits, DSH payments to such facilities and are tied to the amounts paid to such facilities in 1995. A state's aggregate limit on DSH payments to IMDs is set at the lesser of 33% of the states' total computable DSH allotment for the year or the state's 1995 total IMD and other mental health facility DSH expenditures attributable to the state's FFY 1995 DSH allotment. As with the DSH allotments, the IMD DSH limits are published in periodic *Federal Register* notices.

Identifying and Defining DSH Hospitals

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. Most states expand on the minimum criteria to allow additional hospitals to be designated as DSH. Because of the flexibility, there is a great amount of variation across the states in the number and types of hospitals that are designated as DSH.

At a minimum, states must include all hospitals with (1) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state

or (2) a low-income utilization rate of 25%.[6] To be included as a DSH hospital, the hospital must retain at least two obstetricians with staff privileges willing to serve Medicaid patients.[7] A hospital cannot be identified as a DSH hospital if its Medicaid utilization rate is below 1%.[8]

Minimum and Maximum DSH Payments to Hospitals. Even more flexibility is available in terms of the formulas and methods states use to distribute DSH funds among hospitals. The statute provides only the principles by which states should distribute the funds and sets minimum and maximum payment amounts, 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, DSH payments to individual hospitals are subject to a cap. These "hospital-specific" limits, in general, prohibit hospitals from receiving DSH payments that exceed the unreimbursed costs incurred of furnishing hospitals services to individuals who are eligible for Medicaid and those who have no health insurance for services providing during the period. The hospital-specific cap was phased-in for certain public hospitals and became effective for private hospitals in 1995. This cap, when fully phased in, may have been the force behind the large drop in total DSH payments in FY1996. There are, however, exceptions to this rule. The hospital specific cap for certain public hospitals in California is equal to 175% of those unreimbursed costs. For two state fiscal years beginning in 2003, all public hospitals were subject to a hospital-specific cap of 175%. After those two years, the ceiling reverted back to 100%.

Disproportionate Share Payments Today

Current law with respect to Medicaid DSH adjustments can be summarized as follows:

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[6] 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.

[7] There are exceptions to this rule for children's hospitals, hospitals that do not offer non-emergency obstetric services, and certain rural hospitals.

[8] 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.

- States must pay DSH adjustments to hospitals serving a disproportionate share of Medicaid patients and patients with special needs.

- States 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.

- States 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 with a Medicaid utilization rate that is below 1%.

- States have flexibility in calculating DSH payment amounts to hospitals but must pay DSH hospitals at least (1) an amount calculated using the Medicare DSH payment methodology, or (2) 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 100% 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 (for all states except California, which is at 175% of those amounts).

- States cannot obtain federal matching payments for DSH that exceed the state's DSH allotment.

- DSH payments, when aggregated across all states, cannot exceed 12% of total Medicaid benefits payments.

In 2005, according to preliminary state reports, DSH hospital adjustments totaled more than $17 billion. The federal share of those payments was about $9.6 billion and represented 5.6% of total Medicaid payments for benefits, a significant drop from the 1992 high of about 15.3%.[9] Regular Medicaid payments for inpatient hospital services were about $42 billion[10]. The 2005 DSH hospital adjustments to inpatient hospitals totaled about 41% of regular Medicaid payments for inpatient hospital services. This percentage varied considerably among the states, from zero DSH payments to inpatient general hospitals to several times more than regular hospital payments. There were two states in 2005 in which DSH payments to regular inpatient hospitals exceeded regular payments for inpatient hospital services as reported to CMS.

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

[10] This figure does not include payments made to hospitals under managed care arrangements where monthly capitation payments are made to the managed care organization for a set of services including inpatient hospital services.

DSH payments are highly concentrated in a few states. Five states (New York, California, Texas, Louisiana, and New Jersey) accounted for more than half of 2005 DSH payments. Twelve states made over three quarters of all 2005 DSH payments.

Table 4 shows FY2005 DSH payments and DSH payments as a percentage of total medical assistance payments in each state. DSH payments made in 2005 ranged from below than 1% of medical assistance in several states to almost 22% of medical assistance in New Hampshire. 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 2005 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, FY2005

(in millions of dollars)

State	DSH payments		DSH payments as a percentage of medical assistance[a]
	Total federal and state combined	Federal share	
Alaska	19.5	11.3	2.0%
Alabama	408.9	289.6	10.7%
Arkansas	37.5	28.0	1.3%
Arizona	141.4	95.4	2.5%
California	2,514.1	1,257.0	7.5%
Colorado	172.7	86.3	6.2%
Connecticut	274.0	137.0	6.8%
District of Columbia	51.9	36.2	4.1%
Delaware	3.6	1.8	0.4%
Florida	333.5	196.4	2.5%
Georgia	412.3	249.2	5.6%
Hawaii[b]	0.0	0.0	0.0%
Iowa	32.1	20.5	1.3%
Idaho	14.0	9.9	1.4%
Illinois	349.3	174.6	3.2%
Indiana	277.8	174.6	5.3%
Kansas	63.7	38.9	3.2%
Kentucky	196.2	136.6	4.6%
Louisiana	1,031.0	732.5	19.4%
Massachusetts	699.3	349.6	7.3%
Maryland	92.6	46.3	1.8%
Maine	64.0	41.3	2.9%
Michigan	427.9	242.7	4.9%

State	DSH payments		DSH payments as a percentage of medical assistance[a]
	Total federal and state combined	Federal share	
Minnesota	57.3	28.6	1.0%
Missouri	691.7	423.1	10.6%
Mississippi	183.0	141.0	5.5%
Montana	9.3	6.7	1.3%
North Carolina	424.0	269.8	4.8%
North Dakota	1.8	1.2	0.4%
Nebraska	19.2	11.4	1.4%
New Hampshire	273.0	136.5	21.9%
New Jersey	1,025.9	512.9	13.7%
New Mexico	15.9	11.8	0.7%
Nevada	78.4	43.8	6.6%
New York	3,001.3	1,500.6	7.0%
Ohio	93.5	55.4	0.8%
Oklahoma	31.1	21.9	1.1%
Oregon	39.5	24.1	1.4%
Pennsylvania	814.8	439.4	5.2%
Rhode Island	110.5	61.2	6.6%
South Carolina	441.4	308.5	10.8%
South Dakota	0.8	0.5	0.1%
Tennessee[b]	0.0	0.0	0.0%
Texas	1,494.1	908.4	8.7%
Utah	16.4	11.8	1.2%
Virginia	141.2	70.6	3.2%
Vermont	35.2	21.2	4.1%
Washington	347.5	173.8	6.1%
Wisconsin	42.8	25.0	0.9%
West Virginia	82.3	61.4	3.8%
Wyoming	0.0	0.0	0.0%
National Totals	17,089.2	9,626.5	100.0%

Source: CRS tabulations of data from CMS-64.

Notes: Payments differ from allotments because allotments are the cap on the federal share of 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. Did not make DSH payments in 2005.

In 2005, only three 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.

Legislative History

The history of congressional action on DSH payments remains relevant today because DSH amendments are included in almost all major health bills. Ceilings and special rules are routinely moved about or debated. Further, the financing arrangements that Congress has repeatedly tried to address with DSH amendments continues to vex the administration and Congress, as evidenced by recent regulations limiting certain financing arrangements[11]. This section describes why and how DSH law was changed and shaped over time.

The requirement to make DSH payments was originally established in 1981, but by the late eighties, Members of Congress became aware that many states were not making those payments. Several congressional actions followed, including a 1986 provision aimed at supporting state flexibility to make DSH payments and 1987 provisions requiring states to submit a Medicaid plan amendment describing their DSH policies and establishing certain minimum standards and payments.[12]

Omnibus Budget Reconciliation Act of 1986 (OBRA 86, P.L. 99-509)

OBRA 86 included a provision clarifying that the Health Care Financing Administration (now CMS) had no authority to limit payments adjustments to DSH hospitals.

Omnibus Budget Reconciliation Act of 1987 (OBRA 87, P.L. 100-203)

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. 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

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[11] See CRS Congressional Distribution Memorandum "Proposed Medicaid Regulation to Establish a Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership," by J. Hearne, dated February 7, 2007.

[12] 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.

(1) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state, or (2) a low-income utilization rate of 25% be included. 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[13] or a formula providing payments that increase as 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.[14] 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.[15] 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. In addition, the recession shrank 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 factors combined led to an enrollment increase of more than 24%, or 6 million new people, on the Medicaid rolls between 1990 and 1992 and incited states to identify funding mechanisms to increase the flow of federal funds into their states.

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[13] 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 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.

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

[15] 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.

Three funding techniques began to spread among the states to leverage additional 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, often paying back the very providers who gave the state the money in the first place. The Medicaid spending at that time was usually claimed as DSH payments, and would be matched with federal Medicaid matching funds. All or part of the additional federal money generated through these mechanisms would be returned to the states.

At the time, few were aware of the potential for misuse and for escalating federal Medicaid spending except for the Health Care Financing Administration (HCFA, now CMS). In 1988, HCFA indicated that it planned to issue regulations limiting the use of donations as the state's share of Medicaid. The agency also provided instructions to state Medicaid programs that attempted to distinguish between taxes of "general applicability" that would be allowable as a state share of Medicaid and provider-specific taxes, for which federal matching Medicaid payments would not be allowable.

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA, P.L. 100-647)

Before HCFA could issue final regulations defining its position, Congress intervened. TAMRA 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, P.L 101-239) through the end of 1990, and then later the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) 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.[16]

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."[17] The Inspector General asserted that the

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[16] OBRA 90 included two provisions addressing provider specific taxes that were interpreted 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.

[17] 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.

(continued...)

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 use of provider-specific 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.[18]

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234)

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%.

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 prohibited 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.

Despite the remaining intergovernmental transfer loophole, the upper caps on DSH payments had a significant impact on total DSH spending — the rapid climb

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[17] (...continued)
(Hereafter cited as Inspector General memorandum)

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

in DSH payments had been stopped.[19] Concerns then turned to the distribution of those payments among hospitals. 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.

Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66)

In response to these concerns, Congress included in OBRA 1993 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%.[20] 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. The hospital-specific DSH cap was phased-in for certain public hospitals and later became effective for private hospitals.

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.

Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)

Provisions were included in BBA 97 to reduce DSH spending and to address other issues affecting DSH. The formula-based DSH allotments set into law in 1991 were replaced with *fixed* 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).

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[19] More recently, however, intergovernmental transfers have increasingly been used to raise the federal share of Medicaid. Instead of claiming DSH payments with the intergovernmental funds, states have claimed inflated hospital charges for certain public hospitals. See CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia J. Herz.

[20] 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.

BBA 97 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 were limited to the lesser of 33% of the states' total computable DSH allotment for the year or the state's 1995 total IMD and other mental health facility DSH expenditures attributable to the state's FFY 1995 DSH allotment.

Finally, BBA 97 required that states report annually on the method used to target DSH funds and to describe the payments made to each hospital. States were required 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 were required to be reported annually. The bill also clarified that DSH payments be made directly by the states to DSH hospitals and not be included in capitation rates to managed care entities. Finally, BBA 97 established a provision temporarily allowing hospitals in the state of California a hospital-specific ceiling equal to 175% of the costs incurred of furnishing hospitals services to individuals who either are eligible for Medicaid or who have no health insurance.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999)

BBRA 1999 was included in the Consolidated Appropriations Act for FY2000 (P.L. 106-113) by reference. It increased DSH payments for the District of Columbia, Minnesota, New Mexico, and Wyoming for FY2000 through 2002. It 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. BBRA also permanently extended the increased hospital-specific cap for hospitals in the state of California.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

BIPA was incorporated into the Consolidated Appropriations Act of 2001 (P.L. 106-554) by reference. BIPA raised state allotments for 2001 and 2002. For 2003, the allotments returned to the BBA 2002 amounts increased by percentage growth of the CPI-U. Thereafter, allotments were to increase annually by the percentage growth of the CPI-U. The result of reverting to the BBA policy for 2003 was a significant reduction in DSH allotments for most states for that year. (This drop in allotments was referred to as the "DSH dip.")

BIPA established that for extremely low DSH states — defined as states whose FY1999 total DSH payments are greater than zero but less than 1% of the states' total medical assistance spending — DSH allotments for 2001 were equal to 1% of the state's total medical assistance during that fiscal year. For subsequent years, allotments are equal to their allotment for the previous year, increased by the change in the CPI-U for the previous year, and subject to the 12% of medical assistance payments ceiling.

BIPA 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 earmarked 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, BIPA 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 started after September 30, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)

MMA addressed the "DSH dip" — or the dropping allotments for many states for 2003. It did so by exempting 2002 DSH allotment amounts from the 12% of medical assistance spending ceiling, and establishing a 16% increase in DSH allotments for states for FY2004 and raising allotments for certain subsequent fiscal years. Allotments for years after FY2004 were set to be equal to FY2004 amounts unless the Secretary of HHS determines that the allotments as would have been calculated under law prior to MMA are equal to or exceed the FY2004 amounts under MMA. 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.

MMA discontinued the special arrangement for extremely low DSH states and instead raised DSH allotments for low DSH states — defined as those states in which total DSH payments for FY2000 are less than 3% of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 to an amount that is 16% above the prior year's amount. For FY2009 forward, the allotment for low DSH states for each year will be equal to the prior year amount increased by the change in the CPI-U, as for all other states. 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.

The Deficit Reduction Act of 2005 (DRA, P.L. 109-171)

DRA raised DSH allotments for the District of Columbia for FY2000, 2001, and 2002 from $32 million to $49 million. The higher allotments would be used to calculate DSH allotments beginning with FY2005 amounts. The provision would take effect as if enacted on October 1, 2005, and would apply to expenditures made on or after that date.

Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432)

Established an allotment for FY2007 for Tennessee equal to the greater of the amount that the Secretary determines is equal to its federal matching for DSH hospital payment for the demonstration year ending in 2006 or $280 million. The provision, however, only allows for DSH payments of 30% of that amount. In addition, the provision would allow Tennessee to submit a state plan amendment describing its DSH methodologies. The Secretary is instructed to consider DSH payments under this provision as expenditures under the state's TennCare Demonstration project when determining budget neutrality of the project. In addition, TRHCA, established a DSH allotment for Hawaii of $10 million.

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 despite reporting provisions in the law since 1997. 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 DSH payments may be only tenuously related to their original purpose. 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 expenditures, including general health and welfare expenditures."[21]

Based on state reporting collected by CMS for only a few years and from only a portion of the states, Mark Merlis reported that states vary widely in the degree to which they have targeted payments to public hospitals and mental hospitals. For FY1998-FY2002, some states paid nearly all DSH payments to private general hospitals. For others, however, nearly all payments went to public mental hospitals. In addition, some states distributed funds among a large number of hospitals, whereas others make DSH payments to only a handful of facilities.[22]

Reporting requirements originally established in BBA 97 were extended by MMA. A proposed rule was promulgated in August of 2005 (70 *Federal Register*

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[21] 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.

[22] See CRS Report RL32644, *Medicaid Reimbursement Policy*, by Mark Merlis

50262) to implement the reporting and auditing requirements for DSH payments under the MMA provisions. As of the date of this publication, the rule has not been finalized and detailed state reporting is still not being required for DSH payments.

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 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 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.[23] More recently, this disparity is even more striking. Medicare DSH adjustments were estimated to be $9.5 billion in 2006, or 6.9% of Medicare hospital inpatient care.[24] 2005 Medicaid DSH payments were over $17.1 billion, or more than 40% of the size of regular Medicaid payments to hospitals for general inpatient services.[25]

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

[24] CBO Fact Sheet, March 2007 Baseline: Medicare.

[25] Total Medicaid payments to inpatient hospitals were $42.0 billion (excluding mental hospitals) in 2005 based on CMS-64 state financial reports.