THE DEPENDENCE OF SAFETY NET HOSPITALS AND HEALTH SYSTEMS ON THE MEDICARE AND MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT PROGRAMS

Lynne Fagnani and Jennifer Tolbert
National Association of Public Hospitals & Health Systems

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CONTENTS

LIST OF FIGURES AND TABLES

EXECUTIVE SUMMARY

In 1996, an estimated 43 million people, or nearly a fifth of the U.S. population under age 65, had no medical insurance; another 29 million were underinsured. Worse, these numbers are expected to rise in the next ten years. To ensure access to care for these people, our nation relies on a network of hospitals and health centers—so-called "safety net hospitals"— whose members are willing to provide care to anyone in need, regardless of their ability to pay. These providers receive subsidies to compensate them for the unreimbursed care they supply. The major sources of such financing are the Medicare and Medicaid Disproportionate Share Hospital (DSH) programs, along with appropriations from state and local governments. This paper chronicles the history of the former, examines the role they have played in financing safety net hospitals, and recommends necessary reforms.

Both the Medicare and Medicaid DSH programs were created in the early 1980s to compensate hospitals for additional costs associated with caring for low-income patients. The Medicare DSH program has generated relatively little controversy over the years. The legislative history of the Medicaid DSH program, however, is one of tremendous state discretion, abuse of that discretion by some states that used the program in ways Congress never intended, and federal efforts to curb state abuses. This history belies the tremendously important role that the Medicaid DSH program plays in financing healthcare for low-income populations—particularly care to the uninsured and underinsured—and the important role it has played in many states in the survival of the safety net itself.

The Role of DSH in Financing Care for the Uninsured and Underinsured

Hospitals provide healthcare to the poor and uninsured in the form of uncompensated care, defined as the sum of charity care and bad debt charges. Uncompensated care has always been unevenly distributed—urban safety net hospitals have had to assume a disproportionate burden of care for the under- and uninsured. Such hospitals serve predominantly low-income communities; they have substantial caseloads of Medicaid and uninsured patients—and correspondingly small caseloads of privately insured patients on whom to cost-shift; and they are often heavily involved in providing outpatient and specialized community services such as trauma care and medical education. This paper uses data from a 1996 survey of members of the National Association of Public Hospitals & Health Systems (NAPH) to examine the role of DSH in the finances of urban safety net providers. Findings from that data include the following:

- Costs for uncompensated care at a sample of urban, safety net hospitals totaled $4 billion and represented 26 percent of total costs in 1996. These costs were financed through state and local government subsidies (59 percent), Medicaid DSH payments

(29 percent), Medicare DSH payments (9 percent) and cost-shifting from privately insured patients (3 percent).

- Analyses of the revenue-to-cost ratios by payer demonstrate the increasing reliance of these hospitals on Medicare and Medicaid DSH payments to offset the losses on uncompensated care. Before full implementation of Medicaid DSH, these hospitals experienced losses on Medicaid payments; since then they have realized positive Medicaid margins.

- The role of these programs in supporting safety net hospital finances becomes more evident when these same analyses are conducted with both Medicare and Medicaid DSH payments removed from hospital revenue streams. In 1996, without DSH payments, these hospitals would have experienced an alarming negative 7 percent margin on total operations.

- Anticipated cuts in these programs as a result of the Balanced Budget Act of 1997 (BBA) will jeopardize the safety net mission of these hospitals. The DSH cuts will reduce by half the surpluses derived from Medicare and Medicaid payments (without accounting for the impact of any other BBA reductions). Coupled with declining local government appropriations and market forces that include managed care and an eroding Medicaid patient base, these cuts will severely undermine the ability of these hospitals to remain financially viable.

Reform in the Medicare and Medicaid DSH Programs

As the institutional subsidies for uncompensated care are reduced, it is more important than ever to target DSH payments at those hospitals that are truly shouldering the burden of low-income and uncompensated care. Reforms in Medicare and Medicaid DSH programs would correct some deficiencies in the way they function and make them better suited to the needs of the current health marketplace. These reforms include:

1. Medicare and Medicaid DSH qualifying and distribution formulae must reflect current healthcare market realities.

- Medicare and Medicaid DSH qualifying and payment formulae should reflect outpatient as well as inpatient care. Both these programs are inpatient-oriented—qualifying formulae are based on inpatient utilization and payment distributions are made as add-ons to payments for inpatient care. As medical care becomes increasingly outpatient-based, both programs should explicitly acknowledge outpatient low-income care as part of their qualifying formulae and distribution methodologies.

- Medicare DSH qualifying formula should include all costs for low-income care. The fundamental problem with the Medicare DSH program lies in the underlying measure of low-income care in the qualifying formula. It relies on Medicare SSI and Medicaid utilization to approximate the amount of low-income care hospitals provide. For several reasons, including increasing competition for Medicaid patients, managed care, and the very nature of the Medicaid program, Medicaid utilization does not represent an accurate measure of a hospital's commitment to low-income care. In addition, the way Medicare SSI utilization is calculated overstates the true proportion of SSI patients and the true costs of those patients. The most significant problem with the formula, however, is that in relying solely on measures of Medicare SSI and Medicaid populations to arrive at a low-income proxy, it fails to account for uncompensated care—the primary source of hospitals' low-income care. A measure of uncompensated care should be included in the qualifying formula.

2. Medicare and Medicaid DSH payments should be made directly to hospitals.

- Medicare DSH payments should be carved out from the Average Adjusted Per Capita Cost (AAPCC) payments to managed care plans. Currently, DSH payments are not carved out of the AAPCC, which means that these payments are made to managed-care plans that do not provide low-income or uncompensated care, rather than to the hospitals that do. Since the Medicare DSH program was intended to reimburse hospitals, not managed-care plans, for the low-income care they provide, these payments should go directly to hospitals. In the BBA, Congress opted to correct this problem with respect to payments for graduate medical education. It needs to do the same for DSH payments.

- The provision in the Balanced Budget Act of 1997 that requires Medicaid DSH payments be made directly to hospitals should be clarified. The Balanced Budget Act of 1997 required that DSH payments should be paid directly to hospitals, not folded into capitated amounts paid to risk plans. The Health Care Financing Administration (HCFA) needs to clarify and give guidance on the interpretation of this provision.

3. States need to be held accountable for how Medicaid DSH dollars are spent.

- HCFA should expand state data reporting requirements. Perhaps the biggest single barrier to reforming the Medicaid DSH program has been the lack of accountability for how the funds are spent. The need for good data collection on the

national level is imperative. Provisions in the Balanced Budget Act of 1997 require states to submit to HCFA data on how much they pay disproportionate share hospitals. HCFA should use this authority to require more detailed and specific data on DSH expenditures.

- A rational approach to the distribution of Medicaid DSH payments should be developed. The allocation of Medicaid DSH funds bears little relationship to any measure of need. A more rational approach to distributing Medicaid DSH payments should be developed. However, any reallocation should occur only in the context of a total reform of all sources of financing for the uninsured because it would redistribute funds significantly among states. States that make a greater commitment to DSH spending and states that may have used the program less appropriately would be penalized equally.

I. INTRODUCTION

Our nation's healthcare payment system is sustained by health insurance coverage for those who can get it, and by the provision of subsidies to hospitals and health centers that care for those who cannot. In 1996, the number of uninsured was estimated at 43 million, or nearly a fifth of the U.S. population under 65. Another 29 million were underinsured.[1] Both the uninsured and the underinsured have access to healthcare from a committed core group that includes public hospitals, some private nonprofit hospitals, community health centers, and some private physicians.

Care that hospitals provide to the uninsured is called "uncompensated care." This is frequently defined as the sum of charity care and bad debt charges, even though it includes some costs for patients who could afford to pay but choose not to do so. Uncompensated care currently accounts for an average 6.1 percent of annual hospital costs nationally[2], but many "safety net hospitals,"—those whose stated mission is to provide care to anyone in need regardless of their ability to pay—incur uncompensated care costs in excess of 26 percent of total costs.[3] These hospitals rely on local, state, and federal subsidies to obtain financing sufficient to enable them to continue to fulfill their missions.

Aside from local tax appropriations for indigent care, the Medicare and Medicaid disproportionate share hospital (DSH) programs are the most important sources of financial subsidies for providers willing to care for the uninsured, the underinsured and other low-income populations. This paper describes the Medicare and Medicaid DSH programs in detail, defining the role that these programs have played in supporting such hospitals. The paper also describes the legislative history of each program, its importance in financing the healthcare safety net, and reforms needed in both programs.

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[1] Issue Brief on "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey" (Employee Benefit Research Institute, December 1997) for the number of uninsured; and Pamela Farley Short and Jessica S. Banthin, "New Estimates of the Underinsured Younger Than 65 Years," *JAMA* 274 (23/30 March 1994):950, for the number of underinsured.

[2] American Hospital Association, *Uncompensated Care Hospital Cost Fact Sheet* (March 1998), 3.

[3] The National Association of Public Hospitals & Health Systems Hospital Characteristics Survey Data, 1996.

II. THE HISTORY AND STRUCTURE OF THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL PROGRAM

The Medicare DSH adjustment was conceived during the early 1980s when Congress began making major alterations to the Medicare reimbursement system. In 1982, Congress adopted per diem cost limits on Medicare payments for inpatient services. There was hope that these limits would put a brake on overall Medicare spending; at the same time, there was concern that such payment limits might have a negative effect on hospitals that treated large numbers of the poor. At the time, hospital advocates argued that low-income patients were more costly to treat, and therefore, hospitals with large numbers of low-income patients would experience higher-than-average costs.[4] To protect these hospitals, Congress included a provision in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) that required the federal government to take into account the additional costs associated with treating large numbers of low-income patients. Specifically, the legislation required the Secretary of the Department of Health and Human Services to establish exemptions to the per diem cost limits for "public or other hospitals that serve a significantly disproportionate number of patients who have low income or who are entitled to inpatient benefits under Part A."[5]

Implementation of the law fell to the Health Care Financing Administration (HCFA), which failed to take action. After the passage of the Medicare Prospective Payment System (PPS) in 1983, Congress again mandated that HCFA issue implementing regulations for the DSH program. Once again, HCFA refused to act. Frustrated by HCFA's inaction, Congress chose to legislate the program, establishing criteria for designating DSH hospitals and creating a DSH payment system, in the 1986 Comprehensive Omnibus Budget Reconciliation Act (COBRA).

The 1986 legislation established national DSH qualifying criteria that rely on the "disproportionate share patient percentage" as a proxy for the actual amount of care hospitals provide to low-income patients. This percentage is the sum of two ratios: (a) days attributable to Medicare SSI patients over total Medicare days, and (b) days attributable to Medicaid patients not also eligible for Medicare over total days. The percentage threshold needed to qualify for DSH payments varies depending on the type of hospital, ranging from a low of 15 percent to a high of 40 percent. Alternatively, a hospital can qualify if it is an urban hospital with 100 or more beds and receives 30 percent or more of its net inpatient revenues from state and local government. (These are commonly referred to as "Pickle hospitals," a reference to the late Rep. J. J. Pickle of Florida who was responsible for inclusion of this additional criterion). In either case, the respective criteria are applied uniformly to all U.S. hospitals, thus eliminating regional or state differences in the designation of DSH hospitals *(see table 1).*

[4] Although research conducted in the early 1980s supported the presumption that low-income patients were costlier to treat, findings from more recent research in this area have been less conclusive.

[5] Public Law 97-248, Sec. 101

Table 1
Medicare DSH Qualifying Criteria and Payment Adjustment Formulas

Type of Hospital	Qualifying Disproportionate Patient Percentage (P)*	Formula or Fixed Percentage Adjustment**
Urban, 100 or more beds	15%–20.1%	(P-15)(.6)+2.5
Urban, 100 or more beds	20.2%, or greater	(P-20.2)9.7)+5.62
Urban, 100 or more beds	30% of inpatient revenues from state or local indigent care funds	35%
Urban, less than 100 beds	40%	5%
Rural, 500 or more beds	Not specified in law; regulations set threshold at 15%	(P-15)(.6)+2.5
Rural, 100 or more beds	30%	4%
Rural, less than 100 beds	45%	4%
Rural, sole community hospital	30%	10%
Rural, rural referral center, and:		
Not a sole community hospital, 100 or more beds	30%	(P-30)(.6)+4.0
Not a sole community hospital, less than 100 beds	45%	(P-30)(.6)+4.0
Also a sole community hospital	30%	Greater of 10% or (P-30)(.6)+4.0

* P equals the sum of the following ratios: Medicare SSI patient days divided by total Medicare days plus total Medicaid patient days divided total patient days.
** The percentage adjustment is the percentage add-on to the Medicare DRG payment.
Source: Congressional Research Service.

Much of the current qualifying formula's complexity stems from inadequacies in its structure. For several reasons, Medicaid should not be used in isolation to estimate overall low-income care. First, because Medicaid is essentially 51 different programs, hospitals in states with relatively generous Medicaid programs are likely to receive higher DSH payments than those in states with less generous programs. Second, increasing competition for Medicaid patients, particularly children and low-risk pregnant women, means that traditional providers of care to this population are losing their market shares to hospitals that otherwise provide little low-income care. Third, the enrollment of Medicaid recipients in managed-care plans has made it difficult for hospitals to identify these people as Medicaid patients, thus reducing potential DSH payments. Yet another problem with the formula is that the way Medicare SSI utilization is calculated overstates the true proportion of SSI patients and the true costs of those patients.

The DSH payments are made as add-ons to the Medicare DRG rates, so they are tied to both the DSH patient percentage and Medicare inpatient volume. Therefore, these payments do not acknowledge the increasing amount of outpatient care provided to Medicare patients. As with the qualifying threshold, there are ten different payment adjustment formulas, again based on the type of hospital and the DSH patient percentage.

The DSH program was originally intended to compensate hospitals for what were believed to be higher-than-average costs for treating low-income Medicare patients. Over time, however, the purpose of the DSH program has evolved into the much broader one of protecting access to care for low-income patients by supporting the institutions that serve them. Hospitals that treat large numbers of low-income and uninsured patients often face severe financial difficulties as a result of their mission-related activities. Medicare DSH payments to these hospitals ease their financial burden and help to ensure their continued accessibility to the patients who use them. This more expansive mission has gained wide, if not universal, acceptance over the years.

Medicare DSH payments, which totaled $4.5 billion in 1997, have risen dramatically since 1989, primarily because of legislative changes that increased payments to certain hospitals. In 1989, DSH payments represented 2 percent of total PPS payments; in 1997, they accounted for 6 percent.[6] In 1997, Congress cut DSH payments one percent a year beginning in 1998 and running through 2002 as part of an overall cost savings package for Medicare. Currently Medicare DSH payments are made to 1,913 hospitals, or about 40 percent of all PPS hospitals.[7] These payments are concentrated in urban hospitals—almost 96 percent of all payments were made to urban hospitals in 1997, and half were made to only 250 facilities.[8] Payments were also concentrated in hospitals with teaching programs—two-thirds of payments were made to teaching hospitals in 1997. These payment trends have remained constant over time. In 1990, urban hospitals received 95 percent of the $1.6 billion in DSH payments, with two-thirds going to teaching hospitals *(see table 2).*

Table 2
Percent Distribution of Medicare DSH Payments by Hospital Type, 1988–1997

Type of Hospital	Percent of Hospitals	1988	1991	1994	1995	1996	1997
Total Payments (billions of dollars)		$1.1	$1.6	$3.4	$3.8	$4.3	$4.5
Large Urban	15%*	56%	59%	61%	63%	60%	62%
Other Urban	13%*	40%	38%	34%	34%	33%	33%
Rural	9%*	4%	3%	5%	3%	5%	4%
Major Teaching	5%	27%	34%	34%	34%	33%	33%
Other Teaching	16%	37%	36%	33%	32%	33%	33%
Non-Teaching	79%	36%	30%	34%	34%	35%	33%

Note: 1997 data is estimated.
* Percent of hospitals that receive Medicare DSH payments.
Source: ProPAC.

[6] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy, Volume 1: Recommendations* (March 1998), 64.
[7] Ibid.
[8] Ibid.

Payments to Medicare managed-care plans (called the Average Adjusted Per Capita Cost, or AAPCC) include Medicare DSH payments. As a consequence, these payments are made to plans that do not provide low-income or uncompensated care. The assumption is that Medicare managed care plans will pass the DSH payments on to the hospitals with which they contract. Yet there are no guarantees that managed-care plans will contract with DSH hospitals. Hospitals can expect to see decreases in their Medicare DSH payments as more beneficiaries become enrolled in managed care plans and payments are shifted to the health plans.

III. THE HISTORY AND STRUCTURE OF THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM

The history of the Medicaid DSH program is a complicated story of the conflict between federal control and state flexibility. Medicaid is a federal/state partnership—basic program parameters are established in federal law, but states are given wide latitude to adopt optional benefits, expand coverage, and establish payment methods and levels.

The Medicaid DSH payment adjustment was born in a clause in the Omnibus Budget Reconciliation Act of 1981 (OBRA ′81) that required state Medicaid agencies to make allowances when determining reimbursement rates for hospitals that served a disproportionate number of Medicaid or low-income patients. Concerned that cost reimbursement was inflationary, Congress wanted to allow states to substitute prospective payment and other methods to help contain costs. It also wanted to protect facilities that treat "a large volume of Medicaid patients and patients who are not covered by other third party payers." Therefore, OBRA '81 enabled states to experiment with prospective payment mechanisms as long as payments would (in the language of the Boren amendment) be "reasonable and necessary to the efficient and economical delivery of services."[9] The requirement was very broad and vague—it did not define which hospitals were to be assisted, nor did it specify how states should assist the hospitals selected. Consequently, many states either ignored the requirement or did not implement a meaningful DSH program.

Congress tried to remedy this problem by passing more stringent DSH requirements in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which established a federal definition of DSH hospitals and required states to make payments to these hospitals. The new federal DSH definition required states to include, at a minimum:

- Any hospital with a Medicaid utilization rate (Medicaid days divided by total days) of one standard deviation or more over the mean Medicaid utilization rate in the state, or

- Any hospital with a low-income utilization rate of 25 percent or more (the low-income utilization rate is the sum of the ratio of Medicaid revenues divided by total revenues and the ratio of inpatient charity care charges divided by total charges).

These were the minimum criteria for states in designating DSH hospitals. OBRA'87 also gave states the freedom to designate more hospitals as DSH. The legislation also established parameters for the type of DSH adjustments that states should make, although again, the parameters were fairly broad. Basically, states had two options for paying DSH

[9] Omnibus Budget Reconciliation Act of 1981; Public Law 97-35 (repealed by the Balanced Budget Act of 1997; Public Law 105-33).

hospitals: to apply the Medicare DSH formula to Medicaid base inpatient payments; or, to pay a proportional increase based on hospitals' Medicaid or low-income utilization rates. Hence DSH reimbursement varied considerably from state to state because the adjustments came on top of base payments that already varied considerably across states. States had tremendous discretion in establishing their Medicaid reimbursement methods as long as they were "reasonable and necessary to the efficient and economical delivery of services."[10]

Total Medicaid DSH payments remained relatively small until states realized that they could finance the state share of DSH funds with provider taxes and donations. Provider taxes are taxes levied on a particular provider group, usually hospitals, and donations are voluntary payments made to the state by providers, again usually hospitals. This practice was made possible by a 1985 HCFA policy revision that permitted states to use the proceeds of voluntary donations and provider taxes to finance their share of the Medicaid program. States then turned to these programs to help them cope with the increasing demand that Medicaid was placing on state expenditures. In the late '80s, West Virginia and Tennessee became the first states to take advantage of provider donations to leverage federal funds for their indigent care programs and, more generally, for their Medicaid programs. After court and administrative law proceedings upheld the legality of these systems, more states began taking advantage of this leveraging mechanism. In 1990, six states had provider tax and donation programs; by 1992, 39 states had them.

States employed one of three different strategies to determine how to use DSH funds to finance their Medicaid programs:

- They reimbursed hospitals the funds that the hospitals had contributed plus all of the federal matching funds they received; or

- They paid hospitals back their contribution plus some part of the federal share, and retained some amount for other purposes—either for other parts of the Medicaid program or to fund other parts of the state budget; or

- They kept the entire federal match and refunded hospitals only the amounts that they had contributed.

In general, states used these financing mechanisms to dramatically increase their DSH spending. Between 1989 and 1992, total DSH payments increased from $600 million to $17 billion. By the latter year, DSH payments represented 15 percent of total Medicaid spending *(see appendix 1).* This total growth, however, does not reflect the tremendous variation across states in their DSH spending *(see appendix 2).* Some states increased DSH payments so much

[10] Omnibus Budget Reconciliation Act of 1987; Public Law 100-203.

that they became a huge part of their total Medicaid spending—for instance, in New Hampshire, DSH payments represented 51 percent of Medicaid spending; in Missouri, 31 percent; in Louisiana, 36 percent.

In an attempt to limit the explosive and unpredictable growth in Medicaid, and citing what HCFA called an "improper" shift of state responsibilities to the federal government, Congress passed the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991." This law limited provider taxes and eliminated the use of provider donations as a source of the state share of Medicaid funding. The statute also imposed a national aggregate limit on DSH spending of 12 percent of total Medicaid spending, effective in federal Fiscal Year 1993. Each state's total DSH spending was also limited. Allotments for states whose spending in the prior year exceeded 12 percent (called "High DSH" states) were limited to the prior year allotment. Allotments for states whose prior year spending was less than or equal to 12 percent were allowed to grow by a growth factor—the amount by which their total Medicaid spending grows—and a "supplemental amount"—the determination of which is based on a redistribution of national dollars once aggregate DSH spending is kept limited to the cap.

With the elimination of donation programs and curbs on the use of provider tax programs as sources of financing for the states' share of their Medicaid DSH programs, the states turned to intergovernmental transfers (IGT) and state transfers from local public hospitals, state university hospitals, and state psychiatric hospitals. An IGT involves the transfer or certification of a transfer of funds from a government-owned hospital, such as a state university hospital or county hospital, to the state Medicaid agency.[11] The state can then use these funds to collect federal matching payments. A 1995 Urban Institute study of DSH programs in 39 states revealed that provider taxes and donations as a proportion of the state share of DSH payments had declined. On the other hand, transfers were projected to increase from 5 percent of the state share in 1991 to 63 percent in 1994.[12]

Surveys of the National Association of Public Hospitals & Health Systems (NAPH) member hospitals in 1992 and subsequent years indicate that there are now almost no state funds financing the state share of Medicaid for DSH payments. In fact, the amounts hospitals transfer to states include matching federal dollars for DSH payments to other hospitals in their states. In 1996, transfers from NAPH members represented 69 percent of their total Medicaid DSH payments *(see appendix 3).*

[11] In some cases, the local or state governmental entity merely certifies that public funds are expended, and does not actually transfer funds.

[12] Leighton Ku and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* 16 (Spring 1995):33.

The Urban Institute study also found that the states themselves were the primary beneficiaries of their DSH financing mechanisms.[13] They benefited in two ways—by retaining some residual funds for state purposes; and by paying DSH funds to state-owned hospitals. The study estimates that in 1993, states retained $2 billion of $15.3 billion in DSH payments after paying providers for DSH and other payments.[14] Of the amounts paid to providers ($13.3 billion), $4.8 billion, or 36 percent, was paid to state hospitals.[15] These state hospitals contributed only 24 percent of the state share of DSH payments, and represented only 17 percent of all Medicaid days.[16]

With the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress acted to curb abuses by enacting further DSH restrictions. OBRA '93 capped the amount of DSH funds that could be paid to individual hospitals at either their unreimbursed costs or at the amount that the hospital loses on Medicaid patients plus the amount that it loses on charity care patients. In addition, OBRA '93 limited states' ability to designate hospitals as DSH by imposing a one-percent minimum Medicaid utilization threshold. The implementation of OBRA '93 (in conjunction with the OBRA '91 limits) began to have an impact on curbing the growth in Medicaid DSH spending. Between 1994 and 1997, Medicaid DSH payments dropped from $18.1 billion to $14.9 billion—an average of 6 percent per year—as compared to an average annual growth rate of 84 percent in the prior three years.

States are not allowed to provide Medicaid coverage to patients between the ages of 19 and 64 in Institutions for Mental Disease (IMDs). However, state mental hospitals often qualify for DSH payments because they treat a small number of patients who are younger or older than the age restrictions—enough to meet the minimum one-percent Medicaid utilization thresholds. So some states made DSH payments to IMDs that were out of proportion to the institutions' Medicaid utilization, effectively exploiting the DSH program to finance the states' responsibility for IMDs. A six-state General Accounting Office study released in January 1998 revealed that some states were spending more of their DSH program funds on IMDs than they were on acute-care hospitals.[17] Payments to state psychiatric hospitals in these states were larger on average than payments to other DSH hospitals, averaging $29 million per psychiatric hospital as opposed to only $1.8 million for local public hospitals and other private hospitals.[18]

Congress acted to further curb states' use of DSH funds in the Balanced Budget Act of 1997 (BBA). The BBA limited state spending on IMDs to the lesser of the proportion of

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[13] Ku, p. 40.
[14] Ku, p. 37.
[15] Ibid.
[16] Ku, p. 40.
[17] US General Accounting Office (hereafter cited as GAO), *Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals* (January 1998), p.7.
[18] GAO, p.6.

spending on IMDs in 1995, or 33 percent of total spending by the year 2003. In addition, the BBA imposed requirements on states to provide data to HCFA on DSH payments to individual hospitals in order to ensure greater accountability for DSH spending at the national level. The 1997 act also placed absolute limits on all states' DSH allotments. These caps reduced Medicaid DSH payments by 8.6 percent between 1998 and 2002. By 2002, these cuts are expected to reduce spending by an average of 17 percent from 1995 spending levels and 37.7 percent from CBO projected spending in 2002 *(see appendix 4 for a state-by-state listing of the 1998–2002 allotments).*

The legislative history of the Medicaid DSH program is one of tremendous state discretion, abuse of that discretion by some states that used the program in ways that Congress never intended, and federal efforts to curb state abuses. This history belies the tremendously important role that the Medicaid DSH program plays in financing care to low-income populations—particularly care to the uninsured and underinsured—and the important role it has played in the survival of the safety net in many states.

IV. THE ROLE OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS IN FINANCING CARE TO THE UNINSURED AND UNDERINSURED

Charges for care for which hospitals were not compensated ("uncompensated care") totaled $18 billion in 1996, or 6.1 percent of all hospital costs for that year.[19] This percentage has not changed much in the ten years between 1986 and 1996, even though there have been significant changes both in the distribution of uncompensated care and in the sources of financing for such care. The burden of uncompensated care has always been unevenly distributed across providers—some assume a disproportionate share of care for the under- and uninsured. Data from 1994 indicate that urban public hospitals provided 35 percent of all uncompensated care, but represented only 15 percent of total hospital expenses.[20] Public teaching hospitals and hospitals with significant levels of Medicaid patients also provided a disproportionate share of uncompensated care. Major public teaching hospitals provided 26 percent of all uncompensated care, yet represented only 9 percent of total hospital expenses; and hospitals with high numbers of Medicaid patients provided 56 percent of all uncompensated care but only 38 percent of total hospital expenses.[21] Another study of uncompensated care data indicated that in 1994, 8.5 percent of all hospitals providing the highest levels of uncompensated care (at 10 percent or more of their costs), are providing over 38 percent of all uncompensated care nationally.[22]

Historically, hospitals have financed care to the under- and uninsured in a number of ways. They have charged patients with private insurance more than they charge the under- and uninsured and used the difference to cover the costs of care to those with Medicaid or no insurance—a practice known as cost-shifting. They have also drawn subsidies from local or state governments for indigent care, and they have received Medicare and Medicaid DSH payments. In recent years, there have been changes in all three areas that will affect the ability of providers to continue to care for the under- and uninsured.

While a uniform definition of urban safety net hospitals does not exist, a useful definition is one laid out in the OBRA '87 legislation. It defines a DSH hospital as any hospital with a Medicaid utilization rate (Medicaid days divided by total days) of one standard deviation or more over the mean Medicaid utilization rate in the state. Using this definition, Gaskin identified 226 urban safety net hospitals in 115 Metropolitan Statistical Areas (MSAs) in a 1999 study.[23] One-third of these 226 institutions were public hospitals.

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[19] American Hospital Association, *Uncompensated Care Hospital Cost Fact Sheet* (March 1998), 3.

[20] Joyce M. Mann, Glenn A. Melnick, Anil Bamezai, and Jack Zwansiger, "A Profile of Uncompensated Hospital Care, 1983–1995." *Health Affairs* 16 (July/August 1997):228.

[21] Ibid.

[22] Peter J. Cunningham and Ha T. Tu, "A Changing Picture of Uncompensated Care," *Health Affairs* 16 (July/August 1997):169.

[23] Darrell Gaskin, *Safety Net Hospitals: Essential Providers of Public Health and Specialty Services,* The Commonwealth Fund (February 1999).

Medicare and Medicaid DSH payments have been a vital source of financing for these urban safety net hospitals. Members of this group serve predominantly low-income communities, so they have substantial caseloads of Medicare, Medicaid, and uninsured patients, and small caseloads of privately insured patients on whom to cost shift. In addition, these hospitals are often heavily involved in providing outpatient and specialized community services such as trauma care and medical education.

Data on the finances of all hospitals that satisfy Gaskin's definition are not widely available. A significant number, however, are members of the National Association of Public Hospitals & Health Systems (NAPH), a group comprising nearly 100 hospitals and health systems in metropolitan areas across the country. In this section, and throughout the paper, we use data from an annual survey of NAPH members to examine the role of DSH in the finances of urban safety net hospitals. We primarily rely on data from the 1996 NAPH survey, but, where possible, have included time series data from 1989. The NAPH Hospital Characteristics Survey collects annual utilization and financial data from its members. The 1996 survey contains data from 68 hospitals. Because of the specificity of the data and the relatively small sample, we have not tried to correct for incomplete data or nonresponse. The sample size for the time series analyses is smaller because these data include a matched set of hospitals responding to the survey in each year.

This select group of hospitals is an essential part of the healthcare safety net for millions of uninsured and low-income Americans. They fulfill this role in multiple ways:

- All provide routine and specialty care for low-income populations—over 90 percent of NAPH member hospitals' services are provided to those covered by Medicaid and Medicare, or to the uninsured and other low-income patients. In 1996, Medicaid patients received 43 percent of inpatient care in these hospitals; 28 percent of care was given to self-pay patients (typically, self-pay patients in safety net hospitals are uninsured and cannot afford to pay for the services they receive). On the outpatient side, the uninsured accounted for a greater portion of the care—45 percent of outpatient visits were self-pay; and Medicaid visits totaled 32 percent. As the delivery of care moves increasingly into outpatient settings—where the proportion of reimbursed care is lower—the burden of uncompensated care for these providers will increase.

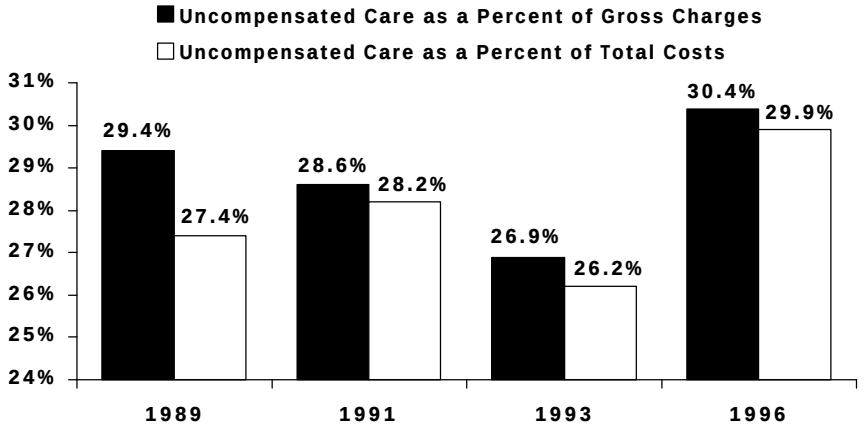
- NAPH member hospitals treat patients regardless of their ability to pay for services. Many are under- or uninsured and have no access to care in other settings. In 1996, these hospitals provided over $4 billion worth of care to the under- and uninsured. Uncompensated care (defined as bad debt and charity care) represented 26 percent of total costs at these hospitals, compared to an industry average of only 6.1 percent.

Such care as a percent of costs declined between 1989 and 1993, most likely due to expansions in Medicaid coverage and DSH payments. However, between 1993 and 1996, uncompensated care as a percent of costs increased from 26 to 30 percent, its highest point during the seven-year period (*see figure 1)*.[24]

- They provide highly specialized care—including trauma care, burn care, neonatal intensive care, and other high-cost services—to anyone in their communities.

- They train large numbers of physicians and other health professionals. In 1996, for example, they trained more than 16,000 residents.

Figure 1
Uncompensated Care as a Percent of Total Costs and Charges for Select Safety Net Hospitals, 1989–1996



Source: NAPH Hospital Characteristics Survey Data, 1989–1996.

Institutional subsidies, like Medicare and Medicaid DSH, will continue to be essential for maintaining the health care safety net, because most health insurance coverage expansion proposals do not encompass the populations most likely to be cared for by safety net hospitals. A recent NAPH survey collected information on the characteristics of the uninsured who sought care at safety net hospitals *(see table 3).* Notably, almost 78 percent had incomes at or below 150 percent of the federal poverty level. In addition, 72 percent were between the ages of 19 and 64; and 45 percent were between ages 21 and 44. Recent coverage expansion proposals have targeted populations other than uninsured low-income adults, those most likely to be cared for by safety net hospitals. In addition, these proposals have not addressed the need to subsidize premiums significantly to ensure participation by low-income individuals.

[24] Data is for a matched set of NAPH members responding to the NAPH survey for each data point and represents a subset of the total hospitals responding to the survey in a given year.

Consequently, Medicare and Medicaid DSH will continue to play a pivotal role in maintaining access to care for the under- and uninsured.

Table 3
Characteristics of Self-Pay Patients at Select Safety Net Hospitals

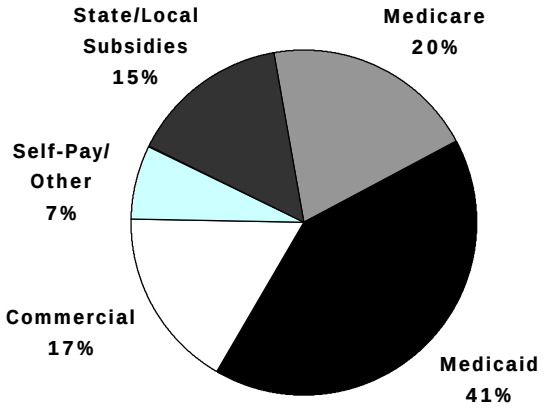
Age	
0–18	16.2%
19–20	3.7%
21–44	45.0%
45–64	23.4%
65+	5.4%
Race/Ethnicity	
Black	40.9%
Asian	2.4%
White	21.3%
Hispanic	31.7%
Income	
<100% FPL	67.3%
100%–150% FPL	10.2%
>150% FPL	11.4%

Source: NAPH Survey of 25 Urban, Safety Net Hospitals, 1998.

V. FINANCING THE SAFETY NET MISSION

In most hospitals, uncompensated care for the under- and uninsured is financed via cost-shifting. In safety net hospitals, where there are few private-pay patients, uncompensated care is financed primarily through Medicare or Medicaid DSH payments or local government subsidies. Medicaid is the single largest source of revenue for these hospitals—in 1996 it accounted for 41 percent of net revenues at NAPH member hospitals. Medicare followed it at 20 percent, with state and local subsidies at 15 percent. Revenues from commercial payers—at 17 percent—represent a relatively small portion of net revenues *(see figure 2).*

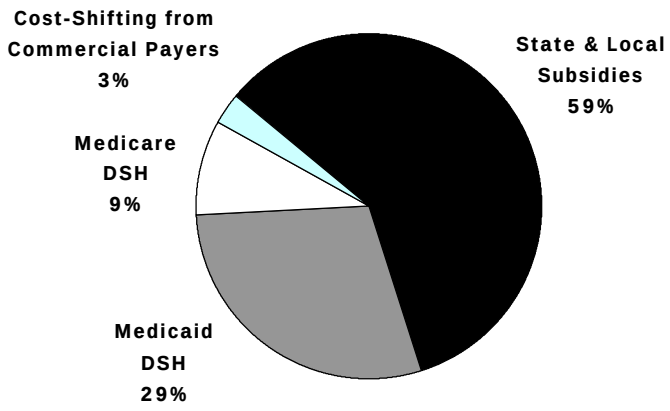
Figure 2
Net Revenues by Payer Source
at Select Safety Net Hospitals, 1996



Source: NAPH Hospital Characteristics Survey Data, 1996.

Figure 3 demonstrates how this same group of hospitals financed uncompensated care in 1996. On average, 59 percent of the revenues were derived from state and local government subsidies, 29 percent from Medicaid DSH payments, and 9 percent from Medicare DSH payments. Only 3 percent came from cost-shifting from privately insured patients.

Figure 3
Sources of Financing for Uncompensated Care
at Select Safety Net Hospitals, 1996



Source: NAPH Hospital Characteristics Survey Data, 1996.

The increasing reliance of urban safety net hospitals on Medicare and Medicaid payments to offset losses on uncompensated care is clearly demonstrated by the following analysis of the revenues-to-costs ratio by payer over time. Like all hospitals, the members of this group cost-shift to commercial payers. However, for these particular hospitals, revenue from cost shifting accounts for a very small part of the overall funding for uncompensated care. Moreover, their ability to cost-shift has declined since its 1993 peak, most likely due to pressures imposed by managed care. The payment-to-cost ratio for Medicaid has also declined since 1993, but the importance of the DSH program in subsidizing uncompensated care is demonstrated by the negative ratio on Medicaid payments experienced before the full implementation of the DSH program in 1992. Since then, these hospitals have realized positive Medicaid margins *(see table 4)*.[25]

Table 4
Ratio of Revenues to Costs by Payer at Select Safety Net Hospitals, 1989–1996

Source	1989	1991	1993	1995	1996
Medicare	0.89	0.82	0.86	1.01	1.02
Medicaid	0.79	0.79	1.07	1.02	1.06
Commercial Insurance	1.11	1.12	1.14	1.05	1.05
Self-Pay/Charity/Bad Debt	0.36	0.23	0.23	0.21	0.18
Other	0.54	0.92	0.74	0.88	0.40
Total	1.03	1.04	1.07	1.02	1.03

Source: NAPH Hospital Characteristics Survey Data, 1989–1996.

[25] Medicaid revenues in this analysis do not include the intergovernmental transfer payments made by safety net hospitals to their states.

To further demonstrate the importance of these payments, the revenue-to-cost ratios were analyzed after excluding DSH payments from hospital revenues. Without Medicare DSH payments, the hospitals would have experienced a 10 percent loss on Medicare payments. In the absence of Medicaid DSH payments, they would have suffered a 13 percent loss on Medicaid payments *(see table 5)*. Without DSH payments, and in the absence of increased payments from local governments or decreases in costs, these hospitals would have experienced an alarming negative 7 percent margin on total operations in 1996.

Table 5
Ratio of Revenues to Costs by Payer at Select Safety Net Hospitals
Under Different Financing Scenarios, 1996

Source	Excluding DSH Payments	Assuming Full Implementation of BBA Cuts in DSH Payments	Including DSH Payments
Medicare	0.90	1.01	1.02
Medicaid	0.87	1.03	1.06
Commercial Insurance	1.05	1.05	1.05
Self-Pay/Charity Care	0.18	0.18	0.18
Other	0.40	0.40	0.40
Total	0.93	1.01	1.03

Source: NAPH Hospital Characteristics Survey Data, 1996.

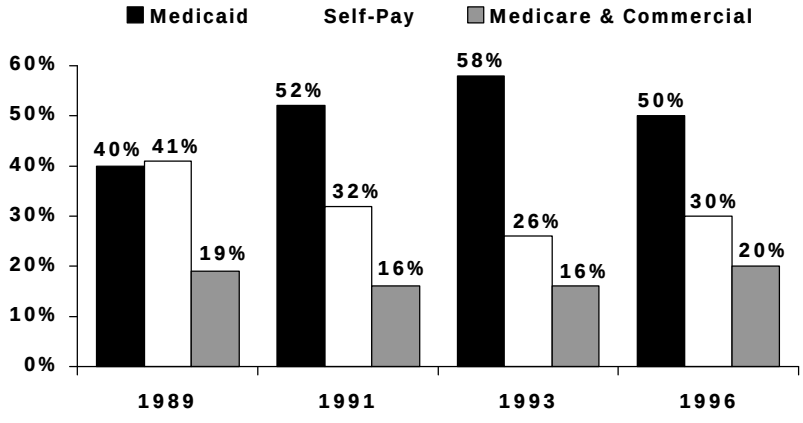
The Balanced Budget Act of 1997 (BBA) cut both Medicare and Medicaid DSH payments to help finance federal deficit reduction. Medicare DSH payments to hospitals were reduced five percent—one percent per year for the years 1998 through 2002—and Medicaid DSH payments were cut by 17 percent for the same time period. To assess the probable effect of these cuts, we have recalculated the 1996 revenue-to-cost ratios for Medicare and Medicaid using the BBA-ordered reductions in payments (five percent for Medicare DSH and 17 percent for Medicaid DSH). This analysis provides only a gross estimate of the effect of the BBA cuts—especially for Medicaid, because Medicaid DSH cuts are not felt uniformly by all states. Furthermore, the analysis only indicates the impact of DSH cuts; it does not reflect the impact of many other Medicare and Medicaid reductions mandated by the BBA.

Independent of any other reimbursement reductions, the BBA-mandated cuts in the DSH programs will reduce by half the current surpluses this group of hospitals reaps from Medicare and Medicaid payments *(see table 5).* The DSH cuts alone result in a one percent positive margin for these hospitals. All the Medicare and Medicaid reductions mandated by the BBA will likely result in negative margins for these hospitals, putting them in financial jeopardy.

In addition to the cuts in DSH payments, safety net hospitals face other healthcare market trends that threaten the traditional sources of financing for uncompensated care. During the 1990s they have seen decreases in state and local governments subsidies—their most important source of uncompensated-care financing. The size of these subsidies, which peaked at 21 percent of total hospital revenues in 1991, has steadily declined—in 1996 they represented only 16 percent of total revenues, a drop of 24 percent. Some of this decrease is undoubtedly attributable to the substitution of federal Medicaid DSH funds for local support, particularly as state and local governments experienced recessions in the early 1990s. Nevertheless, even with budget surpluses, state and local governments have been rethinking their commitments to financing indigent care.

Yet another revenue-threatening trend for traditional providers of low-income care is intense competition for Medicaid patients from non-safety net hospitals. Competitive pressures in the healthcare marketplace have forced providers of all kinds to recruit any patient who is insured, including Medicaid recipients. As downward pressure on prices has decreased income from private patients, providers find Medicaid reimbursement to be fairly lucrative, particularly with DSH payments attached. This practice is most evident in the area of inpatient care. Safety net hospitals saw steady increases in Medicaid discharges in the early '90s. Between 1993 and 1996, however, their Medicaid discharges decreased by 15 percent. To further compound the problem, discharges of uninsured patients increased by 15 percent in the same period *(see figure 4).*

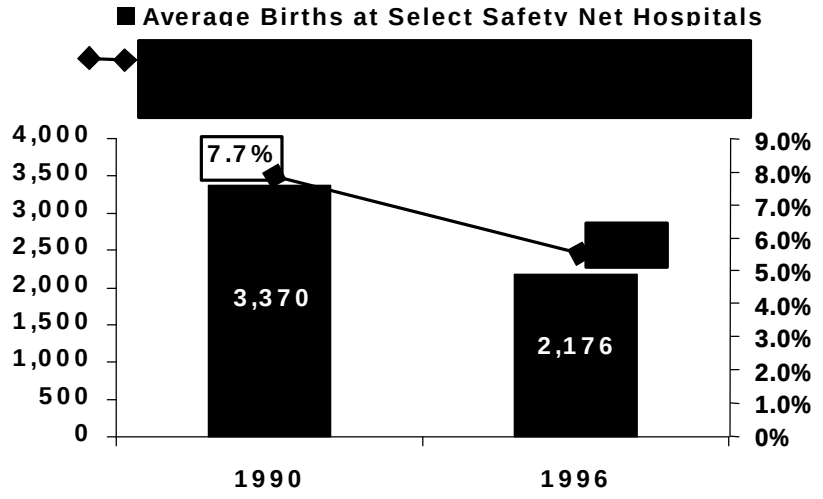
Figure 4
Trends in Medicaid and Self-Pay Discharges
at Select Safety Net Hospitals, 1989–1996



Source: NAPH Hospital Characteristics Survey Data, 1989–1996.

Safety net hospitals' loss of Medicaid market share is most evident in the area of maternity care. Between 1989 and 1994, market share for Medicaid deliveries at public teaching hospitals decreased by more than 50 percent—from 25 to 12 percent.[26] Between 1989 and 1996 Medicaid births declined by 36 percent at a sample of urban, safety net hospitals *(see figure 5).* Most of their market share shifted to non-teaching, nonprofit hospitals, where Medicaid delivery market share increased from 27 percent to 37 percent between 1989 and 1994. To compound this problem, the patients being lost by safety net providers are primarily low-risk maternity patients. In a study of safety net providers in 25 MSAs, Gaskin, et. al. found that although the hospitals experienced an overall decline in the number of Medicaid maternity patients, their share of the high-risk Medicaid maternity patients increased.[27] On the one hand, greater competition for Medicaid patients means beneficiaries have a greater choice of providers—and consequent improvements in quality of care as providers compete for their business. On the other hand, it means that a key source of financing is jeopardized for providers who rely on Medicaid and Medicaid DSH revenues to subsidize care to the uninsured.

Figure 5
Total Births at Select Safety Net Hospitals, 1990–1996



Source: American Hospital Association Annual Survey Data, 1990, 1996.

[26] Data provided by the Association of American Medical Colleges from the AHCPR Nationwide Inpatient Sample.

[27] Darrell Gaskin, Jack Hadley, and V.G. Freeman "Are Urban Safety Net Hospitals Losing Competition for Low Risk Medicaid Patients?" Institute for Health Care Research and Policy, Georgetown University (June 1998), 12.

VI. REFORM IN THE MEDICARE AND MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAMS

Safety net hospitals are more reliant on institutional subsidies for uncompensated care than ever. As policy-makers seek to reduce those subsidies, it becomes more important to ensure that DSH payments are targeted to those hospitals that are truly shouldering the burden of low-income and uncompensated care. To accomplish this goal, both the Medicare and Medicaid DSH programs need reforms that would correct deficiencies in the way they function and equip them to better address the needs of the current healthcare marketplace. Specific reforms include:

1. Medicare and Medicaid DSH qualifying and distribution formulae must reflect current healthcare market realities.

- Medicare and Medicaid DSH formulae should reflect outpatient care as well as inpatient care. Both Medicare and Medicaid DSH programs should explicitly acknowledge outpatient low-income care as part of their qualifying formulae and distribution methodologies. Currently both DSH programs are inpatient-oriented. The Medicare DSH qualifying formula includes inpatient volume only. Moreover, the DSH payment is distributed as a percent add-on to inpatient Medicare PPS payments. Most Medicaid DSH programs also continue to be inpatient-oriented, even though states have tremendous discretion, and thus could recognize outpatient services if they so desired. New technology and pharmaceuticals have made it possible to give more care on an outpatient basis, and there is an increased emphasis on providing care in the most appropriate setting. Consequently, more patient care is shifting to the outpatient setting. These formulae need to change to recognize the changes in health care delivery.

- The Medicare DSH formula should include all costs for low-income care. The fundamental problem with the Medicare DSH program lies in the underlying measure of low-income care in the qualifying formula. This measure relies on Medicare SSI and Medicaid utilization to approximate the level of low-income care that hospitals provide. In doing so, it fails to account for uncompensated care—the primary source of hospitals' low-income care costs. Therefore, the measure has never been a good proxy for low-income care and changes in the healthcare market have rendered it obsolete. For several reasons—increasing competition for Medicaid patients, managed care, and the very nature of the Medicaid program—Medicaid utilization figures alone tell us little about a hospital's commitment to low-income care. For the same reason, those figures shed little light on the cost of uncompensated care. In addition, the calculation of Medicare SSI utilization overstates the true proportion of SSI patients and the true costs of those patients. In fact, much of the

complexity in the current formula results from efforts to adjust implicitly for the failure to include a direct measure of uncompensated care.

Along with the cuts in the program, the Balanced Budget Act of 1997 mandated the Secretary of the Department of Health and Human Services to report by August 1998 on changing the qualifying formula for Medicare DSH. The preparation of this report offers an opportunity to study the ramifications of changing the formula to make it more relevant to the circumstances of the current healthcare market and to correct the inadequacies of the current formula. HCFA has not yet released this report.

2. Medicare and Medicaid DSH payments should be made directly to hospitals.

- Medicare DSH payments should be carved out from the Average Adjusted Per Capita Cost (AAPCC) payments made to managed-care plans. Currently, DSH payments are not carved out of the AAPCC, which means that these payments are made to managed-care plans that do not provide low-income or uncompensated care, rather than directly to the hospitals that do. The rationale for this policy is that the managed-care plans will pass these payment adjustments along to the hospitals with which they contract. However, managed-care plans are not required to contract with DSH hospitals. As more beneficiaries are enrolled in Medicare managed-care plans, hospitals will see erosion of their DSH payments because more of these payments will go instead to the managed-care plans. In the BBA, Congress opted to correct this problem with respect to graduate medical education payments. It needs to do so for DSH payments as well.

- The BBA provision requiring Medicaid DSH payments to be made directly to hospitals should be clarified. The BBA requires that Medicaid DSH payments be paid directly to hospitals, and not folded into capitated amounts paid to risk plans. This provision has a clause that grandfathers "payment arrangements in effect on July 1, 1997" from the requirement, but it does not further define the term "payment arrangement." In the absence of a specific definition, HCFA is allowing states to define the term as they see fit. Instead, the term should be imbued with meaning and specificity, allowing the grandfathering to apply only to state managed-care contracts in effect on that date. Once the contracts come up for renewal, DSH payments should be made directly to hospitals.

3. States should be held accountable for how Medicaid DSH dollars are spent.

- HCFA should expand state data reporting requirements. Medicaid DSH has been reformed a number of times over the years. Most of the program's problems stem from the fact that Medicaid DSH is a federal/state partnership in which states are given a fair amount of discretion in deciding how to fund their contribution. The

Medicaid program as a whole is supported primarily with contributions from both levels of government. In contrast, much of the non-federal funding for Medicaid DSH comes directly from safety net providers and the local governments that own or support them. Perhaps the biggest single barrier to reforming the program has been the lack of accountability for how these DSH funds are spent because states are not required to report on this area of the Medicaid program. There is no national data on how states spend DSH funds, who receives them, how much individual entities receive, and how states finance their share of the program. Given a federal expenditure of $11 billion per year, this lack of accountability is surprising. The need for good data collection on the national level is imperative. Provisions in the Balanced Budget Act of 1997 require states to submit data to HCFA on how much they pay disproportionate-share hospitals. HCFA should use this authority to require detailed and specific data on DSH expenditures.

- A rational approach to the distribution of Medicaid DSH payments should be developed. The allocation of Medicaid DSH funds bears little relationship to any measure of need. Instead, the state-by-state variation in DSH spending is due to different levels of commitment by states to their Medicaid DSH program and different levels of creativity in using the program. A more rational approach to distributing Medicaid DSH payments should be developed. However, any reallocation should occur only in the context of a total reform of all sources of financing for the uninsured because it would redistribute funds significantly among states. States that make a greater commitment to DSH spending and states that may have used the program less appropriately would be penalized equally.

  The political perils of Medicaid DSH reform were apparent in the debate on the Medicaid DSH reductions in the Balanced Budget Act of 1997. In a context of reducing funds for deficit reduction, stakeholders fought any reform of the program, whether uses were consistent with the intent of the program or not. Reform in this climate will be difficult. Reallocation of federal funds among states would be extremely difficult unless it occurred in the context of a total reform of all sources of financing for the uninsured.

The primary obstacle to reforming either the Medicaid or Medicare DSH program is the redistributive impact of change. In both cases, there would be winners and losers. Currently many hospitals or—in the case of Medicaid DSH—the states, receive benefits from these programs and therefore have stakes in how the funds are distributed. Rationalizing Medicare and Medicaid DSH will not be easy—even when good policy dictates that changes are necessary if the programs are to maintain their integrity (and congressional intent) and to continue to support providers that are disproportionately caring for low income populations.

CONCLUSION

Universal health care coverage must continue to be our national goal, even if policy makers attempt to get there via piece-meal coverage expansions. In the meantime, governments at all levels, including local governments, must renew their support for the indigent care mission of safety net hospitals. Such hospitals rely on a combination of payments from the Medicare and Medicaid DSH programs and subsidies from state and local governments to finance the care they provide to the poor and uninsured. This paper has documented the importance of the Medicare and Medicaid DSH programs in ensuring the financial viability of these institutions.

As the numbers of the uninsured continue to grow and proposed solutions fail to keep pace, institutional subsidies must be maintained and increased to ensure a strong and well-financed health care safety net.

Appendix 1
Medicaid DSH Spending as a Percent of Total Medicaid (Federal and State) Spending, 1991–1996

State	DSH as % of Total 1991	DSH as % of Total 1992	DSH as % of Total 1993	DSH as % of Total 1994	DSH as % of Total 1995	DSH as % of Total 1996	Percentage Point Change 1991–96*
Alabama	14.0%	27.2%	24.9%	23.0%	21.0%	20.1%	44%
Alaska	0.0%	7.2%	3.9%	4.8%	5.9%	3.5%	-52%
Arizona	0.0%	0.0%	6.2%	5.8%	7.2%	6.4%	100%
Arkansas	0.2%	0.3%	0.3%	0.3%	0.3%	0.2%	35%
California	1.1%	17.4%	14.4%	13.6%	12.0%	7.8%	612%
Colorado	6.7%	29.3%	11.9%	24.9%	11.1%	10.8%	61%
Connecticut	0.0%	18.9%	17.5%	17.0%	15.9%	15.3%	-19%
Delaware	0.0%	14.3%	1.9%	2.0%	2.0%	2.0%	-86%
District of Columbia	0.0%	0.8%	7.9%	18.6%	5.6%	4.6%	497%
Florida	2.1%	4.5%	4.7%	5.4%	5.4%	6.1%	191%
Georgia	2.5%	11.6%	11.7%	11.5%	11.3%	10.8%	332%
Hawaii	0.7%	12.2%	11.5%	5.4%	0.0%	0.0%	-100%
Idaho	0.0%	0.5%	0.3%	0.5%	0.6%	0.7%	38%
Illinois	3.0%	7.0%	5.9%	6.2%	6.4%	3.8%	28%
Indiana	1.1%	8.3%	10.0%	8.6%	15.0%	2.9%	169%
Iowa	0.3%	0.5%	0.5%	0.5%	1.0%	0.2%	-14%
Kansas	7.6%	22.9%	20.4%	16.3%	9.1%	6.1%	-20%
Kentucky	11.9%	14.1%	7.1%	4.3%	9.0%	10.8%	-10%
Louisiana	7.9%	36.1%	31.1%	28.5%	28.8%	21.3%	169%
Maine	7.6%	18.0%	18.8%	17.6%	17.2%	15.4%	103%
Maryland	0.0%	5.7%	5.8%	5.5%	5.6%	6.2%	8%
Massachusetts	12.4%	11.0%	11.8%	12.7%	11.0%	11.6%	-6%
Michigan	14.2%	13.7%	12.2%	11.8%	8.1%	6.0%	-58%
Minnesota	0.6%	2.0%	1.5%	1.5%	1.0%	1.9%	219%
Mississippi	2.9%	13.7%	12.4%	11.8%	11.6%	13.0%	351%
Missouri	13.2%	30.5%	30.4%	27.4%	25.7%	23.2%	75%
Montana	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	3%
Nebraska	0.2%	0.6%	1.3%	1.5%	1.2%	0.9%	262%
Nevada	0.3%	18.4%	16.8%	18.4%	15.6%	14.9%	4850%
New Hampshire	24.2%	50.6%	50.3%	40.7%	33.5%	5.9%	-76%
New Jersey	4.2%	25.3%	22.8%	23.0%	21.5%	17.6%	321%
New Mexico	0.0%	2.2%	1.5%	1.1%	0.8%	1.2%	-48%
New York	7.6%	15.0%	13.8%	12.8%	12.1%	11.3%	49%
North Carolina	7.1%	12.9%	11.5%	12.1%	10.7%	8.1%	14%
North Dakota	0.0%	0.0%	0.0%	0.4%	0.4%	0.6%	13648%
Ohio	1.7%	9.1%	8.4%	12.3%	9.8%	10.5%	509%
Oklahoma	1.3%	2.0%	2.0%	2.1%	1.9%	2.0%	57%
Oregon	1.0%	2.0%	1.9%	2.1%	2.0%	1.7%	79%
Pennsylvania	9.8%	15.7%	16.6%	13.5%	12.6%	8.2%	-17%
Rhode Island	13.0%	10.2%	11.5%	11.6%	16.8%	7.8%	-40%
South Carolina	16.5%	27.4%	25.0%	22.8%	21.3%	21.0%	27%
South Dakota	0.0%	0.0%	0.0%	0.1%	0.3%	0.5%	13571%
Tennessee	0.0%	17.2%	15.6%	3.9%	0.0%	0.0%	-100%
Texas	5.1%	23.4%	20.4%	17.8%	16.7%	15.7%	208%
Utah	0.7%	1.0%	0.9%	0.9%	0.8%	0.9%	19%
Vermont	0.7%	8.9%	6.6%	8.6%	8.1%	8.9%	1202%
Virginia	1.0%	9.1%	9.2%	9.4%	6.5%	2.2%	108%
Washington	2.5%	10.3%	11.0%	11.3%	11.0%	11.1%	349%
West Virginia	0.0%	8.5%	9.0%	9.6%	6.5%	4.8%	-44%
Wisconsin	0.2%	0.4%	0.0%	0.5%	0.4%	0.4%	153%
Wyoming	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	-100%
Total - U.S.	5.4%	14.6%	10.8%	12.6%	11.3%	9.4%	72%

* Percentage point changes for the following states were calculated from 1992 to 1996: AK, CT, DE, DC, ID, MD, NM, TN, and WV.

Source: HCFA-64 Annual Report.

Appendix 2
Medicaid DSH Spending (Federal and State) by State, 1989–1997
(expenditures in thousands)

State	1989	1990	1991	1992	1993	1994	1995	1996	1997	% Change 1989–95	% Change 1995–97
Alabama	$301	$194,037	$153,857	$417,458	$417,445	$417,458	$417,458	$417,458	$417,458	138590%	0%
Alaska	42	-	-	15,611	10,757	14,640	20,119	11,925	11,925	47801%	-41%
Arizona	-	-	-	-	91,111	105,751	122,727	112,127	112,127	N/A	-9%
Arkansas	607	1,214	1,277	2,540	2,806	3,036	3,242	2,972	2,972	434%	-8%
California	10,400	11,000	99,240	2,191,451	2,191,451	2,191,451	2,191,435	1,387,755	1,387,755	20971%	-37%
Colorado*	3,000	4,000	51,910	302,014	133,542	286,777	174,495	153,069	153,069	5717%	-12%
Connecticut	1,468	1,500	-	408,933	408,933	408,933	408,933	408,933	408,933	27756%	0%
Delaware	-	-	-	32,902	5,194	5,924	7,069	8,871	8,871	N/A	25%
District of Columbia	-	-	-	4,800	56,366	151,039	46,077	41,235	41,235	N/A	-11%
Florida*	77,700	53,964	71,265	191,400	239,693	286,478	334,183	365,793	365,793	330%	9%
Georgia	946	1,389	50,666	300,528	342,770	382,344	407,344	398,549	398,549	42960%	-2%
Hawaii*	-	-	2,043	40,354	45,844	25,620	-	-	-	N/A	N/A
Idaho	-	-	-	1,410	843	1,819	2,081	2,674	2,674	N/A	28%
Illinois*	5,000	63,314	77,045	313,791	311,860	336,820	405,277	242,120	242,120	8006%	-40%
Indiana	1,345	4,479	19,434	211,570	285,367	217,563	319,708	75,988	75,988	23670%	-76%
Iowa	1,850	1,890	2,206	4,633	5,027	5,497	12,011	3,000	3,000	549%	-75%
Kansas	4,478	34,488	53,897	188,935	188,514	165,149	88,251	60,554	60,554	1871%	-31%
Kentucky	-	280	177,528	264,289	136,763	81,155	196,248	230,799	230,799	N/A	18%
Louisiana*	71,785	119,157	161,172	1,217,636	1,178,886	1,217,636	1,211,429	661,655	661,655	1588%	-45%
Maine	3,258	2,000	45,475	139,209	165,317	165,317	165,317	155,284	155,284	4974%	-6%
Maryland*	17,200	-	-	112,979	119,381	129,543	143,100	159,660	159,660	732%	12%
Massachusetts	200	400	563,000	478,337	489,547	567,128	575,289	553,268	553,268	287545%	-4%
Michigan*	50,300	54,400	493,000	544,282	554,346	617,700	438,024	329,840	302,978	771%	-31%
Minnesota	7,000	8,600	10,740	42,005	33,575	38,119	29,497	56,922	56,922	321%	93%
Mississippi	2,100	2,500	24,049	153,342	152,342	158,379	182,608	212,755	212,755	8596%	17%
Missouri	35,788	41,967	224,580	731,894	703,089	713,003	729,181	698,067	698,067	1938%	-4%
Montana	119	131	129	129	539	259	237	224	224	99%	-6%
Nebraska	244	923	1,021	3,108	7,937	9,766	8,260	6,470	6,470	3285%	-22%
Nevada	358	172	599	71,242	73,559	73,560	73,560	73,560	73,560	20447%	0%
New Hampshire**	-	-	97,000	392,006	392,006	394,966	286,670	41,806	41,806	N/A	-85%
New Jersey	27,200	35,700	138,018	1,094,113	1,105,690	1,129,179	1,200,035	954,117	954,117	4312%	-20%
New Mexico	497	1,004	-	11,839	8,678	7,897	6,745	11,025	11,025	1257%	63%
New York	114,000	-	1,361,950	2,784,477	2,783,988	2,831,864	3,023,869	2,845,074	2,845,074	2553%	-6%
North Carolina	4,934	65,174	149,809	332,440	345,545	389,266	429,275	342,568	342,568	8600%	-20%
North Dakota	15	-	10	10	11	1,155	1,203	1,981	1,981	7920%	65%

State	1989	1990	1991	1992	1993	1994	1995	1996	1997	% Change 1989–95	% Change 1995–97
Ohio	-	-	67,117	451,834	449,090	697,710	629,165	682,393	682,393	N/A	8%
Oklahoma	6,538	3,440	11,921	22,340	23,475	23,568	23,293	25,578	25,578	256%	10%
Oregon	1,454	4,349	7,287	17,312	20,279	25,047	31,413	28,195	28,195	2060%	-10%
Pennsylvania	5,543	6,324	431,244	967,407	967,407	967,407	974,108	644,912	644,912	17474%	-34%
Rhode Island	-	-	83,846	81,264	97,160	94,751	171,465	60,789	60,789	N/A	-65%
South Carolina	17,366	61,928	212,866	439,759	439,759	439,759	438,758	439,759	439,759	2427%	0%
South Dakota*	6	6	7	8	11	264	1,072	1,570	1,570	17774%	46%
Tennessee	69,844	92,834	-	430,611	430,246	107,601	-	-	-	N/A	N/A
Texas	4,596	4,837	214,800	1,513,029	1,513,029	1,513,029	1,513,029	1,512,951	1,512,951	32821%	-0%
Utah	325	897	2,696	4,540	4,454	4,843	4,556	5,584	5,584	1302%	23%
Vermont	-	-	1,450	23,097	18,132	26,662	29,051	33,970	33,970	N/A	17%
Virginia*	4,440	6,634	13,750	147,798	172,200	181,493	137,084	47,412	47,412	2987%	-65%
Washington*	15,470	28,038	37,270	219,720	270,562	307,993	335,562	364,302	364,302	2069%	9%
West Virginia	-	-	-	84,440	121,883	121,883	85,850	60,396	60,396	N/A	-30%
Wisconsin	1,480	1,480	2,797	8,683	9,045	10,687	11,102	9,786	9,786	650%	-12%
Wyoming	-	35	88	88	-	-	-	-	-	N/A	N/A
Total - U.S.	$569,197	$914,485	$5,118,059	$17,413,597	$17,525,456	$18,054,889	$18,046,466	$14,945,695	$14,918,833	3071%	-17%

* Some values for these states were changed from the original source, based on edits mentioned by states in a 1994 survey.

** For New Hampshire in 1993, the state's estimate was used, rather than the HCFA-64. The 1993 level for Louisiana was edited to correspond with its DSH cap.

Source: HCFA-64 Annual Reports.

Appendix 3
Medicaid Intergovernmental Transfer Payments and Provider Taxes Paid by NAPH Member Hospitals, 1996

State	Number of Hospitals	Intergovernmental Transfers (IGT) Made by NAPH Members	Provider Taxes (Tax) Paid by NAPH Members	Total Medicaid DSH Payments to NAPH Members	IGT and Tax as % of Total DSH Payments to NAPH Members
Alabama	1	$60,824,111	$-	$64,325,172	95%
California	14	$708,676,732	$-	$939,876,627	75%
Colorado	1	$56,874,732	$-	$81,542,339	70%
Florida	2	$70,162,400	$11,077,193	$116,245,070	70%
Georgia	1	$89,295,284	$-	$133,552,205	67%
Illinois	3	$414,051,345	$495,352	$503,845,632	82%
Massachusetts	2	$14,400,000	$-	$32,267,698	45%
Michigan	1	$203,802,200	$-	$208,600,000	98%
Minnesota	1	$17,606,284	$2,257,380	$28,690,764	69%
Missouri	1	$26,096,908	$5,465,460	$47,256,243	67%
Nevada	1	$45,408,300	$-	$60,611,076	75%
New York	11	$201,621,946	$35,288,619	$487,655,211	49%
Ohio	1	$39,000,000	$-	$69,905,000	56%
Texas	6	$370,063,916	$-	$554,925,330	67%
Virginia	1	$-	$-	$82,327,205	0%
Washington	1	$28,555,053	$-	$44,555,049	64%
Total	48	$2,346,439,211	$54,584,004	$3,456,180,621	69%

Note on data: Data on IGTs and Provider Taxes represent only those payments made by NAPH member hospitals and do not include similar payments made by other hospitals that are not members of NAPH.

Source: 1996 NAPH Hospital Characteristics Survey Data.

Appendix 4
1998–2002 Medicaid Federal DSH Allotments as Specified by the Balanced Budget Act of 1997

State	FY 95 Federal DSH Spending	FY 98 Federal DSH Allotment	FY 99 Federal DSH Allotment	FY 00 Federal DSH Allotment	FY 01 Federal DSH Allotment	FY 02 Federal DSH Allotment
Alabama	$294,099,162	$293,000,000	$269,000,000	$248,000,000	$246,000,000	$246,000,000
Alaska	10,059,297	10,000,000	10,000,000	10,000,000	9,000,000	9,000,000
Arizona	81,000,000	81,000,000	81,000,000	81,000,000	81,000,000	81,000,000
Arkansas	2,390,975	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
California	1,095,725,498	1,085,000,000	1,068,000,000	986,000,000	931,000,000	877,000,000
Colorado	92,656,961	93,000,000	85,000,000	79,000,000	74,000,000	74,000,000
Connecticut	204,466,500	200,000,000	194,000,000	164,000,000	160,000,000	160,000,000
Delaware	3,534,000	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000
District of Columbia	23,038,685	23,000,000	23,000,000	23,000,000	23,000,000	23,000,000
Florida	188,078,192	207,000,000	203,000,000	197,000,000	188,000,000	160,000,000
Georgia	253,480,909	253,000,000	248,000,000	241,000,000	228,000,000	215,000,000
Hawaii	-	-	-	-	-	-
Idaho	1,459,915	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Illinois	202,638,395	203,000,000	199,000,000	193,000,000	182,000,000	172,000,000
Indiana	200,846,935	201,000,000	197,000,000	191,000,000	181,000,000	171,000,000
Iowa	7,521,445	8,000,000	8,000,000	8,000,000	8,000,000	8,000,000
Kansas	51,979,673	51,000,000	49,000,000	42,000,000	36,000,000	33,000,000
Kentucky	136,549,345	137,000,000	134,000,000	130,000,000	123,000,000	116,000,000
Louisiana	880,103,401	880,000,000	795,000,000	713,000,000	658,000,000	631,000,000
Maine	104,645,661	103,000,000	99,000,000	84,000,000	84,000,000	84,000,000
Maryland	71,549,999	72,000,000	70,000,000	68,000,000	64,000,000	61,000,000
Massachusetts	287,644,500	288,000,000	282,000,000	273,000,000	259,000,000	244,000,000
Michigan	248,973,042	249,000,000	244,000,000	237,000,000	224,000,000	212,000,000
Minnesota	16,008,138	16,000,000	16,000,000	16,000,000	16,000,000	16,000,000
Mississippi	143,493,416	143,000,000	141,000,000	136,000,000	129,000,000	122,000,000
Missouri	436,414,913	436,000,000	423,000,000	379,000,000	379,000,000	379,000,000
Montana	167,855	200,000	200,000	200,000	200,000	200,000
Nebraska	4,989,305	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000
Nevada	36,780,000	37,000,000	37,000,000	37,000,000	37,000,000	37,000,000
New Hampshire	143,334,951	140,000,000	136,000,000	130,000,000	130,000,000	130,000,000
New Jersey	600,017,723	600,000,000	582,000,000	515,000,000	515,000,000	515,000,000
New Mexico	4,944,614	5,000,000	5,000,000	5,000,000	5,000,000	5,000,000
New York	1,511,934,684	1,512,000,000	1,482,000,000	1,436,000,000	1,361,000,000	1,285,000,000
North Carolina	277,783,589	278,000,000	272,000,000	264,000,000	250,000,000	236,000,000
North Dakota	826,823	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Ohio	381,840,065	382,000,000	374,000,000	363,000,000	344,000,000	325,000,000
Oklahoma	16,316,898	16,000,000	16,000,000	16,000,000	16,000,000	16,000,000
Oregon	19,564,545	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000
Pennsylvania	528,648,558	529,000,000	518,000,000	502,000,000	476,000,000	449,000,000
Rhode Island	61,538,966	62,000,000	60,000,000	58,000,000	55,000,000	52,000,000
South Carolina	310,952,672	313,000,000	303,000,000	262,000,000	262,000,000	262,000,000
South Dakota	729,888	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Tennessee	-	-	-	-	-	-
Texas	957,898,654	979,000,000	950,000,000	806,000,000	765,000,000	765,000,000
Utah	3,325,486	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000
Vermont	17,583,937	18,000,000	18,000,000	18,000,000	18,000,000	18,000,000
Virginia	69,599,962	70,000,000	68,000,000	66,000,000	63,000,000	59,000,000
Washington	174,391,703	174,000,000	171,000,000	166,000,000	157,000,000	148,000,000
West Virginia	64,043,840	64,000,000	63,000,000	61,000,000	58,000,000	54,000,000
Wisconsin	6,639,829	7,000,000	7,000,000	7,000,000	7,000,000	7,000,000
Wyoming	-	-	-	-	-	-
Total – U.S.	$10,232,213,504	$10,255,200,000	$9,937,200,000	$9,248,200,000	$8,839,200,000	$8,494,200,000

Source: The Balanced Budget Act of 1997.