

UNTANGLING DSH

A Guide for Community Groups
to Using the Medicaid DSH Program
to Promote Access to Care

Prepared for The Access Project by:
Jocelyn Guyer *Center on Budget and Policy Priorities*
Andy Schneider and Michael O. Spivey *Health Policy Group*

The Access Project is a national initiative of The Robert Wood Johnson Foundation, in partnership with Brandeis University's Heller Graduate School and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve health care and promote universal coverage, with a focus on people who are without insurance.

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If you have any questions or would like to learn more about our work, please contact us.

The Access Project
30 Winter Street, Suite 930
Boston, MA 02108
Phone: 617-654-9911
FAX: 617-654-9922
E-mail: info@accessproject.org
Web site: www.accessproject.org

Catherine M. Dunham, Ed.D.
National Program Director
Mark Rukavina, MBA
Deputy Director for Programs and Policy
Gwen Pritchard, MPA
Deputy Director for Communication and Administration

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Center on Budget and Policy Priorities
820 First Street, N.E., Suite 510
Washington, D.C. 20002
Phone: 202-408-1080

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Untangling DSH: An Overview

by *Cathy Levine, Policy Director*

Universal Health Care Action Network of Ohio

“Untangling DSH: A Guide for Community Groups to Using the Medicaid DSH Program to Promote Access to Care”—the title says it all. If you are interested in getting your state to increase access to healthcare services, you may want to learn more about Disproportionate Share Hospital, or DSH, funds.

DSH was created by Congress in 1981 to compensate hospitals for the added costs of serving a disproportionate share of low-income individuals who either are part of the Medicaid program or have no insurance at all. Generally, a state makes a DSH payment directly to a hospital to help finance the additional cost of serving the special needs of this community. Once the state has made such a DSH payment, the federal government reimburses the state for part of the payment, based on the state’s Medicaid matching rate (*see Table 1*). States spend more than *\$9 billion* a year of federal Medicaid funds on DSH payments. These funds are separate from and in addition to other Medicaid funds that states receive. Section II of this guide, “Basic Questions and Answers about Medicaid and DSH” (pp. 13-17), discusses the Medicaid program and DSH funding in detail.

Because the federal law is so flexible, state DSH programs vary in many ways, such as in how much they spend on DSH and how they distribute DSH funds among hospitals, or whether the federal reimbursement is ultimately distributed to healthcare facilities at all. This guide provides several examples of how states have thus far used DSH funds to increase access to health care. For instance, Tennessee has used its DSH funds to help pay for TennCare, a massive coverage expansion.

Recent changes made to the DSH program in the Balanced Budget Act of 1997 will cause many states to make significant changes to their DSH programs over the next few years (p. 16). *These changes may create opportunities for community groups to direct DSH*

(Note: The parenthetical page numbers refer to the main text of this guide.)

funds toward strategies to improve access to care. In many states, DSH funds *could* pay for initiatives to promote access, such as:

- Supporting local hospitals and other providers that serve the uninsured.
- Inducing hospitals to provide more free or sliding-scale primary care to uninsured people.
- Expanding publicly funded health insurance programs to cover more uninsured people.

How to Determine If DSH Funds Can Be Used to Increase Access to Care in Your State

The potential to use DSH funds to promote access varies dramatically from state to state. *The only way to determine the potential for using the DSH funds in your state is to learn about federal DSH rules and how the DSH funding program works in your state.* Reading this guide is a first step—it is designed to help you understand DSH by explaining the complex federal rules that govern DSH funding, the range of what states may do with DSH funds, and some of the ways DSH can be used to promote access to care. It also describes some of the barriers that community groups may confront in their efforts to use DSH to promote access. Some of these barriers may be harder to overcome than others.

Your state may already have committed its DSH payments to another access expansion. If your state has a Section 1115 waiver, you need to determine the role of DSH funds in that waiver. A Section 1115 waiver is a demonstration project using federal Medicaid funds, usually to implement widespread Medicaid managed care programs or to expand coverage to groups not otherwise covered by Medicaid. *In some (but not all) states where DSH funds play a big role in the Section 1115 waivers, there may not be any realistic opportunity for community groups to influence the state's use of DSH funds.* Table 10 lists states where the availability of DSH funds for further access initiatives are limited because of prior commitments to their use in financing the waiver program. To find out how DSH fits into your state's Section 1115 waiver, contact the state Medicaid agency, state legislative staff, or the federal Health Care Financing Administration (HCFA) project officer for your state's waiver. (See pp. 30-31.)

If a Section 1115 waiver is not a barrier to access in your state, what's next? The next step is to learn more about the DSH program in your state, which may involve some detective work. This guide will give you some basic information and show you where to go for more. (Section V, "Sources of Information about DSH," provides a research guide for community groups.) Here are some initial questions to consider:

- **How significant is DSH as a funding source in your state?** In most states, DSH funds are significant. The tables in the guide provide important data on each state's DSH expenditures: Table 2 shows DSH expenditures as a proportion of Medicaid expenditures for each state, and Table 4 shows each state's total spending on DSH payments in fiscal years 1994–1998. However, note that the amount of DSH funds per uninsured person varies dramatically from state to state, as shown in Table 3.

- **What are some signs that community groups should look for in determining whether a state may not be taking full advantage of DSH to promote access to care?** Even with the federal restrictions on DSH programs, states still have broad flexibility to design their DSH programs. Here are some of the indicators (the full list is on pp. 33-35) that may provide community groups with direction for action:
 - **More than 10 percent of Medicaid spending is attributable to DSH.** More than 10 percent indicates that a state has significant DSH resources. But even if a state is below 10 percent, DSH money may still be available for improving access to care.
 - **A state has not used all DSH funds available to it.** Each state has an annual allotment of federal funds available for DSH reimbursement; many states do not take advantage of their full allotments, perhaps because they do not want to invest the necessary state matching funds. (See Tables 7 and 8.) *Considerable potential may exist in states using less than their full allotment to use DSH to promote access.* An additional opportunity comes from the tobacco settlement funds coming to most states, which could be used to draw down federal DSH (p. 34).
 - **There is a significant diversion of DSH payments to general revenues.** Many states use federal DSH funds to supplement general revenues, instead of paying them to DSH facilities or using them for other health purposes. This is done through creative financing arrangements, both to fund the state share of DSH and to use federal dollars for other than their intended purpose. One common such use involves payments to state-owned mental health facilities (pp. 23-24). If a state uses its DSH funds on state mental health facilities it saves the state from having to use general revenues to pay for these facilities—but then DSH funds don't go to help the uninsured. Table 9 shows how much of each state's DSH spending in fiscal year 1998 went to such facilities. The state-specific limits on how much federal DSH money may go to mental health facilities averages 23 percent in fiscal year 2000, and will be further restricted in the future. *These limits on mental health facility spending will force some states to modify their DSH programs, creating opportunities for community groups to have some input on how the DSH funds are to be used.* Other restrictions on how states may raise their share of DSH funds are described on pages 24-25.
- **Are the true “safety net” institutions in the state receiving adequate DSH payments?** Another good starting point for community groups in evaluating their state's use of DSH funds is to identify which hospitals receive DSH payments. Are DSH funds going to the hospitals that provide the most care to the uninsured and Medicaid beneficiaries? This guide tells how to find out what hospitals are part of the state DSH program and how to determine the adequacy of payments to true safety-net institutions (p. 35).
- **Could the hospitals in the state be doing more to meet access goals as a condition of receiving DSH payments?** Under federal law, states can impose performance standards on hospitals as a condition of receiving DSH funds. See page 36

for some of the conditions that community groups may want to press for. (Also see the case study on Georgia in Section VI.)

- **Could the state be using DSH funds to expand Medicaid or other public health insurance programs to cover more of the uninsured?** Because creative financing with DSH funds is still legal, states can divert these funds into general revenues. *If community groups identify the practice of creative financing and amount of funds involved, they may be able to make the case that these funds should be invested in increasing health care access.* For instance, some states have already used DSH funds to finance expansions of coverage under Section 1115 waivers (p. 36).

Medicaid DSH Funds and Access to Care: Three Case Studies

Section VI of this guide examines how three states—Texas, Georgia, and New Jersey—have approached the access issue in their DSH programs. Each case study offers important lessons on how states vary in their approaches to using DSH funds to promote health care access, the variety of strategies available, and how DSH programs operate.

- **Texas** has not adopted any policies to promote access using DSH funds. Instead, its program maximizes payments to state-owned institutions.
- **Georgia** is one of the few states that actively attempted to use DSH funds to induce hospitals to serve the uninsured and to provide primary care to low-income patients. *Both community groups and the media played roles in getting the state to impose additional requirements on how DSH funds are used.* Both the conditions placed on the hospitals for receiving DSH payments in Georgia and suggestions for improving Georgia’s DSH program are discussed in this section.
- **New Jersey** received a Section 1115 waiver in February 1998, allowing it to use DSH funds to develop hospital-based managed care networks for the uninsured; however, it has never been implemented because of resistance from hospitals that objected to the potential added costs of financing uninsured patients’ outpatient care, as well as their hospitalizations. This is another important lesson for community groups.

Given that the number of uninsured in the United States continues to rise and that sources of funds for health access initiatives are scarce, DSH funds are simply too valuable a resource to ignore. We hope that “Untangling DSH” will help community groups determine whether DSH funds can be redirected to improve healthcare access in your state.

Introduction

ANNUALLY, STATES SPEND MORE than \$9 billion of federal Medicaid funds on Disproportionate Share Hospital, or DSH, payments. In many states, these DSH funds are a potentially significant source of funding for healthcare access initiatives. Among other things, the funds can be used to provide support to safety net institutions that serve the uninsured and Medicaid beneficiaries, to encourage hospitals to provide primary and preventive care in community-based settings, and to expand publicly funded health insurance programs. The uninsured who can be helped with DSH funds include people who are ineligible for the regular Medicaid program, such as most low-income adults without children and people barred from Medicaid coverage due to their immigration status.

However, the complexity of DSH rules and the lack of public accountability over how DSH funds are spent has often made it difficult for community groups and others to evaluate how their states use DSH funds and to participate in the decision-making process regarding how they should be used.

The purpose of this guide is to help community groups understand the DSH system and to learn what steps they might take to assess whether their states could be doing more to use DSH funds to meet access goals.

Examples of How DSH Funds Could Be Used to Promote Access

- To support safety net institutions that serve a large number of uninsured people and Medicaid beneficiaries.
- To encourage hospitals to provide primary and preventative care in community-based settings.
- To expand publicly funded health insurance programs to cover more uninsured people.

Why is it important for community groups to understand the Medicaid DSH program?

In many states the Medicaid DSH program represents one of the most significant sources of federal funding to support health care for the uninsured and Medicaid beneficiaries. The federal government is expected to spend more than \$9 billion on the DSH program in fiscal year 2000, an amount that far exceeds what it will spend on the new Children's Health Insurance Program and on community health centers combined. In addition, states have broad flexibility to design their Medicaid DSH programs, creating opportunities for community groups to make a difference in how DSH funds are used. Some examples of how DSH funds could be used to promote access to care for the uninsured and Medicaid beneficiaries:

- **To support safety net institutions that serve a large number of uninsured people and Medicaid beneficiaries.** Hospitals that serve a large number of Medicaid and uninsured patients need DSH payments because Medicaid reimbursement rates are low and because they typically receive little or no reimbursement for the costs that they incur on behalf of uninsured patients. However, not all states use their full share of DSH funds for this purpose. Community groups could work to ensure that hospitals that do provide the most care to the uninsured and to Medicaid beneficiaries are awarded DSH payments, and that the size of their DSH payments reflect the extent to which they provide the uninsured and other low-income patients with access to care.

- **To encourage hospitals to provide primary and preventive care in community-based settings.** States have the option to impose performance standards on hospitals as a condition of receiving DSH funds. Community groups could explore whether their states would be willing to make DSH payments only to hospitals that meet criteria designed to further access goals. For example, hospitals could be asked to meet one or more of the following requirements as a condition of receiving DSH payments:

- The hospital must have an "open door" policy under which it treats all individuals without regard to ability to pay, according to a sliding fee scale.
- The facility must deliver a minimum amount of uncompensated care to uninsured individuals.
- The physicians with admitting privileges at the facility must accept Medicaid patients on an outpatient as well as an inpatient basis.
- Prescription drugs must be made available to clinic patients.

An Example: GEORGIA

Georgia has decided to require hospitals that receive DSH funds to meet a number of conditions designed to improve access, including:

- They must provide a minimum amount of free care or low-cost care to people with incomes below 185 percent of the poverty level.
- They must use at least 15 percent of the amount that they receive from the state in DSH payments to provide primary care to low-income patients.
- See Section VI for details.

- **To expand publicly funded health insurance programs to cover more uninsured people.** One of the most basic ways to promote access is to adopt initiatives that provide more people with health insurance coverage, such as through a Medicaid expansion or through creation of another publicly funded health insurance program that can serve people who are ineligible for Medicaid. Some states have found ways to use their federal DSH funds to help pay for the cost of establishing or expanding health insurance programs for low-income people.

Is there much potential to use DSH funds to promote access in my state?

This guide describes the federal rules that govern DSH funding and provides general information on how DSH funds could be used to promote access to care. But it is important to highlight that the potential to use DSH funds to promote access initiatives varies dramatically from state to state. In some states the amount of DSH funding that is available for initiatives of any sort is minimal. For example, Wyoming historically has not made use of the DSH program and it now is slated to receive only \$100,000 a year in DSH funds. Even in states with significant DSH programs, there may be strong political resistance from the facilities that receive DSH funds to efforts made by community groups to influence how these funds are used. However, in other states, facilities that do serve large numbers of uninsured people and Medicaid beneficiaries might welcome the efforts of community groups to ensure that DSH funds are better targeted.

An Example: NEW YORK

New York has received a special waiver from the federal government that allows it to use DSH funds to help pay for some of the cost of providing healthcare coverage to the state's Home Relief population, a group that includes childless low-income adults who are otherwise largely ineligible for Medicaid.

Since there are a number of factors that affect the potential to use DSH funds for access initiatives in any given state, this guide does not point to specific states in which the potential is the greatest. However, whenever possible, the guide provides state-specific information designed to help community groups evaluate the size of the potential to use DSH funds for access initiatives in their states. Section IV offers suggestions on how community groups could evaluate the potential to use DSH

funds to improve access in their individual states.

How does this guide work?

Section II of this guide answers some basic questions about the Medicaid program and DSH funding. Section III reviews the federal laws and regulations that govern how states can use their DSH funds, highlighting those areas in which the federal government has given states broad flexibility to design their DSH programs. In Section IV some of the ways in which DSH funds could be used to improve access to care are described, and in Section V sources of information about DSH programs are given. Finally, Section VI offers specific examples of how DSH programs work and highlights the kinds of questions that community groups should ask in order to assess whether their states could be doing more with DSH funds to promote access. This section concludes with case studies of the DSH programs in Texas, Georgia, and New Jersey.



Basic Questions and Answers about Medicaid and DSH

What is the Medicaid program?

Medicaid is the nation's largest public health insurance program for low-income families with children, the elderly, and disabled people. In federal fiscal year 2000, the program is expected to cover 42.9 million people at a cost to the federal government of \$116.6 billion. (States are expected to spend an additional \$88 billion.) As part of the Medicaid program, the federal government is expected to provide states with \$9.2 billion in federal funds for payments to hospitals that serve a disproportionately large number of uninsured people and Medicaid beneficiaries.

The federal government and the states share responsibility for financing and, to some extent, for setting the rules that govern the Medicaid program. The federal government establishes minimum requirements for states' Medicaid programs, including requirements to cover certain groups of people and to provide certain benefits. Beyond these minimum requirements, states have broad flexibility to determine how they will operate their Medicaid programs.

Who pays for the Medicaid program?

The federal government pays for anywhere from 50 to 77 percent of the cost of providing benefits under each state's Medicaid program, with the exact proportion determined by a state's Medicaid matching rate or Federal Medical Assistance Percentages (FMAP). For example, the matching rate in Georgia is 60 percent, thus the federal government pays to Georgia 60 percent of the cost of providing Medicaid benefits, while the state pays the remaining 40 percent of costs. The matching rate for each state is determined annually by a formula that provides a higher rate to states with

relatively high per capita income and a lower rate to states with relatively low per capita income. (See Table 1 for states' fiscal year 2000 matching rates). In addition, the federal government and the states each pay 50 percent of the administrative costs associated with operating a Medicaid program.

What is the Disproportionate Share Hospital program?

The Disproportionate Share Hospital, or DSH, program was created in 1981 by Congress in the Omnibus Budget Reconciliation Act of 1981. It was intended to support hospitals serving large numbers of Medicaid beneficiaries and uninsured patients in light of other changes that were occurring in the Medicaid program.

Prior to 1981, states were required to pay hospitals the same rates for Medicaid patients as the federal government paid hospitals for Medicare patients. When Congress enacted the Omnibus Budget Reconciliation Act of 1981, it included a provision that for the first time gave states the flexibility to develop Medicaid reimbursement systems for inpatient hospital services that differed from Medicare's. This provision created a concern that many states would use this new flexibility to cut Medicaid payment rates, making it difficult for hospitals serving large numbers of Medicaid and uninsured patients to make ends meet. In response, Congress also included in the Omnibus Budget Reconciliation Act of 1981 a requirement that states "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" by making "additional" Medicaid payments to those facilities. The requirement to make additional payments to hospitals serving disproportionate numbers of Medicaid and uninsured patients came to be known as the "DSH payment system" or "DSH program."

How does the DSH program work?

Generally, a state makes a "DSH payment" to a hospital that helps it to finance the cost of providing care to uninsured people and Medicaid beneficiaries. After the state makes the DSH payment, the federal government will reimburse the state for part of the cost of this payment, the exact portion of which depends on the state's Medicaid matching rate. For example, consider a state with a Medicaid matching rate of 50 percent. Such a state could make a \$100,000 DSH payment to a hospital to help it cover the costs associated with providing care to uninsured individuals and Medicaid patients. The federal government then would reimburse it for \$50,000 of the \$100,000 payment.

However, federal law accords states broad flexibility to design their DSH programs as they like; consequently, there is much variation in how each state operates its program. Key areas in which state operations vary are found in:

- How much they spend on their DSH program.
- How they determine which hospitals will receive DSH payments.
- How they divide payments among eligible facilities.
- How they determine the size of DSH payments.

- Whether they impose conditions on those hospitals that receive DSH payments.

Another area in which states' DSH programs vary dramatically is in the extent to which they rely on creative financing arrangements. These arrangements, which are explained in detail in the following pages, have been used by some states to divert federal DSH funds into their general treasury. Once DSH funds become part of a state's general treasury, they can be used to finance health access initiatives other than payments to hospitals, as well as other state spending priorities that may have little to do with supporting health care access. States began developing these creative financing arrangements in the mid-1980s, leading to a dramatic growth in federal Medicaid spending in the early 1990s. In response to states' behavior, over the years Congress has imposed a number of restrictions on how states finance their share of the DSH program and how they use federal DSH funds. Although these federal restrictions have limited the rate of growth in federal DSH spending and curtailed the use of creative financing arrangements, states continue to have significant flexibility to design their DSH payment systems as they see fit.

How significant is DSH as a funding source?

In most states, Medicaid DSH funds represent a nontrivial portion of the resources available to support health care access for low-income people. Nationally, the Congressional Budget Office (CBO) estimates that the federal government will spend \$9.2 billion on Medicaid DSH in fiscal year 2000. On average, DSH spending is expected to represent about 8 percent of all Medicaid spending in the United States in fiscal year 2000, although there is significant variation across states. (Table 2 provides state-specific data on actual DSH spending as a proportion of total Medicaid spending in recent years.)

To give some sense of the potential significance of DSH resources relative to other sources of federal funding for increasing access to health care among low-income people, compare the level of federal DSH funds to the amount of federal funds available under the Child Health Insurance Program (CHIP) created by the Balanced Budget Act of 1997 (BBA). CBO has estimated that the federal government will spend more than four times as much on Medicaid DSH in fiscal year 2000 as on CHIP. Over the next five years, it estimates that the federal government will spend \$43.9 billion on Medicaid DSH compared to \$17 billion on CHIP, or more than two and a half times as much. Similarly, in fiscal year 2000, federal spending on health centers is slated to be a little more than \$1 billion, an amount that represents only about 11 percent of the \$9.2 billion in federal funds that is expected to be spent on the DSH program.

Although federal DSH funding is substantial, the extent to which DSH is a significant resource varies dramatically by state. For reasons largely having to do with the political evolution of the DSH program, federal DSH funds are not distributed equitably among the states. For example, in fiscal year 2000, the amount of federal Medicaid funds available per uninsured individual will average some \$214 nationally, but on a state-by-state basis it will range from \$1 per person in Wyoming to over \$1,000 per person in New Hampshire. (See Table 3 for state-specific numbers.)

How do recent federal changes to the DSH program affect its potential to increase access?

In the latest phase of the DSH program's development, the Balanced Budget Act of 1997 reduced the amount of federal DSH funds available to the states. Largely as a result of the BBA, the CBO is projecting that between fiscal year 2000 and fiscal year 2004, federal DSH spending will decline at an average annual rate of 1 percent per year while the rest of the Medicaid program will grow about 6 percent per year over this same period. The BBA also includes other provisions—most notably new restrictions on the portion of DSH funds that can be spent on state mental hospitals—designed to reduce the extent to which states divert federal DSH funds to their general revenues. These provisions will force a number of states to redesign their DSH programs, either by redirecting DSH payments to facilities other than state mental hospitals or by reducing overall DSH payments.

Taken together, the BBA changes will cause many states to make significant changes to their DSH programs over the next few years. These changes could create opportunities for community groups to ensure that Medicaid DSH funds are used in ways that improve access to care. At the same time, these changes could also cause conflicts among providers vying for their share of the shrinking pool of DSH funds, making it a particularly difficult time for community groups to lay claim to DSH funds.

What is meant by promoting access?

When evaluating whether their states' DSH funds could more effectively be used to promote access to care, community groups will first need to decide which access issues they want to address. What kind of care do they want to promote? For whom do they want to promote access? Do they want to promote access by providing support to the institutions that serve the uninsured and Medicaid beneficiaries or by providing individuals with insurance coverage? In the context of DSH funding, promoting access can encompass a number of different approaches:

- **Supporting safety net institutions.** DSH funds usually are thought of as promoting access by providing financial support to hospitals that serve a large number of Medicaid and uninsured patients. DSH payments are needed by these facilities because Medicaid programs often do not reimburse hospitals at levels high enough to cover the costs that they incur when serving Medicaid beneficiaries. The BBA's repeal of the so-called Boren amendment, which required that Medicaid payment rates for inpatient hospital services be "reasonable and adequate," may further exacerbate this problem. At the same time, these safety net institutions may receive little or no reimbursement for the costs that they incur on behalf of uninsured patients who use their facilities when they have nowhere else to go for care. By using DSH funds to support these institutions, states can help to promote access to care by the uninsured, as well as by Medicaid beneficiaries.
- **Providing nonemergency services directly to the uninsured.** The uninsured generally have an easier time securing emergency services than nonemergency services, such as primary and preventive care visits. This is partly because federal law

requires hospitals participating in Medicare—which includes virtually all hospitals in the United States—to guarantee all individuals access to emergency services, regardless of their ability to pay.¹ Although hospitals do not always comply with these antidumping requirements, the requirements do mean that uninsured people are more likely to be in need of nonemergency services.² DSH funds can be used to promote access to nonemergency services for the uninsured in the inpatient or outpatient setting, or both. For example, DSH funds could be used by hospitals to support inpatient services and to provide primary care services, specialty care services, and dental services in community clinics or other outpatient settings. DSH funds also could be used to support prescription drug services provided through hospital clinics.

- **Ensuring that Medicaid beneficiaries have access to providers.** By definition, Medicaid beneficiaries have a source of payment for needed hospital, physician, and other basic health services. Enrollment in Medicaid, however, does not guarantee that a beneficiary can obtain the services that Medicaid covers. In urban areas, there may be a shortage of primary care providers or specialists willing to treat Medicaid patients. In such circumstances, Medicaid DSH funds can potentially be used to encourage (or require) DSH hospitals to make the primary care or specialist physicians who use the hospital's facilities accept Medicaid patients. In rural areas, there may be a shortage of providers of any kind, much less providers willing to accept Medicaid patients. Medicaid DSH funds can potentially be used to upgrade the financial stability of rural hospitals or to encourage (or require) urban DSH hospitals to develop rural physician or clinic networks.
- **Expanding insurance coverage.** One of the most basic ways to promote access is to adopt initiatives that provide more people with health insurance coverage such as through a Medicaid expansion or through creation of another publicly funded health insurance program that can serve people who are ineligible for Medicaid. Some states have found ways to use their federal DSH funds to expand Medicaid to a broader group of low-income people.

1. Section 1867 of the Social Security Act, 42 U.S.C. §1395dd, requires that each participating hospital with an emergency department screen any individuals who present themselves and, if the individual has an emergency medical condition, provide the treatment necessary to stabilize the condition.

2. Negligent violation of the antidumping provisions by a hospital or by a responsible physician is subject to a civil money penalty of up to \$50,000 per violation, §1867(d) of the Social Security Act, 42 U.S.C. §1395dd(d). The antidumping provisions are enforced by the Inspector General of the Department of Health and Human Services. To file complaints, consumers can call 1-800-447-8477 or send e-mail to HTIPS@os.dbhs.gov. For further information, see the Patient Dumping Advisory Bulletin available at www.os.dbhs.gov/org.



Federal Rules Governing How DSH Funds Can Be Used

STATES HAVE BROAD FLEXIBILITY to decide what to do with their DSH funds within some parameters imposed by federal law and regulation. Many of the federal restrictions on how DSH funds can be used were imposed by Congress in the early 1990s in response to a growing practice among states of using creative financing arrangements. States used these creative financing arrangements to fund the state share of their DSH programs and, in some cases, diverted DSH funds from hospitals, instead spending them on state initiatives that were not always related to health care. In response to these practices, new laws were enacted by Congress placing additional restrictions on how states can use their DSH funds.

The restrictions imposed by federal law on the allowable uses of DSH funds are described in the following questions and answers. They affect how much states can spend on their DSH programs, the size of the DSH payments that can be made to individual facilities, and how states raise the state dollars that are used to bring in federal Medicaid matching funds for DSH payments.³

Who finances the cost of making DSH payments?

As with other kinds of Medicaid spending on benefits and services, the federal government and the states are supposed to share the cost of financing DSH payments to hospitals. When a state makes a DSH payment to a hospital, the federal government reimburses the state for 50 to 77 percent of the cost of this payment, with the exact portion depending on the state's matching rate (see Table 1 for states' fiscal year 2000 matching rates).

3. This section summarizes the basic elements of current DSH law, reflecting the amendments made by the Balanced Budget Act of 1997. For more detail on that legislation, see Andy Schneider, Stephen Cha, and Sam Elkin, Center on Budget and Policy Priorities, *Overview of Medicaid DSH Provisions in the Balanced Budget Act of 1997*, September 3, 1997.

The premise underlying Medicaid's matching rate system is that both the federal government and the states will contribute to the cost of financing Medicaid expenditures. In the case of DSH spending, this premise has often been undercut by the use of the creative financing arrangements, which have allowed states to reduce the amount of money that they contribute to DSH payments out of their own general treasuries and, in some cases, to effectively avoid using any of their own funds for DSH payments.

What are creative financing arrangements and why is it important to understand them?

Many of the federal restrictions and limits imposed on how states can operate their DSH programs were enacted in response to some states' use of creative financing arrangements. These allowed states to avoid funding some or all of the state share of Medicaid DSH payments, and in some cases allowed states to use federal Medicaid funds to finance activities that normally would be paid for out of a state's general revenue fund. Without a basic sense of how these creative financing schemes operated, it may be difficult to understand the purpose of many of the federal DSH regulations described in the following questions and answers.

Under the original version of the creative financing arrangements, some states asked or required hospitals to make "donations" or pay "taxes" to finance the state share of Medicaid DSH payments. The states then made DSH payments to these same hospitals in order to reimburse them for their donations or taxes. Since the federal government matches states' spending on DSH payments, the federal government financed 50 percent or more (depending on a state's matching rate) of the cost of reimbursing the hospitals for their donations or tax payments. States could use the federal funds that came in to reimburse the state for the federal share of DSH payments, to make additional DSH payments to the hospitals, or for other spending priorities.

For example, a state with a federal Medicaid matching rate of 50 percent could ask for a donation of \$100 million from its hospitals, then return the donation to them in the form of \$100 million in DSH payments, leaving the hospitals no worse off and no better off. Since the federal government reimburses the state for half of the state's Medicaid expenditures on DSH, the state would have received \$50 million from the federal government for this transaction. The \$50 million that the state received from the federal government in Medicaid matching funds could be passed along to the hospitals in the form of DSH payments that more than offset their original contributions, leaving them better off. Alternatively, the state could have elected to use the \$50 million to build roads, to finance stadiums, or for any other purpose.

Under these arrangements, hospitals were at least held harmless because whatever donations they made or taxes they paid were returned to them in the form of DSH payments. States clearly fared well because they could make DSH payments to hospitals without contributing any of their own funds and, in some cases, they retained a portion of the federal matching funds that such arrangements brought into the state for their own purposes. On the other hand, these arrangements put the federal

government in the position of financing the full cost of DSH payments to hospitals and, in some cases, of seeing federal Medicaid funds re-directed to state spending unrelated to health care.

Although it took a number of states several years to adopt the use of these controversial creative financing arrangements, by the late eighties and early nineties they had sparked an explosion in federal Medicaid DSH spending. Between 1989 and 1993, federal and state spending on DSH grew from less than a million dollars to over \$16 billion. The rapid growth in federal DSH costs spurred Congress in 1991 to enact the first in a series of laws that imposed new restrictions on how states could operate their DSH programs. The restrictions included in the 1991 legislation, as well as in succeeding laws, are described in some of the following questions and answers. Although the additional restrictions have done much to limit the extent to which states use creative financing schemes, they are still in effect in a modified form in some states.

Is there a minimum amount that states must spend on DSH payments?

Under DSH, states are required to “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.” Therefore, all states should make additional payments to hospitals serving a disproportionate number of uninsured people and Medicaid beneficiaries. However, there is no federally specified minimum amount of Medicaid DSH payments each state must make and a few states make very small or even no DSH payments. (See Table 4 for state-specific information on DSH spending in recent years.)

Are there any upper limits on how much states can spend on DSH payments?

Yes. Although the federal government generally offers states open-ended access to federal matching funds for the cost of operating their Medicaid programs, Congress has enacted a series of laws that limit the amount states can spend on DSH payments. These restrictions take three forms:

- The total amount of federal Medicaid funds available for DSH payments in each state.
- The total amount of federal Medicaid funds available for DSH payments to mental health facilities.
- The maximum size of the DSH payment that a state can make to any individual facility.

What is the maximum total amount that each state can spend on federal DSH payments?

Each state faces a different limit—or aggregate cap—on the federal DSH funds it can spend during any given fiscal year. These caps, also known as federal DSH allotments, set an upper limit on how much federal Medicaid money a state can spend in total on

DSH payments. The DSH allotments for each state, which are shown in Table 5, were adopted by Congress in 1997 and are set forth in federal statute for fiscal years 1998 through 2002. After fiscal year 2002, states with relatively small allotments—as measured by whether their DSH allotments account for less than 12 percent of their total federal Medicaid spending—will have their allotments increased at the rate of inflation. States with larger DSH allotments—as measured by whether their DSH allotments account for more than 12 percent of their total federal Medicaid spending—will not receive any increase in the size of their allotments.

Is there anything that prevents a state from using its own funds to make additional payments to safety net hospitals?

No. The DSH allotments impose an upper limit on how much *federal* money is available to match state spending on DSH payments to hospitals. States, of course, are free to spend as much as they like on making additional payments to hospitals. However, once a state has used up its federal DSH allotment, state spending on DSH payments to hospitals will not be matched by federal Medicaid funds.

How did Congress come up with the aggregate cap for each state?

Congress first imposed aggregate caps on federal DSH spending for each state when it passed legislation in 1991 intended to curb the use of creative financing arrangements and slow down the explosive growth in Medicaid spending on DSH payments. The original state-specific caps—which took effect in fiscal year 1993—were based largely on a state’s historical spending on DSH, although states with low DSH spending were given some room to increase their DSH expenditures above historical levels.⁴

Congress revised the caps in the Balanced Budget Act of 1997 to further reduce federal Medicaid spending on DSH payments. In this case, Congress did not use a formula to establish the revised aggregate cap on DSH spending for each state. Instead, it simply wrote each state’s aggregate caps for fiscal years 1998 through 2002 into statute.

The most striking aspect of the process used by Congress to establish the aggregate caps is that they are not based on any measure of the need for DSH payments in the states. Instead, the caps primarily reflect states’ historical spending on DSH payments. Since these in turn often reflect the extent to which a state took advantage of creative financing arrangements, there is little relationship between the size of a state’s cap and the degree to which people in the state are unable to pay for their health care needs.

4. Under the original version of the state-specific caps, high DSH states (defined as states whose DSH spending exceeded 12 percent of total Medicaid spending) were limited to spending the same level of federal DSH funds as they had spent in the previous year. Low DSH states were limited to spending an amount based on what they had spent in the previous year, adjusted by a growth factor (determined by the rate of growth in the state’s overall Medicaid spending) and a supplemental amount designed to redistribute DSH funds once aggregate DSH spending was constrained to 12 percent of total Medicaid spending.

What is the maximum amount of DSH funds that can be paid to mental health facilities?

In addition to the aggregate cap, each state also faces a separate limit—known as the mental health cap—on how much it can receive in federal Medicaid matching funds for DSH payments to institutions for mental diseases (IMDs) and other mental health facilities. (IMDs are hospitals or other facilities of more than 16 beds “primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.”⁵) Table 6 shows the mental health cap for each state for fiscal year 2000. In the aggregate, states can spend no more than \$2.1 billion on mental health facilities in fiscal year 2000, an amount that represents 23 percent of the total of \$9.3 billion in federal DSH matching funds available to all states in FY 2000.⁶ In later years, federal law will further restrict the extent to which states can use DSH funds for payments to IMDs.

Why did Congress impose the mental health cap?

Like the aggregate spending caps, the mental health spending caps were designed to limit the extent to which states can use creative financing arrangements to divert federal DSH funds from their intended purpose to other spending priorities. When legislation enacted in the early 1990s began to limit the extent to which states could use the traditional version of creative financing arrangements, states revised the arrangements to conform to the new laws. In the early 1990s, many states recognized that by making significant payments to IMDs, they could reduce the need to invest their own funds in long-term, institutional mental health care. This strategy freed up states’ revenues for investment in other areas.

The use of DSH payments to support IMDs was controversial because states historically have had responsibility for financing the cost of institutional mental health care. In an effort to prevent federal financing of these facilities, the Medicaid statute has, since its enactment, specifically prohibited states from using Medicaid to pay for the cost of providing services to individuals between the ages of 19 and 64 who are residing in IMDs. However, DSH payments to IMDs gave states a way of supporting IMDs with federal Medicaid funds without directly violating this prohibition.

While not all of the states made DSH payments to IMDs, a General Accounting Office study of six states found that some of them were using the vast majority of their own DSH funds to make payments to IMDs.⁷ For example, the state of Kansas spent 89 percent of its DSH funds on mental health facilities. In response to this report and other accounts of states using federal Medicaid DSH funds to support their IMDs, Congress enacted the mental health caps in the Balanced Budget Act of 1997.

5. 42 U.S.C. §1396(d)(i).

6. 63 *Fed. Reg.* 54142-54148 (October 8, 1998). Note that the references in this paper to states spending \$9.2 billion on DSH in fiscal year 2000 refer to the amount the Congressional Budget Office actually expects states to spend, not the total amount available.

7. General Accounting Office, *Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals*, Letter Report, January 1998, HEHS-98-52.

Why is there such wide variation in the extent to which states are allowed to use their DSH funds for mental health facilities?

Like the aggregate spending caps, the mental health spending caps imposed on each state reflect past state DSH spending patterns. For example, Alaska is allowed to spend 88 percent of its DSH funds on payments to mental health facilities in fiscal year 1999 while Iowa is not allowed to spend any. In this case, Congress did use a formula to determine the size of each state's mental health cap, but the formula is based in large part on the extent to which a state used its DSH funds for mental health facilities in fiscal year 1995, at least initially.⁸ In many states, the fiscal year 1995 spending level on mental health facilities often reflects the extent to which a state elected to use creative financing arrangements when making DSH payments. As a result, the mental health caps generally do not reflect any obvious correlation with the need within a state for DSH funds for IMDs.

Are there restrictions on how states raise their share of DSH funds?

Under the matching rate system used to finance Medicaid, states must use their own funds to cover between 23 percent and 50 percent of Medicaid costs, including DSH payments to hospitals. Over the years, Congress has imposed a number of restrictions on how states raise their share of Medicaid matching funds, largely in order to reduce the extent to which states use creative financing arrangements to avoid making real contributions to Medicaid spending. The restrictions affect both the extent to which states can accept donations for their share of Medicaid spending, as well as the kinds of taxes that states are allowed to use to raise their share of Medicaid funds. They are designed to ensure that providers or other entities making donations or paying taxes are not held harmless for their payments through DSH payments or other means.

■ **Donations.** States cannot use donations to help finance their share of Medicaid costs unless they are “bona fide donations.” A bona fide donation is one that does not have a direct or indirect relationship with Medicaid payments to that provider, to a class of providers, or to a related entity. For example, a state could not use donations from acute care hospitals that participate in the Medicaid program, or from an association of such hospitals, for its share of Medicaid spending. The only exception is that hospitals, clinics, and other similar entities are allowed to make donations that are used to finance the direct costs associated with hiring people to determine Medicaid eligibility and conduct outreach at these various sites. These outreach and eligibility-related donations are considered bona fide donations and so can be used to draw down federal Medicaid matching funds.⁹

8. The statutory formula for calculating the mental health DSH caps is ambiguous and subject to varying interpretations. (See Schneider, Cha, Elkin, 1997) In promulgating the dollar limits for each state, HCFA adopted the interpretation that gave states the greatest latitude to make DSH payments to IMDs. *Federal Register*, volume 63, number 175.

9. Note, however, that outreach and eligibility-related donations cannot exceed 10 percent of administrative spending in a state

- **Restrictions on healthcare related taxes.** States also face special restrictions on the kinds of healthcare related taxes that they can use to raise state matching funds, although they otherwise have broad flexibility to finance their share of Medicaid costs through whatever revenue streams they deem appropriate. A healthcare related tax is any tax that imposes 85 percent or more of its burden on healthcare providers. If a tax meets this standard, then it may be used as the state share of Medicaid costs only if:
 - The tax is “broad based” (e.g., it must apply to at least all nonfederal, non-public providers in a class, such as hospitals or nursing homes, and it must be imposed uniformly on every provider in the class) and;
 - The state (or a locality) has not adopted a system under which it provides a payment that holds the provider harmless for any portion of the cost of the tax (e.g., a state cannot impose a tax on all hospitals in the state, but then make DSH payments to these hospitals that offset the impact of the tax).
- **Intergovernmental transfers.** When the restrictions on provider taxes and donations went into effect in the early 1990s, many states responded by shifting the source of the state share of DSH payments to intergovernmental transfers. The shift occurred because states can still use public funds for their share of Medicaid spending that have been transferred from other jurisdictions or public entities within a state (e.g., counties, public hospital districts, individual state-owned facilities).¹⁰ Moreover, federal law does not prohibit states from holding contributing state agencies, counties, or other public entities harmless by returning all of their transferred revenues back to them in the form of federal Medicaid DSH payments. (As discussed below, state and local hospitals are now subject to hospital-specific caps on the total amount of Medicaid DSH payments they can receive.)

For example, a state with a 50 percent matching rate could ask a hospital district (a public entity with taxing authority) to transfer \$10 million to the state, and then transfer the \$10 million back to the hospital district in the form of a DSH payment. The hospital district is no better and no worse off as a result of the transaction. The state, however, can receive reimbursement from the federal government for 50 percent of the cost of its DSH payment, allowing it effectively to capture \$5 million in federal Medicaid matching funds to use as it likes.

Which hospitals are eligible for DSH payments?

Federal law gives states broad flexibility to determine the hospitals to which they will make DSH payments. The only federal statutory requirements are that at least one percent (this is *not* a typo) of a facility’s total inpatient days are attributable to Medicaid patients, and that, if the hospital offers obstetrical services, at least two obstetricians with staff privileges have agreed to serve Medicaid beneficiaries. However, this latter requirement does not apply if the hospital does not offer obstet-

10. 42 C.F.R. §433.51.

rical services. Thus, a mental hospital may qualify as a Medicaid DSH facility if at least one percent of its total inpatient days are attributable to Medicaid patients.¹¹

Beyond these minimal requirements, it is up to each state to decide which hospitals will receive DSH payments. Although a state could elect to impose additional requirements, federal law does not require that states limit DSH payments to hospitals that take certain steps to improve access (e.g., by serving a certain number of uninsured patients or by operating an emergency room or outpatient clinic).

Which hospitals must receive DSH payments?

Under federal law, states are required to “deem” some hospitals as DSH hospitals. Specifically, federal law requires states to deem as DSH hospitals those facilities that meet one or more of the following criteria:

- The facility’s Medicaid inpatient utilization rate—which is defined as the number of inpatient days attributable to Medicaid beneficiaries divided by the total number of inpatient days—is at least one standard deviation above the mean for all Medicaid-participating hospitals in the state, or;
- The facility’s “low-income utilization rate” is greater than 25 percent. In this context, a facility’s “low-income utilization rate” refers to the sum of:
 - The hospital’s total Medicaid revenues and state and local uninsured care subsidies as a percentage of the hospital’s total patient care revenues
 - The hospital’s charity care charges for inpatient services (net of state or local uninsured care subsidies) as a percentage of the hospital’s total inpatient care charges.

However, these minimum criteria do not guarantee that hospitals deemed DSH facilities under federal law receive adequate DSH payments. The size of a facility’s DSH payment—and more fundamentally whether it receives any payment at all—is set by the formula a state uses to determine how much each hospital will receive in DSH payments.

What determines how much a DSH hospital receives in DSH payments?

Federal law does not specify a *minimum* payment amount that states must make to DSH hospitals, although it does impose a limit on the *maximum* amount that states can make in DSH payments to any individual hospital. Other than this cap on the maximum amount that states can pay to any individual facility—federal law accords states broad flexibility to decide the size of DSH payments. Federal law gives states

11. This feature of federal Medicaid law is part of what has enabled states to direct federal DSH funds toward state mental hospitals. Historically, federal Medicaid law prohibited payments to IMDs on behalf of any Medicaid beneficiary under age 65 on the grounds that the funding of state mental institutions was a state, not a federal, responsibility. However, if Medicaid-eligible patients under age 22 and over age 65 account for at least one percent of total inpatient days at an IMD, federal DSH payments can be made to the facility (up to the facility-specific cap and state-specific mental health cap).

three different options for determining the size of DSH payments, none of which has been amplified in regulations or other administrative guidance:

- States can make a DSH payment that varies according to the type of hospital, as defined by the state.
- States can pay hospitals an additional amount or percentage that is proportional to the extent to which the hospital serves Medicaid patients.¹²
- States may use the *Medicare* disproportionate share adjustment percentage. This adjustment percentage takes into account the size of a hospital, the location of a hospital (i.e., rural versus urban), whether the hospital is the sole provider in a community, and the extent to which a hospital's patient population consists of low-income people. It is based on rules established by the federal government for the *Medicare* program, not on rules established for the *Medicaid* program.

Most commonly, states use the first option as the basis for their DSH payment methodologies. If a state uses this option, federal law requires that the payment methodology apply equally to all hospitals of each type, and that it result in a DSH payment for each type that is “reasonably related to the costs, volume, or proportion of services” provided to Medicaid beneficiaries or to low-income patients. Under this option, payments may be made on a lump sum or on a per-claim basis and may be made prospectively or retrospectively. (See Section V for a discussion of sources of information on a state's payment methodology.)

What is the maximum amount that a state can make in DSH payments to an individual hospital?

Federal law limits the maximum size of the DSH payment that can be made to any given hospital. The limit allows the state to use DSH funds to cover all of the costs that a hospital incurs to deliver care to Medicaid beneficiaries and uninsured patients for which the hospital is not otherwise reimbursed (through Medicaid or out-of-pocket payments). However, the limit prevents a state from using DSH funds to help hospitals cover the costs associated with caring for privately insured patients or Medicare beneficiaries.

The hospital-specific cap requires that DSH payments to an individual hospital over the course of a fiscal year do not exceed 100 percent of the unreimbursed costs the hospital incurs in delivering inpatient *and* outpatient services to Medicaid beneficiaries and to uninsured individuals.¹³ When calculating a hospital's unreimbursed costs for Medicaid and uninsured patients, states must subtract the amount that the hospital receives in (non-DSH) Medicaid payments and the amount the hospital receives in out-of-pocket payments from the uninsured for such care. For purposes of the hospital-specific cap, payments from state or local general assistance programs

12. Specifically, states can make DSH payments in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid utilization rate for all hospitals in the state.

13. The Balanced Budget Act of 1997 set this level at 175 percent for DSH hospitals in California through the state fiscal year ending June 30, 1999. HCFA also granted a §1115 waiver to Los Angeles County addressing this facility-specific cap.

on behalf of uninsured patients are not treated as third-party payments to the hospital. Instead, people who are eligible for such programs are considered to be uninsured, and payments on their behalf do not reduce the amounts available under the cap to DSH hospitals. In addition, any *Medicare* disproportionate share payments the hospital may receive are not used to reduce the amount available under the cap to DSH hospitals. Children enrolled in separate state insurance programs financed by CHIP are not considered uninsured and so the costs a hospital incurs on their behalf do not increase the hospital-specific cap.

What is the point of the hospital-specific cap?

At first blush, the hospital-specific cap might appear superfluous given that states would seem to have little reason to want to give hospitals DSH payments that exceed the unreimbursed costs that they incur on behalf of uninsured patients and Medicaid beneficiaries. However, this regulation like many others, was adopted in response to some states' use of creative financing arrangements.

For example, consider a state-owned hospital with \$10 million in unreimbursed costs incurred on behalf of uninsured and Medicaid patients. Prior to adoption of the hospital-specific caps, a state with a 50 percent matching rate might have had such a facility transfer \$100 million to the state. The state could then return the \$100 million to the facility in the form of a DSH payment even though the hospital's unreimbursed costs were only \$10 million. In the meantime, the state could retain the \$50 million in federal Medicaid matching funds that it received for making a \$100 million DSH payment to the hospital. In this example, the hospital-specific cap ensures that the state cannot make DSH payments in excess of \$10 million to its state-owned facility. It restricts, but does not completely eliminate, the potential use of creative financing arrangements.

What is the difference between DSH payments to hospitals and regular Medicaid payments to hospitals?

Regardless of how a state decides to structure its DSH payment methodology, DSH payments are in addition to the regular payments that a state makes to hospitals on behalf of Medicaid beneficiaries for the inpatient care that they receive. Although it is generally beyond the scope of this guide to address in any detail how states set their basic payment rates to hospitals to reimburse them for providing inpatient care to Medicaid beneficiaries, it is worth noting that states also have significant discretion in setting inpatient hospital payment rates.¹⁴ Through a regulation issued by Health Care Financing Administration (HCFA), the federal government has imposed an upper limit on the aggregate amount of regular Medicaid payments a state may make to all hospitals for outpatient services. However, federal law expressly exempts Medicaid DSH payments from these upper payment limits.

14. With its 1997 repeal of the so-called Boren amendment requirement, Congress has given states even more discretion than they had in the past to establish hospital reimbursement rates.

Can DSH funds be used to help people who are ineligible for regular Medicaid, such as certain immigrants and adults without children?

There is nothing in federal law that prevents states from ensuring that the DSH funds provided to hospitals are used to the benefit of all uninsured individuals, including people who are ineligible for regular benefits under the Medicaid program. Two groups often left out of the traditional Medicaid program are adults without children and many immigrants. Although they are eligible for emergency services, undocumented immigrants and most legal immigrants who entered the United States on or after August 22, 1996, as well as other select categories of legal immigrants, are ineligible for “regular” federally funded Medicaid.¹⁵ DSH funds represent a potentially important source of funding for supporting and encouraging the provision of health care to these and other groups left out of the regular Medicaid program.

What is the relationship between DSH payments and managed care payments?

Many states are requiring Medicaid beneficiaries to enroll in managed care organizations (MCOs).¹⁶ When a Medicaid beneficiary enrolled in managed care receives covered inpatient hospital care from a DSH hospital, the disposition of the Medicaid DSH payment associated with that beneficiary becomes an issue. In most states that rely on managed care for Medicaid beneficiaries, the cost of a beneficiary’s covered hospital care is included in the monthly capitation payment that the state makes to the MCO on behalf of each Medicaid enrollee.

Regardless of the methodology a state elects to use when paying DSH hospitals, it must make DSH payments directly to each eligible facility. Federal law prevents states from channeling DSH payments through MCOs by including them in the monthly capitation payments to the MCOs. The purpose of this prohibition is to prevent MCOs from delaying or diverting DSH payments from the facilities for which they are intended. Two states (Alabama and Wisconsin) are exempted from this requirement and are allowed to fold DSH payments into their MCO capitation rates.

What are “Section 1115 waivers”?

Section 1115 of the Social Security Act gives the Secretary of the Health and Human Services (HHS) the authority to waive aspects of the federal Medicaid law to allow states to conduct demonstration projects with federal Medicaid matching funds. States have used Section 1115 waivers to implement widespread Medicaid managed

15. For a detailed description of the rules that restrict legal immigrants’ eligibility for Medicaid coverage, see Kelly Carmody, *State Options to Assist Legal Immigrants Ineligible for Federal Benefits*, Center on Budget and Policy Priorities, February 25, 1998.

16. In 1997, 15.3 million Medicaid beneficiaries were enrolled in managed care; 40 states had enrolled more than one fourth of their Medicaid eligibles in managed care. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Facts: Medicaid and Managed Care*, September 1998, www.kff.org.

care programs, to expand coverage to groups who otherwise could not be covered by Medicaid, and for other purposes, such as Oregon's test of benefits rationing. Currently, 18 states are operating statewide Section 1115 Medicaid waivers involving some or all of their beneficiary groups: Alabama, Arkansas, Arizona, California (L.A. County), Delaware, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New York, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont.

Although HHS has broad flexibility to waive federal Medicaid law under a Section 1115 waiver, there are a number of restrictions on what states can do through the waiver process. Most important, HHS will grant a waiver to a state for a demonstration program only if it is budget neutral, from the federal government's point of view. In order for a Section 1115 waiver to be deemed budget neutral, a state must show that its projected Medicaid expenditures under the waiver for the succeeding five years will be equal to or less than they would be if the waiver were not granted. When evaluating budget neutrality, HCFA and a state generally must agree upon a baseline of Medicaid spending that represents what projected Medicaid expenditures would be throughout the proposed demonstration period if the waiver were not enacted. Then, the state must prove to HCFA's satisfaction, that any changes enacted under a Section 1115 waiver will not result in spending above the baseline level.

How do Medicaid DSH payments relate to a Section 1115 waiver?

DSH funds can be part of Section 1115 waivers in two ways. First, at least one state, New Jersey, has sought a waiver that allows it to disregard some of the federal restrictions on how DSH funds can be used. As described in detail in Section VI, New Jersey has a Section 1115 waiver that allows it to require DSH hospitals to offer some of their uninsured patients the kind of care that is available to people with insurance coverage. Under this demonstration, hospitals would be responsible for enrolling the uninsured into a hospital-based managed care program offering inpatient and outpatient services. Participating hospitals would be paid a fixed amount of DSH funds on a per-person, per-month basis.

More commonly, a number of states have used DSH funds to help establish budget neutrality for Section 1115 demonstration projects. For example, a state might agree to reduce DSH spending and to use the savings generated by such reductions to expand coverage to new groups of low-income people. For example, Missouri uses a Section 1115 waiver to, among other things, provide Medicaid to all custodial parents and selected noncustodial parents with income below 100 percent of the federal poverty level. To establish budget neutrality for this project, Missouri agreed to reduce Medicaid spending on DSH payments, as well as to generate savings through implementation of managed care.

The extent to which states with Section 1115 waivers relied on DSH funding to establish budget neutrality varies. For example, Arizona's waiver was first implemented in 1982, years before the federal government began spending Medicaid funding on DSH

payments. However, several states have relied heavily on DSH payments to establish budget neutrality for Section 1115 waivers:

- Hawaii and Tennessee both have a “0” federal DSH allotment for fiscal year 1998 through fiscal year 2002 because all of their DSH funds were folded into their Section 1115 waivers prior to 1995, the base year for calculation of the allotments (see Table 5). Both of these waivers expanded coverage to populations that otherwise would have been ineligible for Medicaid.
- Los Angeles County used DSH funds to help establish budget neutrality for its Section 1115 waiver, which is designed to shift the site of care for the county’s uninsured patients from an inpatient to an ambulatory care setting.
- New York used a Section 1115 waiver, financed in part with DSH funds, to secure federal Medicaid matching funds for the cost of providing healthcare coverage to the state’s Home Relief population, a group that includes adults without children who otherwise are largely ineligible for Medicaid.
- The Massachusetts Section 1115 waiver, which also relied to some extent on DSH funds to establish budget neutrality, allows the state to use federal Medicaid funds to support two major DSH hospitals in the Boston area through enhanced managed care payments on behalf of previously uninsured individuals made eligible for Medicaid under the waiver.

Community groups in states with Section 1115 waivers need to begin their analysis of the DSH-related access options in their states by investigating the role that DSH funds played in establishing budget neutrality for their waivers. DSH funds may be so integrally related to the operation or budget neutrality (or both) of a particular state’s waiver that there may not, as a practical matter, be any realistic opportunity for community groups to persuade a state to change the way in which it is using its DSH funds.

In order to implement a Section 1115 waiver, a state must file an application with HCFA and receive approval of the application. When HCFA approves an application for a Section 1115 waiver, it sends a state an approval letter and a set of special terms and conditions. Together, these documents begin to delineate the role of DSH funds, if any, in a state’s waiver. The state Medicaid agency, state legislative staff, or the HCFA project officer for that state’s waiver may be able to provide additional clarification about how a state’s Section 1115 waiver operates.¹⁷

17. The name and phone number of the HCFA official responsible for serving as the contact on any given state’s §1115 waiver can be found at <http://www.bcfa.gov/medicaid/ord-1115.htm>.

IV.

Implications for Community Groups

EVEN WITH THE ADDITIONAL federal restrictions imposed on DSH programs throughout the 1990s, states still have broad flexibility to design their DSH programs. The following questions and answers describe the kinds of actions community groups can take to determine whether their states are taking full advantage of the opportunities created by DSH to improve access to care for the uninsured and Medicaid beneficiaries.

What are some signs that a state may not be taking full advantage of the potential created by DSH to promote access to care?

The wide variation across states in how much DSH money is available, as well as in how the DSH program currently operates, makes it difficult to produce a definitive list of states in which the potential for using DSH funds to expand access to care is the greatest. In addition, political constraints and other factors, including the fiscal health of safety net facilities, will affect DSH possibilities in each state. But there are several indicators that community groups should consider when evaluating the potential of DSH in their state:

■ **More than 10 percent of the state's Medicaid spending is attributable to DSH.**

If more than 10 percent of a state's overall Medicaid spending is spent on DSH payments, it is a sign that the state has a significant amount of DSH resources, at least relative to other states. Table 2 shows the portion of overall Medicaid spending attributable to DSH for each of the states in recent years; states for which this figure exceeds 10 percent in either fiscal year are indicated with an asterisk. Of course, even in states in which DSH payments account for less than 10 percent of Medicaid

spending, federal DSH funds can be an important resource. For example, in fiscal year 1998 Illinois spent \$270 million (federal and state) on DSH; while this represented only 3.8 percent of the state's overall Medicaid spending that year, it is nonetheless a significant amount of resources. In comparison, the CHIP program provided Illinois with up to \$122.5 million in federal funds for fiscal year 1998. If the state had used its full CHIP allocation, it would have spent a total (state and federal) of \$188.5 million on children's coverage.

- **The state has not used all DSH funds available to it.** Some states have not made full use of the DSH funds available to them under their federal allotments, likely due to their reluctance to invest the necessary state matching funds. In these states, there may be considerable potential to use DSH to promote access because there are federal DSH funds on the table that have not already been claimed. Moreover, each state is slated to receive a significant amount of money as a result of the settlement with tobacco companies that could be used to draw down unspent DSH funds.¹⁸ Table 7 shows the portion of each state's allotment used by the state in recent years. Since DSH allotments are slated to go down over time in some states, Table 8 indicates the portion of its fiscal year 2002 allotment each state would spend if it spent in fiscal year 2002 the same amount it spent in fiscal year 1998.
- **There has been a significant diversion of DSH payments to general revenues.** As already noted, many states still use their federal DSH funds to supplement general revenues instead of for payments to DSH facilities or for other health care purposes. There is no national data source on the extent to which states use creative financing arrangements to divert a significant share of DSH funds into general revenues, but, because states often rely on payments to state-owned mental health facilities as part of creative financing arrangements, community groups may be able to get an indication of whether their state is engaged in such practices by looking at whether it directs a significant share of its DSH funds to mental health institutions. Table 9 shows how much of each state's DSH spending in fiscal year 1998 was attributable to such facilities. Note that in future years, due to the limits on the portion of DSH funds that can be spent on mental health facilities, states with a high portion of spending on such facilities will likely need to modify how they restructure their DSH programs, creating both opportunities for community groups and the possibility of cuts in DSH spending.
- **The state has not folded its DSH funds into a Section 1115 waiver demonstration project.** In states that have already used some or all of their DSH funds to finance demonstration projects authorized under Section 1115 of the Social Security Act, the opportunities for community groups to see DSH funds used for new access initiatives are likely to be significantly more limited than in the non-

18. On November 23, 1998, 46 states, the District of Columbia, and five territories agreed to a settlement with the five major tobacco manufacturers. It is estimated that the payments to states under the settlement—known as the "master settlement agreement"—will amount to \$204.5 billion over the next 26 years (through 2025). The four states that are not parties to the master settlement agreement—Florida, Mississippi, Texas, and Minnesota—reached a settlement with the tobacco manufacturers prior to completion of the master settlement agreement and will receive \$43.6 billion over this same period. For more details on the settlement, as well as information on how much money each state is expected to receive, see the National Association of Attorney Generals' web site at www.naag.org or the National Conference of State Legislatures' website at www.ncsl.org/programs/health/tobacco.htm.

waiver states, at least for the duration of the waiver. The terms and conditions under which the Secretary of Health and Human Services approves waivers are often quite prescriptive as to how federal DSH funds are to be spent, at what point, and in what amounts. Once a waiver has been negotiated and approved, it becomes a package deal that is very difficult to reopen during the term of the waiver. The states with Section 1115 waivers that might affect the potential to use DSH funds for access initiatives are listed in Table 10.

Are the true “safety net” institutions in the state receiving adequate DSH payments?

Within broad guidelines, states have discretion to determine which hospitals receive DSH payments. Community groups could begin their evaluation of how their states are using DSH funds by identifying which hospitals in their states receive DSH payments.¹⁹ Are these the hospitals that provide the most care to the uninsured and to Medicaid beneficiaries? For example, some states treat state or private psychiatric hospitals as DSH facilities and make substantial DSH payments to them. If a community group’s policy goal is to increase access to basic acute care services, then it makes little sense to direct DSH funds to these facilities. Similarly, if a for-profit hospital chain treats a significant number of Medicaid-eligible pregnant women but does not provide nonemergency care to the uninsured, it may not be the best use of DSH funds to provide such facilities with DSH payments.

Community groups also may want to explore the adequacy of the payments received by the safety net hospitals in the state. Does the formula that the state uses to distribute DSH payments provide larger payments to the hospitals with higher uncompensated care costs? In particular, are the net DSH payments (i.e., gross DSH payments minus the intergovernmental transfer applied to the state share of DSH payments) these facilities receive—as opposed to gross DSH payments—adequate? One potential measure of the adequacy of a facility’s DSH payment is the extent to which it offsets the hospital’s uncompensated care costs.

Could the hospitals in the state be doing more to meet access goals as a condition of receiving DSH payments?

Since states have the flexibility under federal law to impose performance standards on hospitals as a condition of receiving DSH funds, community groups could explore whether their states would be willing to make DSH payments only to facilities that meet various criteria designed to further access goals. For example, DSH facilities

19. As explained in Section V, states now are required to submit to HCFA annual reports that identify the facilities that receive DSH payments, as well as the size of the payments. Although there are some significant limitations to these reports as a source of information, they can provide a starting place for at least identifying which hospitals within a state are part of the DSH program.

could be asked to meet one or more of the following standards as a condition of receiving DSH payments:²⁰

- The hospital must have an open door policy under which it treats all individuals without regard to ability to pay, according to a sliding fee scale.
- The facility must deliver a minimum amount of uncompensated care to uninsured individuals.
- The physicians with admitting privileges at the facility must accept Medicaid patients on an outpatient as well as an inpatient basis.
- Prescription drugs must be made available to clinic patients.

Could the state be using DSH funds to expand Medicaid or other public health insurance programs to serve more of the uninsured?

Despite numerous reforms designed to prevent the practice, states nevertheless still have legal means at their disposal to divert DSH funds into general revenues. If community groups can identify states using such practices and the amount of DSH funds that have been diverted, they may be able to make the case that these funds should be invested in promoting health care access. Since these funds are already part of states' general revenues and thus free of any federal restrictions on how DSH funds are spent, the funds could be used for any kind of health access project, including expansions of health insurance coverage.

Also, some states already have used their federal DSH funds to help finance expansions in coverage under Section 1115 waivers. Although it often requires arduous negotiations to secure such waivers, states can use them to convert their DSH funds into a resource that is available to expand health insurance coverage further up the income scale or to cover groups of people who otherwise are ineligible for Medicaid regardless of the extent of their impoverishment. For example, New York has received a special waiver from the federal government that allows it to use DSH funds to help pay for some of the cost of providing health care coverage to the state's Home Relief population, a group that includes low-income adults without children who otherwise are largely ineligible for Medicaid.

Even if a state does not want to use DSH funds for a statewide expansion of coverage, it still may be able to secure a Section 1115 waiver that promotes access goals in other ways. For example, as described in Section VI, New Jersey has received approval from HCFA for a Section 1115 waiver that allows it to require DSH hospitals to offer some of their uninsured patients the kind of care that is available to people with insurance coverage.

20. Hospitals that are deemed to be Medicaid DSH hospitals under federal law (due to their Medicaid or low-income utilization rates) may argue that states cannot impose such additional regulatory requirements upon them as a condition of the receipt of DSH funds. Both the statute and the regulations are silent on this issue, and it has not yet been addressed by a court or HCFA. Even if this argument has merit, however, there is no question that states have the authority to impose such requirements on DSH hospitals that are not deemed. Also, states could build into their payment methodologies incentives to reward the deemed facilities that meet these requirements, instead of simply imposing the requirements as a condition of DSH funding.

V.

Sources of Information about DSH

IT CAN BE DIFFICULT FOR COMMUNITY GROUPS to gather information on DSH spending in their state because of the sheer complexity of the program and the fact that decisions about how DSH funds will be used are often closely held by policymakers and the hospital industry (or by certain hospitals). However, the following sources could prove useful, depending on the state.

Federal Resources

At the national level, a source of potential information on DSH programs is the Health Care Financing Administration, the federal agency with jurisdiction over the Medicaid program. Despite recent legislative efforts to improve the quality of information available from HCFA, the agency continues to provide relatively minimal information on DSH programs. At present, HCFA primarily provides DSH information in the following areas.

- **DSH spending levels.** As part of its normal operation of the Medicaid program, HCFA gathers information from states on how much they spend on various aspects of the Medicaid program, including DSH payments. These expenditure data—which are gathered by HCFA through what is known as Form 64—include how much states spend on DSH payments to inpatient care hospitals, as well as to IMDs. Although there is often a significant delay between when HCFA receives this information from the states and when it is made publicly available, community groups can gain access to the Form 64 data through the agency’s web site.²¹
- **State-specific reports on DSH payments to individual facilities.** Under provisions of the Balanced Budget Act of 1997, each state must submit a report to HCFA

21. As of October 1999, the address for Form 64 data was www.hcfa.gov/medicaid/m64.htm.

describing the size of the Medicaid DSH payment it made to each DSH hospital during the preceding fiscal year, beginning with federal fiscal year 1998. HCFA has recommended to states that they conform with this new reporting requirement by submitting hospital-specific data (name of hospital, type of hospital, for example children, psychiatric, public vs. private, and annual payment).²² States were supposed to submit their first report to HCFA regional offices by December 31, 1998. Community groups should be able to obtain a copy by contacting their HCFA regional office.

Why Is It Important to Consider “Net” DSH Payments?

A hospital’s net DSH payments are a far better measure than gross DSH payments of how much a hospital receives from the DSH program. Net DSH payments take into account the extent to which a hospital must return some of its DSH payment to a state in the form of an Intergovernmental Transfer (IGT) or other payment. In some cases, the difference between gross and net payments can be significant.

For example, according to the report Texas submitted to HCFA on which of its hospitals receive DSH payments, the Harris County Hospital District (Houston) received a \$185.8 million DSH payment in fiscal year 1998. However, the report does not show that in order to receive this amount the Harris County Hospital District had to make an IGT to the state of \$108.7 million. Thus, Harris County received \$77 million, not \$185.8 million. This net \$77 million amount represents about 38 percent of Harris County’s hospital-specific DSH cap of \$200.4 million for fiscal year 1998.

At this point, it is not yet clear how much useful information will be made publicly available as a result of the new reporting requirement. As of July 1999, six months after the deadline, HCFA was able to provide reports from 30 states. Among the states that did submit reports, there was considerable variation in the data provided; some reported only the names of each hospital and the DSH amounts paid, while others identified hospitals by type and by public or private status. In those states that have elected to provide the more detailed information requested by HCFA, the reports can be used to identify what portion of the DSH funds in a state are paid to various kinds of hospitals, including public hospitals, children’s hospitals, and/or state-owned facilities. In the remaining states, the reports at least allow community groups to determine which hospitals in a state receive DSH payments, as well as how heavily concentrated those payments are on individual facilities.

At the same time, there is much that these reports do not tell us. Most important, these reports do not indicate how each state’s DSH program is financed, or how much each hospital is contributing toward the state’s share of DSH matching funds. As a result, they can be used by community groups only to determine each hospital’s gross

DSH payment, not how much a hospital receives from the DSH program on net after taking into account any intergovernmental transfers or tax contributions made by the hospital to the state.

The state submissions also do not contain any information on how a hospital used its DSH funds or how much care a hospital provided to the uninsured.²³ This

22. 63 *Fed. Reg.* 54146-54147 (October 8, 1998).

23. The American Hospital Association collects this information but does not report it on a hospital-specific basis. State Medicaid agencies either collect or estimate hospitals’ costs of care to the uninsured in calculating hospital-specific DSH caps; however, this information is generally not made available to the public.

information, combined with data on DSH payments net of IGTs, would enable community groups to determine how effectively a state's DSH payment distribution formula targets facilities serving the uninsured.

- **Description of DSH payment methodologies.** The Balanced Budget Act of 1997 required each state to submit to HCFA, by October 1, 1998, a description of the methodology the state uses to identify and make payments to DSH hospitals on the basis of the proportion of low-income and Medicaid patients served. However, in an October 1998 *Federal Register* notice, HCFA indicated that it “believes that the majority of States’ current DSH methodologies contained in their State plan satisfies the methodology requirements [under this statutory provision].”²⁴

HCFA’s decision to allow states to satisfy the reporting requirement created by the Balanced Budget Act of 1997 by simply referring to their existing state plans has generated some controversy. The Medicaid state plans are lengthy documents that describe all aspects of states’ Medicaid programs. They are kept on file at HCFA’s regional offices and are supposed to be updated regularly. However, in the past, state plans have not been particularly useful sources of information, in part because they often are outdated. It is possible that over time HCFA will take additional steps to ensure that it can provide the public with information about states’ payment methodologies. In the meantime, HCFA regional offices should be able to provide community groups with the sections of a state’s Medicaid plan that describe its DSH payment methodology, although there is no guarantee that this information will be current.

- **Other national sources.** At the national level, research organizations, such as the Urban Institute, also can serve as an additional source of information on states’ DSH programs. For example, the Urban Institute has produced a number of papers on the DSH program and has issued a series of reports on health care and other safety net programs in individual states as part of its New Federalism project which frequently address DSH funding issues.²⁵

State and Local Resources

To supplement what can be learned through the federal reports, community groups may be able to gather useful information from the following state and local resources:

- The state Medicaid agency and the state legislative committees with jurisdiction over the funding or operation of the state’s Medicaid program.
- DSH hospitals, either individually or through their trade associations (state hospital associations, public hospital associations, children’s hospital associations).

24. 63 *Fed. Reg.* 54146 (October 8, 1998).

25. State-level reports already are available on Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. See www.urban.org for details.

- State-level think tanks, policy organizations, and academic centers that consider issues relating to health care financing or access to care.²⁶

In sum, the information available on states' DSH programs is severely limited. It may require considerable persistence on the part of community groups, and, in some states, the help of sympathetic legislators, to gather reliable information about how a state's DSH program operates.

26. For example, the Medi-Cal Policy Institute in California has commissioned a paper on the state's DSH program (see William Huen, *California's Disproportionate Share Hospital Program: Background Paper*, January 1999, Medi-Cal Policy Institute, www.medi-cal.org/publications/reports/dsh.cfm).

VI.

Medicaid DSH Funds and Access to Care: Three Case Studies

WE TURN NOW TO AN EXAMINATION of how three states—Texas, Georgia, and New Jersey—have approached the access issue in their DSH programs. Table 11 offers a comparison of levels of Medicaid beneficiaries, uninsured individuals, and federal DSH allocations for the three selected case study states.

While there is no such thing as a representative DSH state, these three offer some important lessons for community groups on the variation in the extent to which DSH funds are used to promote access, as well as in the variety of strategies available to states for doing so:

- **Texas** has elected not to adopt any policies explicitly designed to promote access. Instead, the state has designed a DSH program that maximizes payments to state-owned institutions and that uses DSH payments to offset the impact on public hospitals of making intergovernmental transfer payments to the state.
- **Georgia** appears to be one of relatively few states that has actively attempted to use its Medicaid DSH funds to induce hospitals to serve the uninsured and to provide primary care to low-income patients, including Medicaid beneficiaries and the uninsured. However, numerous questions remain about how successful these attempts have been.
- **New Jersey** has obtained an innovative section 1115 waiver that allows it to use federal DSH funds to develop hospital-based managed care networks for the uninsured. Although New Jersey has not implemented the waiver, due to concerns raised by hospitals in the state, the waiver proposal offers an interesting precedent of what other interested states might be able to do with DSH funds. It also illustrates that DSH access strategies can be difficult to move forward when they

require imposing new conditions on hospitals that already are accustomed to receiving DSH payments.

Texas

Under almost any measure, Texas is a state with significant healthcare access issues. The state has the highest uninsured rate of any state in the country: in the mid-1990s, 4.8 million Texans under the age of 65 lacked health insurance coverage. This represented more than one out of four nonelderly people in the state.

Texas is also a state with a large DSH program. This year, the state has a federal DSH allotment of \$806 million, placing it third among all the states in the size of its federal DSH resources. Texas also has a long history of taking full advantage of the DSH program; in fiscal year 1998, as in previous years, Texas spent 100 percent of its federal DSH allotment.²⁷ That same year, DSH spending accounted for 15 percent of the state's total Medicaid spending.

■ **State spending on DSH.** The federal matching rate for Texas in fiscal year 2000 was 61 percent, but the state has designed its DSH system in such a way that it does not contribute any state dollars toward its 39 percent share of DSH spending. Instead, the state share of the Texas DSH program is financed entirely through IGTs to the state from the University of Texas Hospital System, eight public hospital districts, and the city of Austin.²⁸ The public hospital districts are entities with their own taxing authorities which are used to raise the revenues that fund their IGTs to the state.

■ **Hospitals receiving DSH payments in Texas.** Texas has elected to make DSH payments only to those hospitals deemed to be DSH facilities under the minimum criteria established in federal statute.²⁹ Of approximately 450 hospitals, only 151 qualified as DSH facilities in state fiscal year 1998.

■ **Payment methodology.** Texas's methodology for distributing DSH payments among eligible hospitals appears to be designed to achieve two objectives: (1) to enhance payments to state-owned facilities in order to reduce the need for state appropriations to these facilities, and (2) to enhance payments to the public hospitals that provide the state matching funds for Texas's DSH program through IGTs.

In order to meet these apparent objectives, Texas divides its DSH funds into two pools, one for state-owned hospitals and one for all other eligible hospitals. Texas reserves for the state-owned hospital pool the maximum amount allowed under federal law, assuring that its own facilities receive the largest DSH payments possible. To calculate the size of the state-owned hospital pool, Texas sums up the

27. The data available from HCFA on Form 64 suggests that Texas used \$896 million out of the \$979 million available to it in fiscal year 1998, but data available directly from the state indicate that the state has used its full allocation.

28. The city of Austin makes an intergovernmental transfer on behalf of Breckenridge Hospital. Breckenridge is owned by the city of Austin but managed pursuant to a long-term lease by a local not-for-profit hospital.

29. Under §1923(b)(1) of the Social Security Act, 42 U.S.C. §1396r-4, a hospital is deemed to be a Medicaid DSH facility if (1) its Medicaid inpatient utilization rate is at least one standard deviation above the mean for all Medicaid hospitals in the state or (2) its low-income utilization rate exceeds 25 percent.

hospital-specific caps for the state-owned institutions. After setting aside the maximum amount of DSH payments allowed for its own facilities, Texas uses its remaining federal DSH funds—approximately 60 percent of the state’s federal DSH allocation—for its “all other” eligible hospitals pool.

- **The state-owned hospital pool.** Texas uses the state-owned hospital pool to pay each state-owned facility the maximum amount allowed under federal law (i.e., their hospital-specific DSH caps). The facilities that receive funds out of this pool include the hospitals in the University of Texas system, state psychiatric hospitals, and state chest hospitals. The purpose of maximizing the size of federal DSH payments to these facilities is to allow the state of Texas to limit its own spending on these facilities. For example, Texas can spend less of its own revenues on its psychiatric hospitals and chest hospitals than would otherwise be necessary because these facilities receive federal DSH payments.³⁰

Similarly, the hospitals in the University of Texas system that receive DSH payments are not allowed to retain their DSH payments. Instead, they make inter-governmental transfers back to the state general revenue fund; at a minimum, the University of Texas hospitals transfer the federal portion of DSH payments back to the state’s general revenue fund. Although on paper, hospitals in the University of Texas system might appear to receive significant federal DSH funding, these funds are not available to support uncompensated care since they are recycled back into the state’s general revenue fund through IGTs.

- **The all other pool.** Texas uses a different methodology to determine how much to make in DSH payments to all other eligible hospitals. The amount a hospital receives in payments from the all other hospital pool is based on a formula that provides a larger share of the payments to hospitals with relatively high numbers of Medicaid beneficiaries and low-income patients. The basic formula, which gives more weight to the treatment of Medicaid beneficiaries than to other low-income patients, is:

$$\text{share of pool} = \frac{\text{Medicaid days} \times 2 + \text{low-income days}}{\text{total Medicaid days} \times 2 + \text{low-income days} \text{ For all eligible DSH hospitals}}$$

Since the basic formula bases DSH payments primarily on Medicaid utilization and not on care to uninsured patients, hospitals that serve a relatively large number of uninsured patients are reimbursed for a smaller proportion of their costs.

In addition, although not noted above, the state modifies its basic formula to give extra weight to the Medicaid days of those hospitals that make IGTs to the state.

30. The extent to which Texas can make payments to its own psychiatric hospitals appears to have been curtailed by the mental health cap included in the Balanced Budget Act of 1997. According to HCFA data, Texas spent 26.1 percent (or \$395 million) of its DSH funds on state psychiatric facilities in fiscal year 1997. However, the Balanced Budget Act of 1997 allows it to spend no more than 18.7 percent of its fiscal year 1999 allocation on IMDs.

However, this additional weighting is not sufficient to offset the impact of their IGTs on public hospitals. As a result, the eight hospital districts in Texas that make IGTs to the state receive net DSH payments—gross DSH payments minus the cost of IGTs back to the state—that reimburse them for a lower percentage of their uncompensated care costs than the DSH payments made to for-profit hospitals. For example, in state fiscal year 1998, the eight public hospital districts in Texas received *net* DSH payments that compensated them for between 38 and 53 percent of the costs they incurred treating uninsured patients. In contrast, several for-profit hospitals in the state received DSH payments that reimbursed them for over 90 percent of their uncompensated care costs.³¹

■ **Conditions for receiving DSH payments.** Texas places few restrictions on the use of Medicaid DSH funds by eligible hospitals. A facility's charges for charity care must exceed certain percentages of its DSH payments (net of IGTs). Each DSH hospital must advise patients of the availability of charity and low-cost care, report on their use of DSH funds, and undertake an annual "assessment of the health needs of the community." In addition, each hospital must actively participate in the development of a regional trauma network. In reality, the Texas Medicaid agency has done little to enforce these requirements, presumably because hospitals have not been eager to comply with them. As a result, their effectiveness is questionable.

■ **Implications for access.** The Texas DSH program raises a number of questions about whether federal DSH funds could more effectively be used to promote access to care. Among the issues raised by a DSH program such as Texas's are:

■ **Could the formula for distributing DSH payments be improved?**

At present, the formula used to distribute the DSH funds available in Texas's all other pool gives more weight to the treatment of Medicaid beneficiaries than to the treatment of the uninsured. It also does little to take into account the extent to which public facilities make IGTs to the state, offsetting some of the potential benefit of their DSH payments. This structure raises at least two questions:

- Should Texas be giving more weight to hospitals that treat the uninsured? If the goal of a DSH program is to subsidize base Medicaid payments to DSH hospitals, the Texas approach fulfills this goal. However, if the goal of a DSH program is to subsidize uninsured care or to support safety net hospitals with relatively higher levels of uninsured care, the Texas approach is questionable.
- Could Texas design a payment methodology that does not effectively penalize those hospitals that are called upon to make the IGTs that finance much of the state's share of the Medicaid program? Addressing this issue would eliminate the anomaly that in some cases for-profit, private hospitals benefit more from DSH payments than the public hospitals that make IGTs to finance the state share of DSH spending in Texas.

31. Based on information available to the Health Policy Group through its work with hospitals in the state of Texas.

■ **Could the federal DSH funds that Texas retains be put to better use?**

Texas has successfully reduced state general revenue support of state-owned hospitals and replaced state funds with federal funds. While it is clear that the University of Texas System hospitals do not retain the full amount of DSH funds to which they are entitled, it is not clear how funds recycled to the general revenue fund are being used. Community groups might want to explore ways to ensure that DSH funds are retained by DSH hospitals or otherwise ensure that these funds are being used in ways that expand health coverage or public health initiatives.

■ **Could Texas require DSH hospitals to do more to promote access as a condition of receiving DSH payments?**

At present, Texas imposes only minimal conditions on hospitals that receive DSH payments and even these are not enforced in many cases. Community groups might want to explore whether more meaningful conditions could be imposed on DSH hospitals. For example, could they be required to provide nonemergency acute care in an outpatient setting to a certain number of uninsured patients? Although DSH hospitals currently are required to conduct assessments of the health needs of the community, could they also be required to undertake a project to meet some of these health needs?

Georgia

Georgia also has a relatively high uninsured rate—nearly one out of five people in Georgia (19.4 percent) lacked health insurance coverage in the mid-1990s. To date, it has taken full advantage of the Medicaid DSH program. Georgia spent over \$400 million in state and federal DSH funds in fiscal year 1998, accounting for 11 percent of its total Medicaid expenditures.

Georgia has elected to use its DSH program to achieve a number of different policy objectives: To establish an indigent care program that provides free or reduced cost care to patients whose income level is 185 percent of the poverty level (\$25,678 for a family of three in 1999); to require hospitals to invest some funds in primary care initiatives for the uninsured; to expand Medicaid coverage; and to support medical education. It has also elected to use a portion of its DSH funds for purposes that are at best indirectly associated with increasing access to health care.

■ **Spending on DSH.** The federal matching rate for Georgia in fiscal year 2000 is 60 percent, but, like Texas, the state has designed its DSH system in such a way that it does not contribute any state dollars toward its 40 percent share of DSH spending. The state share of Georgia’s Medicaid DSH program is fully funded by IGTs. In fiscal year 1999, 66 of the 87 hospitals in Georgia that received DSH payments made IGTs. The IGTs are deposited in the Indigent Care Trust Fund (ICTF) and are used to draw down federal Medicaid matching funds. Then, Georgia’s Medicaid agency determines how the money in the trust fund will be expended.

The Medicaid agency has also sought and received IGTs in excess of the amount necessary to fund the state share of DSH payments. For fiscal year 1999, over a quar-

ter of total IGTs (\$47 million out of \$178 million) were used for purposes other than making DSH payments to hospitals. Among other things, the state has used these excess funds to expand Medicaid eligibility (some \$22 million) and to support medical education. But the state has also used these funds for purposes that arguably have not contributed to improving health care access. For example, some excess funds have been used to subsidize interns employed by the state Medicaid agency.

■ **Hospitals receiving DSH payments.** In contrast to Texas, Georgia makes Medicaid DSH payments not only to acute care hospitals that are deemed to be DSH hospitals under federal law, but also to additional hospitals that meet the state's criteria. In Georgia, the following hospitals are eligible for DSH payments:

- Hospitals with inpatient and outpatient Medicaid charges exceeding 15 percent of total revenues
- Hospitals with the largest number of Medicaid admissions in each metropolitan statistical area, excluding state hospitals
- Children's hospitals
- Hospitals that have been designated by the Department of Human Resources as Regional Perinatal Centers
- Hospitals that have been designated by their fiscal intermediaries as Medicare rural referral centers and Medicare DSH providers
- Hospitals that are Medicare rural referral centers and that have 10 percent or more Medicaid patient days and 30 percent or more Medicaid services
- State-owned and operated teaching hospitals administered by the Board of Regents
- Small, rural public hospitals with a Medicaid inpatient utilization rate of at least one percent³²

During fiscal year 1999, 87 of the 192 hospitals in Georgia were eligible for Medicaid DSH payments.

■ **Payment methodology.** Georgia uses a complex formula to distribute DSH funds among eligible hospitals. The formula attempts to reward those DSH hospitals that serve as a critical part of the safety net by increasing DSH payments to these facilities. In calculating DSH payments, the state provides enhanced DSH payments to public hospitals, sole community hospitals, and certain rural hospitals. In addition, DSH payments are increased based upon the degree to which a hospital exceeds 1,000 Medicaid admissions and the statewide mean Medicaid utilization rate. The formula also takes into account Medicaid births as a percentage of total births. The more of these criteria a hospital meets, the more disproportional the hospital is considered and the greater the DSH payment to the facility—subject, of course, to each facility's hospital-specific DSH cap. In practice, most

32. These categories are set forth in the approved state Medicaid plan. In several instances, the state has amended its state plan to target DSH funds to particular providers.

DSH hospitals in Georgia are paid amounts equal to their hospital-specific DSH caps even though they often otherwise would be entitled to greater amounts under the state’s payment formula.

In fiscal year 1998, Georgia’s DSH eligibility criteria and payment methodology resulted in 92 percent of the state’s DSH funds going to public hospitals. In contrast to Texas, these public hospitals do not include state mental hospitals.³³

At the same time, the formula appears to have some shortcomings. For example, the hospital that provides the highest volume of care to uninsured patients in the state—Grady Memorial Hospital—does not receive the full DSH payment it is allowed under its hospital-specific cap. This occurs primarily because the formula relies on proxies, such as the percentage of deliveries attributable to Medicaid patients, to assess disproportionate share status. While this formula was intended originally to recognize Grady’s status as a significant DSH hospital, the formula no longer functions as intended. With this in mind, the Georgia Medicaid agency has announced its intent to revise the formula to base payments on hospitals’ facility-specific caps.

■ **Conditions for receiving DSH payments.** As a condition of receiving DSH funds, hospitals in Georgia must comply with various access requirements, including:

- They must agree to provide a certain amount of free or reduced-cost care to low-income, uninsured patients.

As a condition of receiving DSH payments, hospitals are required to provide a certain amount of free or reduced-cost care to people whose incomes are below 185 percent of the poverty level (\$25,678 for a family of three). The care must be provided to low-income people on a sliding fee basis, and people with incomes below 125 percent of the poverty level must be provided with care for free. As part of this indigent care program, DSH hospitals are obligated to notify the public about the availability of free or low-cost care, to provide information to families about how to apply for the program, and to identify a person or office within the hospital that can handle questions or complaints about the program. Moreover, DSH hospitals must keep logs of uninsured patients and the care provided, and submit quarterly reports to the Medicaid agency.

The size of the indigent care program at each DSH hospital is tied to the amount it receives in DSH payments—a DSH hospital is relieved of its obligation to provide services without charge once it has spent at least 90 percent of net DSH payments (gross DSH payments minus IGTs) on care for such patients. Following some discussion over what constitutes a reasonable way of calculating how much a hospital has spent on indigent care, Georgia regulations now explicitly specify that hospitals can count only 65 percent of the amount they *charge* uninsured patients for their care.

33. As a result of the state-specific mental health caps included in the Balanced Budget Act of 1997, Georgia is now precluded from using any of its DSH funds to make payments to mental health facilities.

- They must use 15 percent of their DSH payments to provide primary care. As a condition of receiving DSH payments, a hospital must file a primary care plan annually with the Medicaid agency that details how it will use 15 percent of its net DSH payments for primary care. The plan must be approved by the state Medicaid agency and endorsed by the local Department of Public Health. Hospitals are ineligible for DSH payments if they do not have an approved primary care plan. To date, the kinds of activities for which the primary care funds have been used include:
 - To conduct health education programs
 - To construct or support primary care clinics for the homeless or other underserved populations
 - To provide primary care to the uninsured, women, and minorities
 - To pay staff to help people apply for and take advantage of programs operated by pharmaceutical companies to provide prescription drugs to low-income individuals who otherwise would go without needed medication, as well as to provide prescription drugs to people while their applications are being evaluated
 - To conduct health screenings
 - To operate programs to reduce infant mortality

At this point, it is difficult to gauge the impact of the hospitals' primary care plans because they have not been evaluated. Moreover, a number of hospitals have elected to use their primary care funds to undertake capital projects and it is difficult to determine whether these projects would have been undertaken in the absence of the primary care set-aside.

- They must ensure that patients are not transferred or denied services for economic reasons.
 - They must make arrangements with sufficient numbers of physicians who accept payment from Medicaid to ensure that Medicaid patients have full access to the facility's services without being required to pay physicians for Medicaid covered services.
 - They must document which physicians with staff privileges will accept and see Medicaid patients in their offices, and assist Medicaid patients with referrals to such physicians.
 - They must ensure that Medicaid beneficiaries and medically indigent patients are not required to pay preadmission deposits; moreover, the hospital must ensure that inability to pay does not act to deny or substantially delay receipt of medically necessary services.
- **Implications for access.** Georgia has used its flexibility to determine which hospitals receive DSH payments to ensure that most of its DSH funds are distributed to public hospitals and to other safety net providers. It also has elected to impose a number of conditions on hospitals receiving DSH payments that are designed to ensure that low-income people have access to

Why Has Georgia Taken More Steps Than Other States to Ensure That Its DSH Funds Are Used to Promote Access?

It is difficult to say with certainty why Georgia has decided to ensure that its DSH funds are used to promote access, but it is clear that both community groups and the media played a role in this outcome.

In 1993, a reporter with the Morris News Service wrote a series of investigative articles on Georgia’s DSH program. His series turned up numerous accounts of hospitals using DSH funds for purposes that did not appear to primarily benefit uninsured and underinsured patients. As explained at the beginning of one of the stories, “Georgia hospitals are spending millions of taxpayers’ dollars earmarked to aid the poor on buildings, machines, and six-figure salary guarantees for doctors, often for the benefit of paying patients more than the needy.” The series also highlighted the state’s failure to develop a system for holding hospitals accountable for how they used DSH funds. After some of the Morris News Service articles appeared, other reporters and editorial writers prepared pieces on the issue and in relatively short order the state had adopted additional regulations to impose tighter controls on how DSH funds are used.

Community groups were instrumental in generating the media’s interest in how DSH funds were being used in Georgia, as well as in helping to ensure that the state responded to the negative

publicity by imposing some additional controls on DSH hospitals. They were especially concerned that, while receiving millions of dollars to compensate them for serving uninsured people, hospitals were billing and suing uninsured patients with low incomes. Advocates have worked over the years to ensure that DSH hospitals abide by the free care requirements and other protections put in place under the regulations. For example, Georgia Legal Services distributes a flyer to low-income families that explains their right to receive free or subsidized care at DSH hospitals. The flyer identifies the hospitals at which free care is available and provides families with information on how to establish their eligibility for the care. It also explains to potential patients the other benefits that DSH hospitals must provide, such as making sure that doctors will treat Medicaid patients at the hospital without charge. ... In the absence of the involvement of community groups such as Georgia Legal Services, it is doubtful that the Georgia DSH program would so strongly encourage the provision of care to the uninsured.

* Frank LoMonte, Morris News Service, “Caring for the Needy: Funds Set Aside for Indigent Care Spent Elsewhere—And It’s Legal,” *Savannah News-Press* (February 14, 1993).

hospital-based care, as well as to primary care services. Moreover, although it has sought and received IGTs in excess of the amount required to support the DSH program, it has used at least a portion of these funds to expand Medicaid coverage to more of the uninsured.³⁴ At the same time, there are a number of questions that the Georgia strategy raises about whether DSH funds in the state could be used more effectively.

■ **Could Georgia improve its implementation of the free care and other access requirements?**

Advocates report that despite the favorable provisions in regulations and guidelines, too many patients still do not know that they may be eligible to participate in the hospitals’ free and reduced-price care programs. Too many patients continue to receive bills or collection notices when they

34. The Georgia Medicaid agency has recently indicated its intent to reduce the extraneous uses of IGTs and to reduce the amount of IGTs received from providers.

should have qualified for free care. Hospitals are inconsistent in their implementation of these programs, and business office staff often are uninformed about the programs their facilities offer. The state agency also has not audited hospitals' compliance with their free-care obligations, although it is involved in discussions about how to improve compliance and oversight. Could the program achieve its full promise with changes such as better reporting, on-site monitoring, audits, strengthened notice requirements, requirements for facility staff training, a formal state-level complaint process?

■ **Should Georgia's payment methodology better take into account hospitals that serve a disproportionately large share of the uninsured?**

As noted above, Grady Memorial Hospital does not receive a DSH payment equal to its hospital-specific cap, even though it is the hospital in the state that provides the highest volume of care to uninsured patients. This raises the question of whether the payment methodology in Georgia could be amended to better reflect the extent to which hospitals provide care to uninsured patients.

(*Note:* As of October 1999, the Medicaid agency in Georgia has indicated that it intends to pay each hospital the same proportion of its hospital-specific caps. While the new formula will not take into account that some hospitals are "more disproportionate than others" it will eliminate some of the inequities in the current formula).

■ **Could steps be taken to increase the effectiveness of the requirement that hospitals invest some DSH funds in primary care projects?**

Although Georgia has gone further than most states in requiring that hospitals commit to using at least a portion of their DSH funds for providing primary care services to the uninsured, it may be that there are opportunities to increase the effectiveness of this requirement. For example, could the state conduct an evaluation of the requirement to determine whether the primary care projects undertaken by the hospitals are effective? Could the requirement be modified in any way to encourage hospitals to undertake new projects, as opposed to projects that they would have completed even in the absence of DSH funding? Are there opportunities to create a more formal role for community groups to participate in the process used to decide how the primary care DSH funds are used?

New Jersey

A relatively wealthy state, New Jersey's federal matching rate is 50 percent. An estimated 18.5 percent of its nonelderly residents were uninsured in the mid-1990s, a rate that is about the same as the national average. DSH payments represented almost 19 percent of all Medicaid spending in New Jersey in fiscal year 1998, an amount that accounted for 85 percent of the state's DSH allotment. Of the total

amount spent on DSH by New Jersey in fiscal year 1998, nearly one-third—30 percent—was dedicated to mental hospitals.

New Jersey has secured federal approval for a Section 1115 waiver project that would demonstrate how federal Medicaid DSH funds could be used to encourage hospitals to apply managed care principles to the delivery of health services to the uninsured. This waiver program has not been implemented by the state (and is not likely to be implemented) due to concerns on the part of New Jersey hospitals, which objected to the potential added costs of financing uninsured patients' outpatient care as well as their hospitalizations. Nevertheless, the proposal is worth examining as a potential approach for expanding access to care for the uninsured. Presumably, since HCFA has already approved the waiver, it would likely be receptive to similar waiver proposals from other states.

Currently (in the absence of implementation of the waiver), New Jersey's Medicaid DSH program is organized into five payment funds:

- **Hospital Relief Subsidy Fund.** This fund is used for payments to hospitals serving a large proportion of low-income people and provides a high volume of targeted services for conditions such as HIV and tuberculosis.
- **Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients.** This fund makes payments to hospitals serving large numbers of low-income individuals with mental illness or developmental disabilities.
- **Unreimbursed Costs of Public Psychiatric Hospitals and for the University Hospital.** This fund makes payments to state mental hospitals and to the state medical school's hospital.
- **Community Mental Health Contracts.** This fund is used for payments to certain acute care hospitals for uncompensated care costs that they incur as a result of operating mental health programs.
- **Charity Care Fund.** This fund makes payments to hospitals for charity care (inpatient and outpatient hospital services to uninsured individuals with incomes below 300 percent of the poverty level). In fiscal year 1996, \$350 million, or about 35 percent of the state's total DSH spending, was allocated to this fund.

In the Section 1115 waiver approved by HCFA in February 1998, the Charity Care Fund would have been restructured. Under the demonstration, hospitals receiving DSH payments from the Charity Care Fund would be required to establish "hospital-centered managed care networks" to provide managed care to certain uninsured patients outside of the hospital, including through physicians' offices and community clinics. Each hospital could develop its own managed charity care plan, but all would have to meet certain minimum requirements. Hospitals would have the option to provide these networks with a set dollar amount per each patient treated. Alternatively, they could reimburse the networks on a fee-for-service basis. Hospitals also would have the option to subcontract with existing managed care organizations or behavioral health organizations (or both) or to develop their own networks.

The new charity care program would require participating hospitals to provide care management for the uninsured with diagnoses that account for at least 20 percent of their inpatient charity care cases or 33 percent of their charity care revenue. Hospitals would be required to provide care-management services for substance abuse and mental health and would be able to provide care management for other conditions that would benefit from care coordination, such as diabetes, hypertension, and pregnancy. Under the waiver, the state also would require hospitals participating in the new charity care program to establish both a utilization management program and a quality assurance program to monitor care delivered through their networks.

Under the proposed demonstration project, hospital care-management programs would be evaluated using objective criteria on access, quality, and finances developed by the state. If a hospital did not meet the criteria, the state would appoint a charity care administrator to operate the charity care program. Furthermore, the state would reduce the hospital's charity care funding by twice the cost of the administrator. Half of this reduction would be distributed to other hospitals meeting the criteria.

Eligibility rules for charity care under the demonstration would be the same as under the current Charity Care Fund. Uninsured individuals with family incomes up to 200 percent of the poverty level would receive free care, while those with incomes between 200 and 300 percent of the poverty level would receive partial subsidies. Families would be allowed to deduct the cost of their medical bills from their income, making it possible for some higher income individuals to spend down to eligibility for the Charity Care Fund. In addition to meeting an income test, people also must have assets below \$7,500 per individual and \$15,000 per family in order to be eligible for subsidies through the Charity Care Program.

Under the waiver, uninsured patients would be allowed to participate in the demonstration on a voluntary basis. Hospitals would be responsible for identifying those charity care patients likely to benefit from a coordinated plan of treatment, and those identified by the hospital could elect to enroll in its managed charity care program. If they chose not to, they would continue to be eligible for charity care on the same basis as under the current program.

The projected federal cost of the new charity care program is \$300 million per year for each of the five years of the waiver (fiscal years 1998 through 2002). The waiver was considered budget neutral because the state agreed to keep spending on the new charity care program below a baseline level negotiated with HCFA. Under the baseline, New Jersey can spend no more on its new managed care program than: (1) the amount it spent on DSH in 1996, adjusted upward by a growth factor of 5.1 percent, or (2) the amount available to it under its federal DSH allotment (whichever is smaller).³⁵

35. The growth factor of 5.1 percent is based on the average annual growth rate projected in national Medicaid DSH spending by the Office of Management and Budget at the point that the waiver was negotiated.

Under the waiver, hospitals would continue to receive DSH payments, but, unlike in the past, they would be required to participate in the new charity care program as a condition of receiving their DSH payments. To take into account the fact that hospitals that succeed in managing care would likely see some of their uncompensated care costs shift from the inpatient setting to settings outside of the hospital, the waiver also allowed New Jersey to include the cost of nonhospital services delivered to managed care patients in the calculation of hospital-specific caps. This change was important because it would prevent hospitals that succeed in reducing inpatient costs—by increasing their investment in nonhospital services—from being fiscally harmed by a smaller hospital-specific cap.

- **Implications for access.** New Jersey’s waiver proposal attempts to address one of the major weaknesses of current DSH policy, which illustrates the principle that at times “no good deed goes unpunished.” In particular, the facility-specific DSH cap—which limits DSH payments to the unreimbursed costs hospitals incur on behalf of Medicaid and uninsured patients—can have a perverse effect. If a DSH provider reduces costs by successfully managing the care of a Medicaid or uninsured patient, the provider’s facility-specific DSH cap declines and usually with it its DSH payments. (If the amount a facility receives in DSH payments falls below the amount that it is eligible for under its hospital-specific cap, then DSH payments will not necessarily decline). In short, DSH hospitals that aggressively seek to manage the care provided to Medicaid and uninsured patients may risk a decline in DSH payments for doing so.

The potentially troubling incentives created by the hospital-specific caps can only be solved by federal waiver or changes in federal law. For example, making DSH payments on a capitated basis (i.e., in accordance with the number of low-income or uninsured patients a hospital serves) would give hospitals an incentive to coordinate and manage care. While using DSH funds to make capitated payments to hospitals on behalf of uninsured patients raises several concerns for DSH providers, this approach can potentially improve patient access to services, particularly for patients with chronic conditions. Community groups may want to consider exploring the possibility of a demonstration involving capitation with progressive DSH facilities and state Medicaid agencies.

VII.

Conclusion

IN MANY STATES, DSH funds can play a major role in promoting access to health care among the uninsured and Medicaid beneficiaries. As this guide makes clear, though, community groups that pursue efforts to ensure that DSH funds are used effectively will likely face some significant challenges. First and foremost, it may take considerable persistence simply to secure basic information about how a state's DSH program is currently being operated. Even if such information is available, given the typical pattern of a relatively small group of state officials and, in some cases, providers tightly controlling DSH funding decisions, it may be difficult to use the information to influence how DSH funds are used. Moreover, many public hospitals, children's hospitals, and other safety net institutions that are already struggling to fulfill their missions will understandably be wary of any effort that takes away from their share of DSH funds or that imposes new conditions on their receipt of DSH funds.

At the same time, given that the number of uninsured people in the United States continues to increase and that there remain relatively few new sources of funding for health access initiatives despite the strong economy, it may be worthwhile to take on the challenge of understanding DSH funding. In many states, DSH is a major source of funding for health care; indeed, nationally, DSH spending levels are expected to exceed spending for the CHIP program for the indefinite future. Moreover, the DSH program is flexible enough that community groups can promote a wide array of access initiatives using DSH funds. Some states already have identified ways to use their DSH funds to encourage hospitals to provide primary and preventive care to uninsured patients, to promote the provision of case management for the uninsured, and to expand Medicaid to cover more of the uninsured. In this area, information is power, and we encourage health access advocates to aggressively use the information resources available to pursue their goals.



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TABLE 1 Federal Medicaid Matching Rates for FY 2000

State	FY 2000 Medicaid Matching Rate	State	FY 2000 Medicaid Matching Rate
Alabama	70%	Nebraska	61%
Alaska	60%	Nevada	50%
Arizona	66%	New Hampshire	50%
Arkansas	73%	New Jersey	50%
California	52%	New Mexico	73%
Colorado	50%	New York	50%
Connecticut	50%	North Carolina	62%
Delaware	50%	North Dakota	70%
District of Columbia	70%	Ohio	59%
Florida	57%	Oklahoma	71%
Georgia	60%	Oregon	60%
Hawaii	51%	Pennsylvania	54%
Idaho	70%	Rhode Island	54%
Illinois	50%	South Carolina	70%
Indiana	62%	South Dakota	69%
Iowa	63%	Tennessee	63%
Kansas	60%	Texas	61%
Kentucky	71%	Utah	72%
Louisiana	70%	Vermont	62%
Maine	66%	Virginia	52%
Maryland	50%	Washington	52%
Massachusetts	50%	West Virginia	75%
Michigan	55%	Wisconsin	59%
Minnesota	51%	Wyoming	64%
Mississippi	77%	Territories	50%
Missouri	61%		
Montana	72%		

Source: Dept. of Health & Human Services, <http://aspe.hhs.gov/health/fmap00.htm>.

**TABLE 2 DSH Expenditures as a Proportion of Medicaid Expenditures
FY97 and FY98 (in millions)**

STATE	FY97			FY98		
	Total State and Federal DSH Expenditures	State and Federal Medicaid Expenditures	DSH Spending as % of Total Medicaid Expenditures	Total State and Federal DSH Expenditures	State and Federal Medicaid Expenditures	DSH Spending as % of Total Medicaid Expenditures
Alabama*	\$417	\$2,241	18.6%	\$394	\$2,381	16.5%
Alaska	\$15	\$396	3.8%	\$15	\$398	3.9%
Arizona	\$141	\$1,876	7.5%	\$123	\$1,999	6.2%
Arkansas	\$3	\$1,380	0.2%	\$2	\$1,493	0.1%
California*	\$2,104	\$16,849	12.5%	\$2,451	\$19,558	12.5%
Colorado	\$153	\$1,573	9.7%	\$139	\$1,669	8.3%
Connecticut*	\$454	\$2,778	16.3%	\$370	\$2,926	12.6%
Delaware	\$10	\$432	2.3%	\$8	\$442	1.8%
D.C.	\$41	\$876	4.7%	\$33	\$907	3.6%
Florida	\$366	\$6,482	5.6%	\$371	\$6,620	5.6%
Georgia*	\$402	\$3,665	11.0%	\$410	\$3,735	11.0%
Hawaii	\$0	\$579	0.0%	\$0	\$617	0.0%
Idaho	\$6	\$449	1.3%	\$2	\$467	0.5%
Illinois	\$274	\$7,032	3.9%	\$270	\$7,071	3.8%
Indiana	\$172	\$2,564	6.7%	\$195	\$2,687	7.2%
Iowa	\$17	\$1,270	1.3%	\$20	\$1,416	1.4%
Kansas	\$61	\$1,062	5.7%	\$45	\$1,157	3.9%
Kentucky	\$231	\$2,610	8.9%	\$195	\$2,678	7.3%
Louisiana*	\$576	\$3,117	18.5%	\$738	\$3,274	22.6%
Maine*	\$155	\$1,093	14.2%	\$122	\$1,127	10.9%
Maryland	\$160	\$2,884	5.5%	\$136	\$2,785	4.9%
Massachusetts*	\$545	\$5,066	10.8%	\$497	\$5,662	8.8%
Michigan	\$303	\$6,138	4.9%	\$319	\$6,218	5.1%
Minnesota	\$56	\$2,877	1.9%	\$56	\$3,193	1.8%
Mississippi*	\$214	\$1,724	12.4%	\$184	\$1,724	10.7%
Missouri*	\$698	\$3,212	21.7%	\$666	\$3,404	19.6%
Montana	\$0	\$399	0.1%	\$0	\$416	0.0%
Nebraska	\$0	\$786	0.0%	\$6	\$897	0.7%

STATE	FY97			FY98		
	Total State and Federal DSH Expenditures	State and Federal Medicaid Expenditures	DSH Spending as % of Total Medicaid Expenditures	Total State and Federal DSH Expenditures	State and Federal Medicaid Expenditures	DSH Spending as % of Total Medicaid Expenditures
Nevada*	\$74	\$501	14.8%	\$74	\$542	13.6%
New Hampshire*	\$142	\$766	18.5%	\$128	\$773	16.6%
New Jersey*	\$1,020	\$5,670	18.0%	\$1,020	\$5,720	17.8%
New Mexico	\$11	\$993	1.1%	\$9	\$1,069	0.9%
New York*	\$2,829	\$25,204	11.2%	\$1,860	\$27,978	6.6%
North Carolina	\$342	\$4,531	7.5%	\$354	\$4,733	7.5%
North Dakota	\$2	\$338	0.6%	\$1	\$344	0.3%
Ohio*	\$682	\$6,630	10.3%	\$657	\$6,836	9.6%
Oklahoma	\$26	\$1,300	2.0%	\$23	\$1,464	1.6%
Oregon	\$26	\$1,604	1.6%	\$27	\$1,860	1.5%
Pennsylvania	\$616	\$8,378	7.4%	\$546	\$8,849	6.2%
Rhode Island	\$61	\$939	6.5%	\$56	\$998	5.6%
South Carolina*	\$440	\$2,186	20.1%	\$446	\$2,380	18.7%
South Dakota	\$2	\$337	0.5%	\$1	\$367	0.3%
Tennessee	\$0	\$3,698	0.0%	\$0	\$4,097	0.0%
Texas*	\$1,513	\$10,001	15.1%	\$1,439	\$10,354	13.9%
Utah	\$6	\$663	0.8%	\$4	\$730	0.6%
Vermont	\$36	\$393	9.2%	\$22	\$430	5.2%
Virginia	\$159	\$2,353	6.8%	\$161	\$2,462	6.5%
Washington*	\$364	\$3,428	10.6%	\$333	\$3,591	9.3%
West Virginia	\$0	\$1,305	0.0%	\$22	\$1,411	1.6%
Wisconsin	\$12	\$2,802	0.4%	\$11	\$2,879	0.4%
Wyoming	\$0	\$222	0.0%	\$0	\$210	0.0%
United States	\$15,937	\$165,652	9.6%	\$14,962	\$176,994	8.5% *

*Denotes states that spent more than 10% of total Medicaid expenditures on DSH in either FY97 or FY98. Source: Fiscal year 1997 and 1998 data are from the HCFA web site: www.hcfa.gov/medicaid/m64.htm.

TABLE 3 Available Federal DSH Resources Per Uninsured Person

State	Average Number of Uninsured (1996–1998)	Federal DSH Allotment for FY 2000 (in millions)	Available Federal DSH Funds Per Uninsured Person
Alabama	640,411	\$248	\$387
Alaska	105,325	\$10	\$95
Arizona	1,162,112	\$81	\$70
Arkansas	561,136	\$2	\$4
California	6,994,056	\$986	\$141
Colorado	611,782	\$79	\$129
Connecticut	391,988	\$164	\$418
Delaware	103,841	\$4	\$39
District of Columbia	83,448	\$32	\$383
Florida	2,701,532	\$197	\$73
Georgia	1,334,453	\$241	\$181
Hawaii	103,579	\$0	\$0
Idaho	214,750	\$1	\$5
Illinois	1,561,587	\$193	\$124
Indiana	702,527	\$191	\$272
Iowa	313,418	\$8	\$26
Kansas	288,602	\$42	\$146
Kentucky	577,651	\$130	\$225
Louisiana	844,571	\$713	\$844
Maine	162,670	\$84	\$516
Maryland	698,443	\$68	\$97
Massachusetts	716,297	\$273	\$381
Michigan	1,106,113	\$237	\$214
Minnesota	455,427	\$33	\$72
Mississippi	540,744	\$136	\$252
Missouri	646,208	\$379	\$586
Montana	159,736	\$0	\$0

State	Average Number of Uninsured (1996–1998)	Federal DSH, Allotment for FY 2000 (in millions)	Available Federal DSH Funds Per Uninsured Person
Nebraska	175,029	\$5	\$29
Nevada	316,705	\$37	\$117
New Hampshire	129,558	\$130	\$1,003
New Jersey	1,321,970	\$515	\$390
New Mexico	403,783	\$9	\$22
New York	3,161,225	\$1,436	\$454
North Carolina	1,137,182	\$264	\$232
North Dakota	83,501	\$1	\$12
Ohio	1,252,771	\$363	\$290
Oklahoma	587,307	\$16	\$27
Oregon	472,546	\$20	\$42
Pennsylvania	1,196,455	\$502	\$420
Rhode Island	95,446	\$58	\$608
South Carolina	622,801	\$262	\$421
South Dakota	83,983	\$1	\$12
Tennessee	773,676	\$0	\$0
Texas	4,798,207	\$806	\$168
Utah	271,223	\$3	\$11
Vermont	59,512	\$18	\$302
Virginia	870,469	\$66	\$76
Washington	706,896	\$166	\$235
West Virginia	287,186	\$61	\$212
Wisconsin	483,429	\$7	\$14
Wyoming	74,852	\$0.1	\$1
National	43,148,121	\$9,278	\$215

Source: FY 2000 DSH allotments are from HCFA; data on the number of uninsured are based on calculations performed by the CBPP using data from the Census Bureau's 1997, 1998, and 1999 Current Population Surveys.

TABLE 4 States' Total Spending on DSH Payments in FY94–FY98

State	Total (Federal and State) DSH Spending				
	FY94	FY95	FY96	FY97	FY98
Alaska	\$17	\$18	\$14	\$15	\$15
Alabama	\$417	\$417	\$395	\$417	\$394
Arkansas	\$3	\$3	\$4	\$3	\$2
Arizona	\$106	\$122	\$129	\$141	\$123
California	\$2,009	\$2,915	\$1,408	\$2,100	\$2,451
Colorado	\$106	\$355	\$97	\$153	\$139
Connecticut	\$409	\$450	\$442	\$450	\$370
District of Columbia	\$53	\$50	\$38	\$41	\$33
Delaware	\$6	\$7	\$9	\$10	\$8
Florida	\$285	\$334	\$340	\$360	\$371
Georgia	\$355	\$410	\$372	\$400	\$410
Hawaii	\$30	\$1	\$0	\$0	\$0
Iowa	\$6	\$5	\$12	\$17	\$20
Idaho	\$0	\$4	\$2	\$6	\$2
Illinois	\$300	\$413	\$244	\$274	\$270
Indiana	\$295	\$398	\$163	\$172	\$195
Kansas	\$165	\$74	\$55	\$61	\$45
Kentucky	\$67	\$220	\$152	\$231	\$195
Louisiana	\$1,326	\$1,265	\$805	\$576	\$738
Massachusetts	\$541	\$610	\$571	\$545	\$497
Maryland	\$151	\$160	\$146	\$160	\$136
Maine	\$165	\$165	\$165	\$155	\$122
Michigan	\$615	\$438	\$347	\$303	\$319
Minnesota	\$44	\$24	\$36	\$56	\$56
Missouri	\$713	\$729	\$725	\$698	\$666
Mississippi	\$158	\$183	\$200	\$214	\$184
Montana	\$0	\$0	\$0	\$0	\$0
North Carolina	\$390	\$429	\$363	\$342	\$354

	Total (Federal and State) DSH Spending				
	FY94	FY95	FY96	FY97	FY98
North Dakota	\$1	\$1	\$1	\$2	\$1
Nebraska	\$9	\$9	\$3	\$0	\$6
New Hampshire	\$380	\$329	\$230	\$142	\$128
New Jersey	\$1,034	\$1,287	\$997	\$1,020	\$1,020
New Mexico	\$8	\$7	\$12	\$11	\$9
Nevada	\$74	\$74	\$74	\$74	\$74
New York	\$2,507	\$2,917	\$2,663	\$2,829	\$1,860
Ohio	\$498	\$630	\$652	\$682	\$657
Oklahoma	\$24	\$18	\$19	\$26	\$23
Oregon	\$21	\$28	\$28	\$26	\$27
Pennsylvania	\$817	\$792	\$638	\$616	\$546
Rhode Island	\$95	\$171	\$0	\$61	\$56
South Carolina	\$481	\$440	\$440	\$440	\$446
South Dakota	\$0	\$1	\$1	\$2	\$1
Tennessee	\$108	\$0	\$0	\$0	\$0
Texas	\$1,513	\$1,513	\$1,513	\$1,513	\$1,439
Utah	\$5	\$5	\$5	\$6	\$4
Virginia	\$140	\$145	\$147	\$159	\$161
Vermont	\$19	\$37	\$31	\$36	\$22
Washington	\$309	\$348	\$348	\$364	\$333
Wisconsin	\$12	\$12	\$11	\$12	\$11
West Virginia	\$103	\$25	\$3	\$0	\$22
Wyoming	\$0	\$0	\$0	\$0	\$0
United States	\$16,890	\$18,990	\$15,049	\$15,921	\$14,961

Source: Urban Institute for data on FY94–FY96; HCFA for data on FY97 and FY98.

TABLE 5 Federal DSH Allotments for FY 1998 Through FY 2002 (in millions)

State	FY98	FY99	FY00	FY01	FY02
Alabama	\$293	\$269	\$248	\$246	\$246
Alaska	\$10	\$10	\$10	\$9	\$9
Arizona	\$81	\$81	\$81	\$81	\$81
Arkansas	\$2	\$2	\$2	\$2	\$2
California	\$1,086	\$1,068	\$986	\$931	\$877
Colorado	\$93	\$85	\$79	\$74	\$74
Connecticut	\$200	\$194	\$164	\$160	\$160
Delaware	\$4	\$4	\$4	\$4	\$4
District of Columbia	\$23	\$23	\$32	\$32	\$32
Florida	\$207	\$203	\$197	\$188	\$160
Georgia	\$253	\$248	\$241	\$228	\$215
Hawaii	\$0	\$0	\$0	\$0	\$0
Idaho	\$1	\$1	\$1	\$1	\$1
Illinois	\$203	\$199	\$193	\$182	\$172
Indiana	\$201	\$197	\$191	\$181	\$171
Iowa	\$8	\$8	\$8	\$8	\$8
Kansas	\$51	\$49	\$42	\$36	\$33
Kentucky	\$137	\$134	\$130	\$123	\$116
Louisiana	\$880	\$796	\$713	\$658	\$631
Maine	\$103	\$99	\$84	\$84	\$84
Maryland	\$72	\$70	\$68	\$64	\$61
Massachusetts	\$288	\$282	\$273	\$259	\$244
Michigan	\$249	\$244	\$237	\$224	\$212
Minnesota	\$16	\$16	\$33	\$33	\$33
Mississippi	\$143	\$141	\$136	\$129	\$122
Missouri	\$436	\$423	\$379	\$379	\$379
Montana	\$0	\$0	\$0	\$0	\$0
Nebraska	\$5	\$5	\$5	\$5	\$5
Nevada	\$37	\$37	\$37	\$37	\$37
New Hampshire	\$140	\$136	\$130	\$130	\$130

State	FY98	FY99	FY00	FY01	FY02
New Jersey	\$600	\$582	\$515	\$515	\$515
New Mexico	\$5	\$5	\$9	\$9	\$9
New York	\$1,512	\$1,482	\$1,436	\$1,361	\$1,285
North Carolina	\$278	\$272	\$264	\$250	\$236
North Dakota	\$1	\$1	\$1	\$1	\$1
Ohio	\$382	\$374	\$363	\$344	\$325
Oklahoma	\$16	\$16	\$16	\$16	\$16
Oregon	\$20	\$20	\$20	\$20	\$20
Pennsylvania	\$529	\$518	\$502	\$476	\$449
Rhode Island	\$62	\$60	\$58	\$55	\$52
South Carolina	\$313	\$303	\$262	\$262	\$262
South Dakota	\$1	\$1	\$1	\$1	\$1
Tennessee	\$0	\$0	\$0	\$0	\$0
Texas	\$979	\$950	\$806	\$765	\$765
Utah	\$3	\$3	\$3	\$3	\$3
Vermont	\$18	\$18	\$18	\$18	\$18
Virginia	\$70	\$68	\$66	\$63	\$59
Washington	\$174	\$171	\$166	\$157	\$148
West Virginia	\$64	\$63	\$61	\$58	\$54
Wisconsin	\$7	\$7	\$7	\$7	\$7
Wyoming	\$0	\$0	\$0.1	\$0.1	\$0.1
United States	\$10,256	\$9,938	\$9,278	\$8,869	\$8,524

Source: 63 *Federal Register* 54142-54148 (October 8, 1998).

TABLE 6 How Much of State DSH Allotments Can Be Spent on Institutions for Mental Diseases (IMD's) in FY 2000?

State	FY00 Federal Share DSH Allotment	FY00 Limit on Federal DSH Payments to IMDs	IMD Limit as a % of the Federal FY00 DSH Allotment
Alabama	\$248,000,000	\$2,644,671	1.1%
Alaska	\$10,000,000	\$8,753,105	87.5%
Arizona	\$81,000,000	\$18,770,654	23.2%
Arkansas	\$2,000,000	\$0	0.0%
California	\$986,000,000	\$0	0.0%
Colorado	\$79,000,000	\$269,276	0.3%
Connecticut	\$164,000,000	\$42,339,676	25.8%
Delaware	\$4,000,000	\$0	0.0%
District of Columbia	\$23,000,000	\$3,267,073	14.2%
Florida	\$197,000,000	\$84,618,910	43.0%
Georgia	\$241,000,000	\$0	0.0%
Hawaii	\$0	\$0	n/a
Idaho	\$1,000,000	\$0	0.0%
Illinois	\$193,000,000	\$42,577,808	22.1%
Indiana	\$191,000,000	\$94,811,835	49.6%
Iowa	\$8,000,000	\$0	0.0%
Kansas	\$42,000,000	\$36,607,658	87.2%
Kentucky	\$130,000,000	\$23,030,823	17.7%
Louisiana	\$713,000,000	\$74,226,426	10.4%
Maine	\$84,000,000	\$31,820,895	37.9%
Maryland	\$68,000,000	\$57,438,157	84.5%
Massachusetts	\$273,000,000	\$50,128,491	18.4%
Michigan	\$237,000,000	\$164,898,220	69.6%
Minnesota	\$16,000,000	\$2,706,414	16.9%
Mississippi	\$136,000,000	\$0	0.0%
Missouri	\$379,000,000	\$107,712,495	28.4%
Montana	\$0	\$0	n/a

State	FY00 Federal Share DSH Allotment	FY00 Limit on Federal DSH Payments to IMDs	IMD Limit as a % of the Federal FY00 DSH Allotment
Nebraska	\$5,000,000	\$1,096,393	21.9%
Nevada	\$37,000,000	\$0	0.0%
New Hampshire	\$130,000,000	\$47,376,974	36.4%
New Jersey	\$515,000,000	\$153,366,960	29.8%
New Mexico	\$5,000,000	\$0	0.0%
New York	\$1,436,000,000	\$287,397,385	20.0%
North Carolina	\$264,000,000	\$145,182,535	55.0%
North Dakota	\$1,000,000	\$696,086	69.6%
Ohio	\$363,000,000	\$53,906,537	14.9%
Oklahoma	\$16,000,000	\$2,248,378	14.1%
Oregon	\$20,000,000	\$11,977,065	59.9%
Pennsylvania	\$502,000,000	\$286,613,976	57.1%
Rhode Island	\$58,000,000	\$1,254,040	2.2%
South Carolina	\$262,000,000	\$43,039,703	16.4%
South Dakota	\$1,000,000	\$516,293	51.6%
Tennessee	\$0	\$0	n/a
Texas	\$806,000,000	\$155,823,818	19.3%
Utah	\$3,000,000	\$615,439	20.5%
Vermont	\$18,000,000	\$5,620,663	31.2%
Virginia	\$66,000,000	\$3,741,054	5.7%
Washington	\$166,000,000	\$81,048,593	48.8%
West Virginia	\$61,000,000	\$13,420,087	22.0%
Wisconsin	\$7,000,000	\$2,640,404	37.7%
Wyoming	\$0	\$0	n/a
United States	\$9,248,000,000	\$2,144,114,970	23.2%

Source: CB PP calculations based on the mental health cap formula described in *Federal Register*, Vol 63, No. 195.

TABLE 7 Percentage of Total DSH Allotment Spent (in millions)

State	FY96 DSH Federal Allotment	% of DSH Allotment Spent	FY97 DSH Federal Allotment	% of DSH Allotment Spent	FY98 DSH Federal Allotment	% of DSH Allotment Spent
Alabama	\$292	94.6%	\$290	100.0%	\$293	93.1%
Alaska	\$11	66.1%	\$13	59.7%	\$10	92.0%
Arizona	\$54	158.6%	\$0	0.0%	\$81	99.5%
Arkansas	\$3	99.7%	\$3	79.0%	\$2	60.0%
California	\$1,096	64.2%	\$1,099	96.2%	\$1,086	115.6%
Colorado	\$158	40.4%	\$158	50.7%	\$93	77.7%
Connecticut	\$204	108.1%	\$204	111.1%	\$200	92.6%
Delaware	\$4	100.0%	\$4	111.4%	\$4	100.0%
D.C.	\$31	66.0%	\$40	51.6%	\$23	100.0%
Florida	\$190	100.0%	\$204	100.0%	\$207	99.6%
Georgia	\$264	87.2%	\$263	94.2%	\$253	98.5%
Hawaii	\$41	0.0%	\$40	0.0%	\$0	n/a
Idaho	\$2	97.4%	\$2	236.2%	\$1	150.0%
Illinois	\$271	44.9%	\$303	45.2%	\$203	66.4%
Indiana	\$214	47.6%	\$219	48.2%	\$201	59.5%
Iowa	\$10	75.7%	\$11	103.0%	\$8	156.3%
Kansas	\$11	292.0%	\$111	32.0%	\$51	52.7%
Kentucky	\$200	53.2%	\$217	74.6%	\$137	100.0%
Louisiana	\$875	66.1%	\$869	47.3%	\$880	58.8%
Maine	\$105	100.0%	\$105	93.9%	\$103	78.5%
Maryland	\$75	96.7%	\$85	94.3%	\$72	94.4%
Massachusetts	\$288	99.2%	\$299	91.3%	\$288	86.3%
Michigan	\$390	50.6%	\$383	43.7%	\$249	68.7%
Minnesota	\$34	96.8%	\$38	78.8%	\$16	183.1%
Mississippi	\$157	99.6%	\$169	98.6%	\$143	99.2%
Missouri	\$440	99.0%	\$439	95.4%	\$436	92.7%
Montana	\$1	16.8%	\$1	15.4%	\$0	n/a
Nebraska	\$7	26.2%	\$8	0.0%	\$5	72.0%

	FY96 DSH Federal Allotment	% of DSH Allotment Spent	FY97 DSH Federal Allotment	% of DSH Allotment Spent	FY98 DSH Federal Allotment	% of DSH Allotment Spent
Nevada	\$37	100.0%	\$37	100.0%	\$37	99.5%
New Hampshire	\$196	58.7%	\$196	36.2%	\$140	45.9%
New Jersey	\$547	91.1%	\$547	93.2%	\$600	85.0%
New Mexico	\$15	58.5%	\$17	48.3%	\$5	136.0%
New York	\$1,524	87.4%	\$1,763	80.2%	\$1,512	61.5%
North Carolina	\$296	79.0%	\$311	70.4%	\$278	80.4%
North Dakota	\$1	71.5%	\$1	152.7%	\$1	80.0%
Ohio	\$392	100.0%	\$405	100.0%	\$382	100.0%
Oklahoma	\$2	756.9%	\$18	101.1%	\$16	100.0%
Oregon	\$20	83.8%	\$21	75.1%	\$20	83.0%
Pennsylvania	\$512	65.9%	\$546	59.6%	\$529	55.1%
Rhode Island	\$60	0.0%	\$62	53.1%	\$62	48.1%
South Carolina	\$311	100.0%	\$310	100.0%	\$313	100.0%
South Dakota	\$1	68.3%	\$1	97.4%	\$1	70.0%
Tennessee	\$283	0.0%	\$278	0.1%	\$0	n/a
Texas	\$943	100.0%	\$947	100.0%	\$979	91.5%
Utah	\$5	82.9%	\$5	85.6%	\$3	100.0%
Vermont	\$19	99.0%	\$21	104.9%	\$18	76.7%
Virginia	\$114	66.3%	\$125	65.5%	\$70	118.1%
Washington	\$177	98.8%	\$184	100.0%	\$174	99.8%
West Virginia	\$97	2.0%	\$98	0.0%	\$64	25.2%
Wisconsin	\$7	97.6%	\$8	90.2%	\$7	94.3%
Wyoming	\$1	0.0%	\$1	0.0%	\$0	n/a
United States	\$10,987	90.5%	\$11,477	73.8%	\$10,256	80.0%

Source for data on states' federal DSH Allotments: *63 Federal Register* 54142-54148 (October 8, 1998); source for data on actual spending during FY96: The Urban Institute; source for actual spending during FY97 and FY 98: HCFA Form 64.

Note: These data should be treated cautiously because they suggest that some states have spent more than they are allowed. Although HCFA's Form 64 does not address why this is the case, it more likely reflects changes that need to be made.

TABLE 8 FY 1998 DSH Expenditures as a Percentage of the Federal Allotment for FY2002 (in millions)

State	FY98 Federal DSH Expenditures	FY02 Federal Allotment	% of Allocation Spent in FY02, Assuming FY98 Spending Levels
Alabama	\$272.9	\$246	110.9%
Alaska	\$9.2	\$9	102.2%
Arizona	\$80.6	\$81	99.5%
Arkansas	\$1.2	\$2	60.0%
California	\$1,255.0	\$74	143.1%
Colorado	\$72.3	\$74	97.7%
Connecticut	\$185.1	\$160	115.7%
Delaware	\$4.0	\$4	100.0%
District of Columbia	\$23.0	\$23	100.0%
Florida	\$206.2	\$160	128.9%
Georgia	\$249.2	\$215	115.9%
Hawaii	\$0.0	\$0	n/a
Idaho	\$1.5	\$1	150.0%
Illinois	\$134.8	\$172	78.4%
Indiana	\$119.5	\$171	69.9%
Iowa	\$12.5	\$8	156.3%
Kansas	\$26.9	\$33	81.5%
Kentucky	\$137.0	\$116	118.1%
Louisiana	\$517.0	\$631	81.9%
Maine	\$80.9	\$84	96.3%
Maryland	\$68.0	\$61	111.5%
Massachusetts	\$248.6	\$244	101.9%
Michigan	\$171.1	\$212	80.7%
Minnesota	\$29.3	\$16	183.1%
Mississippi	\$141.8	\$122	116.2%
Missouri	\$404.2	\$379	106.6%
Montana	\$0.2	\$0	n/a

State	FY98 Federal DSH Expenditures	FY 2002 Federal Allotment	FY 2002 % of Allocation Spent in FY02, Assuming FY98 Spending Levels
Nebraska	\$3.6	\$5	72.0%
Nevada	\$36.8	\$37	99.5%
New Hampshire	\$64.2	\$130	49.4%
New Jersey	\$510.2	\$515	99.1%
New Mexico	\$6.8	\$5	136.0%
New York	\$930.3	\$1,285	72.4%
North Carolina	\$223.4	\$236	94.7%
North Dakota	\$0.8	\$1	80.0%
Ohio	\$382.0	\$325	117.5%
Oklahoma	\$16.0	\$16	100.0%
Oregon	\$16.6	\$20	83.0%
Pennsylvania	\$291.7	\$449	65.0%
Rhode Island	\$29.8	\$52	57.3%
South Carolina	\$313.0	\$262	119.5%
South Dakota	\$0.7	\$1	70.0%
Tennessee	\$0.0	\$0	n/a
Texas	\$896.1	\$765	117.1%
Utah	\$3.0	\$3	100.0%
Vermont	\$13.8	\$18	76.7%
Virginia	\$82.7	\$59	140.2%
Washington	\$173.6	\$148	117.3%
West Virginia	\$16.1	\$54	29.8%
Wisconsin	\$6.6	\$7	94.3%
Wyoming	\$0.1	\$0	n/a
United States	\$7,216	\$8,494	89.3%

Source: Health Care Financing Administration

TABLE 9 Percentage of DSH Funds Going to Mental Hospitals in Recent Years (in millions)

State	FY96 Total Federal and State Mental Health DSH Payments	FY96 Mental Health as % of Total	FY97 Total Federal and State Mental Health	FY97 Mental Health as % of total DSH	FY98 Total Federal and State Mental Health DSH Payments	FY98 Mental Health as % of Total DSH
Alabama	\$48	12.2%	\$29	7.0%	\$4.5	1.1%
Alaska	\$14	100.0%	\$15	100.0%	\$15.4	100.0%
Arizona	\$0	0.0%	\$0	0.0%	\$0	0.0%
Arkansas	\$0	0.0%	\$0	0.0%	\$0.5	29.4%
California	\$0	0.0%	\$0	0.0%	\$0	0.0%
Colorado	\$0.16	0.1%	\$0	0.2%	\$0.1	0.1%
Connecticut	\$161	36.5%	\$162	35.6%	\$103.3	27.9%
Delaware	\$8.6	100.0%	\$10	100.0%	\$8.0	100.0%
D.C.	\$5.4	13.4%	\$6	13.5%	\$2.8	8.5%
Florida	\$169	49.7%	\$182	49.7%	\$149.0	40.2%
Georgia	\$0	0.0%	\$0	0.0%	\$0	0.0%
Hawaii	\$0	0.0%	\$0	0.0%	\$0	n/a
Idaho	\$0	0.0%	40	0.0%	\$0.0	0.0%
Illinois	\$66	27.2%	\$116	42.3%	\$119.3	44.3%
Indiana	\$80	49.4%	\$103	60.1%	\$98.4	50.5%
Iowa	\$0	0.0%	\$0	0.0%	\$0	0.0%
Kansas	\$49	89.4%	\$54	89.6%	\$38.9	86.4%
Kentucky	\$34	22.3%	\$65	28.2%	\$34.5	17.7%
Louisiana	\$109	13.5%	\$78	13.6%	\$83.6	11.3%
Maine	\$50	30.3%	\$53	34.4%	\$44.8	36.6%
Maryland	\$108	73.8%	\$122	76.7%	\$116.2	85.4%
Massachusetts	\$129	22.6%	\$109	20.1%	\$103.8	20.9%
Michigan	\$241	69.4%	\$231	76.3%	\$211.0	66.1%
Minnesota	\$8	12.7%	\$6	11.1%	\$4.6	8.2%
Mississippi	\$0	0.0%	\$0	0.0%	\$0	0.0%
Missouri	\$154	21.2%	\$209	30.0%	\$199.0	29.9%

State	FY96 Total Federal and State Mental Health DSH Payments	FY96 Mental Health as % of Total	FY97 Total Federal and State Mental Health DSH Payments	FY97 Mental Health as % of total DSH	FY98 Total Federal and State Mental Health DSH Payments	FY98 Mental Health as % of Total DSH
Montana	0	0.0%	0	0.0%	\$0.0	0.0%
Nebraska	\$0.14	4.3%	\$0	0.0%	\$0.0	0.0%
Nevada	\$0	0.0%	\$0	0.0%	\$0.0	0.0%
New Hampshire	\$138	60.2%	\$42	29.4%	\$25.0	19.5%
New Jersey	\$331	33.2%	\$326	32.0%	\$303.0	29.7%
New Mexico	\$0	0.0%	\$0	0.0%	\$0.0	0.0%
New York	\$282	10.6%	\$357	12.6%	\$604.8	32.5%
North Carolina	\$198	54.7%	\$149	43.4%	\$166.4	47.0%
North Dakota	\$0.75	83.3%	\$2	89.7%	\$1.0	83.3%
Ohio	\$0	0.0%	0	0.0%	\$93.4	14.2%
Oklahoma	\$2.4	12.5%	\$4	16.1%	\$3.2	14.1%
Oregon	\$21	76.8%	\$21	81.8%	\$17.8	65.9%
Pennsylvania	\$329	51.6%	\$384	62.3%	\$330.3	60.5%
Rhode Island	\$0	0.0%	\$0	0.1%	\$0.0	0.1%
South Carolina	\$44	10.1%	\$38	8.6%	\$37.6	8.4%
South Dakota	\$0.75	70.6%	\$1	79.6%	\$0.8	72.7%
Tennessee	\$0	0.0%	\$0	0.0%	\$0.0	n/a
Texas	\$319	21.1%	\$395	26.1%	\$264.4	18.4%
Utah	\$1.3	25.3%	\$1	18.3%	\$0.8	19.5%
Vermont	\$10	30.2%	\$9	25.5%	\$2.2	9.9%
Virginia	\$8.4	5.7%	\$0	0.2%	\$8.2	5.1%
Washington	\$105	30.1%	\$107	29.4%	\$105.4	31.7%
West Virginia	\$1.8	65.6%	0	0.0%	\$3.8	17.4%
Wisconsin	\$8.4	73.2%	\$5	46.4%	\$2.8	25.0%
Wyoming	\$0	0.0%	\$0	0.0%	\$0.0	0.0%
United States	\$3,234	28.68%	\$3,392	27.25%	\$3,309	26.26%

Source: FY1996 are from the Urban Institute, while FY97 and FY98 data are from the HCFA Form 64.

TABLE 10 States with Section 1115 Waivers that Might Affect Access

California- Los Angeles County

Delaware

Florida (approved but not implemented)

Hawaii

Massachusetts

New Jersey (approved but not implemented)

New York

Ohio (approved but not implemented)

Tennessee

Vermont

TABLE 11 Levels of Medicaid Beneficiaries, Uninsured Individuals, and Federal DSH Allocations in Texas, Georgia, and New Jersey

State	Medicaid Beneficiaries*	Number of Uninsured**	Uninsured Rates	FY00 Federal DSH Allocations (in millions)
Texas	2,538,655	4,768,985	26.8%	\$806
Georgia	1,208,445	1,326,838	19.4%	\$241
New Jersey	537,890	1,301,076	18.5%	\$515

* Source: HCFA 2082 data for FY00.

** Source: CBPP calculations based on March CPS data.

*** Source: Dept. of Health and Human Services.

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