California's Disproportionate Share Hospital Program: Background Paper

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Introduction

Disproportionate Share Hospitals (DSH) are hospitals that receive federal and state funds to subsidize the costs associated with providing care to indigent and very low-income people. California's DSH program accounted for more than $1 billion in federal matching payments to 127 public and private hospitals in FY 1997-98.[1,2] Combined state and federal DSH funds represent approximately 12% of total Medi-Cal expenditures.[3] Since its inception in 1980 through the Boren Amendment, the DSH program has evolved into an important source of support for safety net hospitals and health systems. However, the program's ability to supplement the safety net effectively has been an issue of constant debate. Moreover, dramatic changes in health care financing have further challenged the DSH program's effectiveness. This background paper is an effort to summarize many of these significant changes and outline upcoming challenges.

I. Federal Overview

Boren Amendment in the Omnibus Budget Reconciliation Acts of 1980 and 1981

The Medicaid Disproportionate Share Hospital (DSH) program was established to support hospitals that serve large numbers of Medicaid and low-income patients. Its creation was based on the belief that these hospitals required additional financial support because of Medicaid's low reimbursement rates and the costly burden of serving the uninsured. In addition, because hospitals serving low-income patients often have low numbers of privately insured individuals, their ability to shift the costs of uncompensated care to private insurers is limited. As a result, the Boren Amendment in the Omnibus Budget Reconciliation Acts (OBRA) of 1980 and 1981:

- Mandated that Medicaid programs take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs when determining payment rates for inpatient hospital care.

OBRA 1986

Despite the 1981 legislation, states were slow to take advantage of the new program. Up until 1991, California's DSH program established by SB 4563 had been limited. One significant barrier was that in 1983 the Health Care Financing Administration (HCFA) mandated that states could not pay more for Medicaid inpatient care or long-term services than what was paid in the Medicare program. This was referred to as the "Medicare upper payment limit." In response, OBRA 1986:

- Allowed states to pay disproportionate share hospitals above the Medicare upper payment limit.

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Realizing the underutilized potential benefits of the DSH program, states developed mechanisms to come up with the state share of DSH funding. These mechanisms included provider donations, provider taxes and intergovernmental transfers. Through the DSH program, this state share, less a state "administrative fee," was matched with federal funds and the total redistributed to providers. Through these programs, especially at a time of widespread recession and state budget pressures, DSH represented a valuable source of support to the safety net.

However, Congress became alarmed with the DSH program's growth. The number of state DSH programs increased from 6 to 39 between 1990 and 1992.[4] During this period, DSH spending grew from $1.3 billion to $17.7 billion.[5] Congress responded with the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which:

- Banned provider donations.
- Capped provider taxes so that revenues could not exceed 25% of the state's share of Medicaid expenditures.
- Required that provider taxes be "broad based" and providers not be "held harmless."
- Capped DSH payments at approximately 1992 levels with a 12% cap on national expenditures.

OBRA 1993

In 1993, Congress became concerned with how DSH payments were being distributed. There were some reports that hospitals that were not large Medicaid providers were receiving payments. Other hospitals were found to be receiving payments in excess of financial losses. In instances where DSH payments exceeded total Medicaid reimbursements, it was feared that states were using payments to supplement general state funds rather than to bolster the safety net. As a result, OBRA 1993 mandated that:

- Hospitals must have a Medicaid use rate of at least 1% to receive DSH payments.
- DSH payments to a single hospital could not exceed the unreimbursed costs of providing inpatient care to Medicaid and uninsured patients. (Public hospitals, however, were given a two year exemption allowing them to receive payments of up to 200% of unreimbursed costs. This exemption was extended for California by BBA 1997 until June 1999 at a rate of 175%.)

OBRA 1993 forced many states to seriously restructure their distribution methodologies. Because of the new restrictions, many states have had difficulties in spending their full DSH allotments, creating financial hardships for some safety net hospitals.

Balanced Budget Act of 1997

The drive for a balanced budget subjected the DSH program to serious cuts through the Balanced Budget Act of 1997 (BBA 1997) – approximately $17 billion in gross Medicaid reductions by 2002. Congress reasoned that DSH payments had not been well targeted in supporting the safety net. Critics pointed out that the DSH program allowed states to accept large "administrative fees" that supplement general funds, and that these fees were being used to support non-health related programs. Furthermore, critics argue that the distribution between states is not to be based on need, but rather, determined by the historical development of the program. The major actions of the BBA 1997 included:

- State specific DSH allotments from 1998 until 2002. After 2002, federal DSH expenditures will be allowed to increase by the percentage change in the Consumer Price Index, not to exceed 12% of total state Medicaid expenditures.
- Limits on allotments to institutions for treatment of mental diseases.
- Requirements that DSH payments must be paid directly to providers rather than included in capitation rates to managed care organizations.

The ultimate impact of the BBA 1997 DSH reductions on states is uncertain. It is clear, however, that states will face great challenges as they look to the future of health care provision for low-income people.

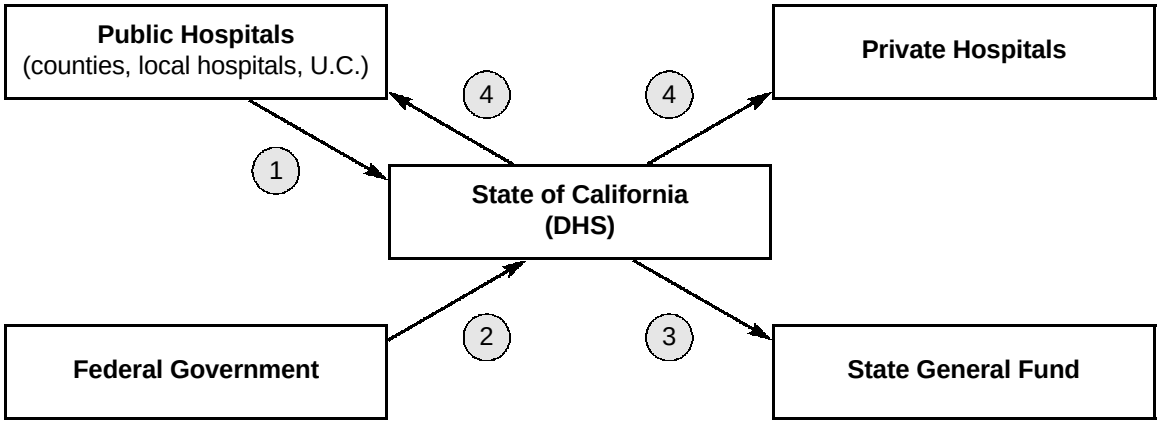
II. California's Experience

Many public and private California hospitals depend upon the DSH program (referred to as SB 855) as an important part of their annual budgets. Under the SB 855 program, public entities—counties, local hospital districts and the University of California—supply the state share of DSH funds through intergovernmental transfers (IGTs). California's Department of Health Services (DHS) then uses these funds as the basis for a federal match. As of October 1998, the federal Medicaid matching rate for California, including its DSH program, was 51.55%.[6] The state retains a portion of the resulting $2.1 billion DSH fund as an "administrative fee." That administrative fee goes into the general state fund. In FY 1997-98, the state retained approximately $154 million in administrative fees through the DSH program.[7] California redistributes the remaining combined state and federal DSH funds as supplemental payments to both public and private hospitals based on the percentage of Medi-Cal and indigent care provided in the previous year.

California's federal allotment of DSH dollars is one of the highest in the country, second only to New York's.[8] In FY 1997-98, the DSH program benefited 127 hospitals and accounted for approximately 12% of total Medi-Cal expenditures.[9,10] Federal DSH payments to individual hospitals in the same period ranged from less than $100,000 to more than $50 million.[11]

Combined federal and state DSH funds of approximately $2.1 billion make up a significant portion of the total funds allocated to provide health care to the indigent: according to the Legislative Analyst's Office 1996 estimate, approximately $2 billion to $2.5 billion is spent annually on indigent health expenditures in California.[12,13] However, it is not clear what proportion of public DSH funds are targeted towards indigent care rather than towards the replacement of declining Medi-Cal revenues.

California's SB 855 DSH Program



1. State collects revenue through inter-governmental transfers (IGTs) from public entities, including counties, local hospital districts, and the University of California.
2. Federal government matches the State's share at California's federal Medicaid matching rate: 51.55%.
3. State retains a portion of the combined fund as an "administrative fee."
4. State distributes combined funds as supplemental payments to both public and private hospitals.

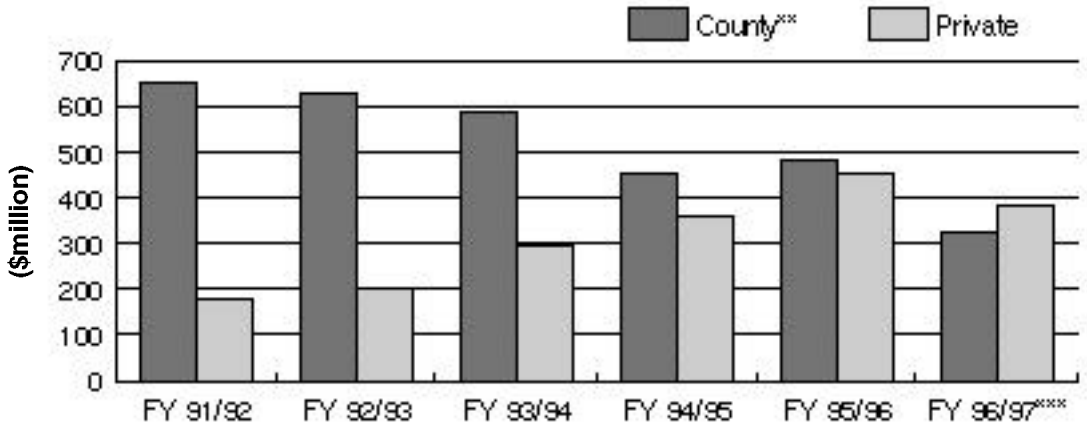
Distribution Formulas: Public/Private Mix

In California, both public and private hospitals are eligible to receive DSH funds. The formula for calculating DSH payments takes into account the number of inpatient days of both Medi-Cal and uncompensated care, more heavily rewarding Medi-Cal care. To qualify for DSH funds, a hospital must meet one of two criteria: (1) its number of Medi-Cal inpatient days must be at least one standard deviation above the statewide mean; or (2) its revenues from low-income utilization (including Medi-Cal and uncompensated care) must account for 25% or more of its total revenues.

Though private providers do not transfer money to the state, the private share of DSH payments has been steadily growing as these hospitals are increasingly serving more Medi-Cal patients. Due to the 25% low-income utilization criteria, it is possible for hospitals that don't provide any uncompensated care to qualify for DSH funds if they have a high Medi-Cal utilization rate.

The percentage of private DSH-eligible hospitals has been steadily rising, increasing from 9.8% in 1992-93 to 16.7% in 1994-95.[14] Many experts believe this increase is largely driven by the attractiveness of Medi-Cal rates in an increasingly competitive health care market and

SB 855 Net Benefit:* Private and County Hospitals



* Net benefit: total supplement less intergovernmental transfer and "administrative fee."
** The trends for public non-profit hospitals may be similar to those of county hospitals.
*** In FY 96/97, due to the passage of AB 768, the total public/private distribution of DSH funds was 50/50 (public including both the county hospitals depicted in this table as well as non-profit public hospitals).

Source: California Association of Public Hospitals and Health Systems (CAPH). *1997 Status Report of The Medi-Cal Disproportionate Share Hospital Program: Broke and Broken.* February 1997.

the expansion of Medi-Cal managed care. Moreover, although California recently received a special exemption to pay public hospitals up to 175% of unreimbursed costs (BBA 1997), the OBRA 1993 hospital-specific caps have also limited the ability to make payments to public hospitals. As a result, public hospitals, which are responsible for the bulk of indigent care, have seen decreasing returns on their transfers to the DSH program. In addition, as public facilities continue a trend of privatization, due in part perhaps to the impending loss of DSH dollars, public hospitals worry that the number of entities responsible for making IGTs is decreasing.

Public hospitals argue that their ability to cross-subsidize indigent care is threatened by the DSH formula that weighs Medi-Cal care more heavily than indigent care. Almost all of the private DSH hospitals qualify for benefits due to their Medi-Cal caseload, while a much larger percentage of public hospitals qualify due to their indigent care caseloads. Further, private hospitals are not required to put money into the pool in order to receive the benefits of DSH payments. On the other hand, private hospitals that have taken on larger caseloads of Medi-Cal patients counter that they deserve compensation for the care they provide to Medi-Cal recipients. Due to low hospital payment rates, the private hospitals argue, DSH supplemental payments are necessary to provide care to Medi-Cal recipients. Moreover, private facilities point out that they are not capable of making intergovernmental transfers.

Medi-Cal Managed Care and a Hospital-Centric System

The shift to Medi-Cal managed care has also raised debate over the distribution and availability of DSH payments. The difficulty is that although DSH payments have evolved into an important mechanism for covering care for the uninsured, DSH is largely tied to Medi-Cal inpatient days. This financing mechanism has been criticized for perpetuating a hospital-centric system that generates incentives for treating patients in more costly settings and that is resistant to downsizing. However, Medi-Cal managed care's attempts to provide care in more appropriate outpatient settings represents decreased patient days for hospitals, and therefore decreased DSH supplemental payments to the county systems that provide the bulk of care to the indigent. In other words, some would say that the DSH mechanism places the need for appropriate and efficient care to Medi-Cal recipients at odds with the desire to supplement the cost of care for the indigent.

Balanced Budget Act 1997

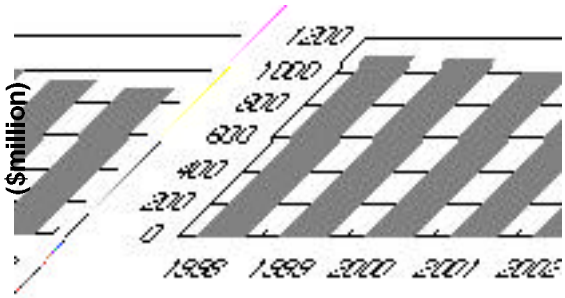
BBA 1997 presents California with relatively large reductions in DSH financing. Federal participation in the DSH program is incrementally reduced to $877 million by FY 2002, a 19% reduction from 1995 allotments of $1.1 billion in 1995.

BBA 1997 also recreates a ratcheted down version of the OBRA 1993 unreimbursed cost exemption for California, allowing the state to pay individual public hospitals up to 175% rather than 100% of their total unreimbursed costs until June 1999. It is estimated that restricting payments to 1993 caps of 100% would have resulted in public hospitals receiving only one-third of the net benefit from the DSH program and California losing $200 million in federal allotments.[15]

Estimated Impact of BBA 1997 on Federal DSH Spending for California

	% Change
1998 reduction relative to 1995 spending levels	–9%
2002 reduction relative to 1995 spending levels	–19%

Source: T.A. Coughlin and D. Liska, "The Medicaid Disporportionate Share Hospital Payment Program: Background and Issues." The Urban Institute. *New Federalism: Issues and Options for States.* Series A, No. A-14, October 1997.



Source: A. Schneider, S. Cha and S. Elkin, "Overview of Medicaid 'DSH' Provisions in the Balanced Budget Act of 1997." Center on Budget and Policy Priorities. September 1997.

Stabilization and Maximization: AB 768 and AB 2087

The compounding of these major issues in 1997 prompted advocates such as the California Association of Public Hospitals to announce that DSH was on the verge of a "meltdown."[16] In response, and to meet the requirements of BBA 1997, California passed AB 768 in 1997 to enact a major stabilization plan. The plan sought to maximize the use of federal funds and to ensure the public share of DSH payments. Among the major strategies included in the plan, AB 768 mandated:

- The creation of a supplemental DSH payment in addition to base payments to maximize state use of federal allotments for both FY 1997 and FY 1998.

- The recasting of the DSH base payments at a level of $1.75 billion, to be split approximately 50:50 between public and private hospitals.

- A $75 million reduction in the state "administrative fee" to $154 million.

In June 1998, California submitted a proposed Medi-Cal state plan amendment to HCFA based on AB 2087, which extends the provisions of AB 768 for two years. HCFA approved the amendment on September 23, 1998. In addition to extending AB768, the amendment:

- "Accelerates" payments from three months in FY 1999 into FY 1998, and from FY 2000 to FY 1999, to maximize federal participation. This creates a "five-quarter year" to lessen the impact of hospital-specific payment caps that are to become active in June 1999.

- Limits DSH payments to public hospitals that convert to private ownership.

Both AB 768 and AB 2087 were written with the support of all participating DSH hospitals. Motives for these changes included concerns over hospital-specific limits, reductions in the number of participating public hospitals due to conversions, and the diminishing return on the public hospitals' matching payments.

III. SB 1255 Emergency Services Supplemental Payments Fund

The Emergency Services and Supplemental Payments Fund (known as "SB 1255") is a DSH-type program that supplements hospitals in the form of higher rates during annual negotiations with the California Medical Assistance Commission (CMAC). CMAC is a commission appointed by the Governor and the Legislature that selectively contracts with hospitals to provide services to Medi-Cal beneficiaries. In FY 1998-99, about 65 of the 127 hospitals eligible for SB 855 payments are also eligible for SB 1255.[17] Hospitals that are eligible to negotiate with CMAC for SB 1255 payments must:

- Meet disproportionate share hospitals criteria.
- Be licensed providers of emergency medical services (or children's hospitals which provide emergency services in conjunction with another licensed hospital).
- Contract with CMAC to serve Medi-Cal patients through the Selective Provider Contracting Program.

SB 1255 is similar to the federal DSH program in terms of transfer and payment methodology. *Voluntary* intergovernmental transfers from public entities are matched with federal funds, which are not counted against California's DSH allotment. CMAC then distributes payments to public and private hospitals through negotiations. However, this discretionary fund is not subject to the same federal regulations of the DSH program.

Although the SB 1255 program is smaller than SB 855, it has grown substantially in the last few years. SB 1255 payments almost doubled between 1992-93 and 1994-95 from approximately $180 million to $344 million.[18] With the future of SB 855 payments in jeopardy, the demands on the SB 1255 program have increased even further. In FY 1997-98, 64 eligible disproportionate share hospitals received a total of $910 million from the SB 1255 fund.[19]

IV. The Future of DSH

DSH is a complex supplemental financing mechanism that is fraught with design inconsistencies. Despite these challenges, however, it has provided significant support to the hospitals that serve Medi-Cal recipients and the uninsured. The program's imminent downsizing raises many questions for California:

- What will be the impact of DSH reductions and other changes on the safety net? On Medi-Cal recipients? On the uninsured?

- The California Association of Public Hospitals states that since the DSH program has made federal support available, "the state has provided no or minimal Medi-Cal rate increases to hospitals during this period, contributing to California's near-bottom rankings of expenditures per beneficiary." Will the state of California offset federal reductions with state support, or will it pass the burden on to providers and county governments?

- Can California sustain the maximized use of federal allotments with its current strategies?

- How will California resolve the problem of the public/private DSH payment mix as the pressures of managed care and privatization continue to decrease public hospitals' ability to cross-subsidize for indigent care?

References

[1] California Association of Public Hospitals and Health Systems. *1997 Status Report of the Medi-Cal Disproportionate Share Hospital Program: Broke and Broken.* February 1997. Page 1.

[2] California Department of Health Services. *List of Eligible Hospitals: Disproportionate Share Hospital Payment Program, Fiscal Year 1997/98*. October 1997.

[3] Medical Care Statistics Section, California Department of Health Services. *Annual Statistical Report: 1998 Draft Report.* Table 12.

[4] Ku L. and T. Coughlin. *Medicaid Disproportionate Share and Other Special Financing Programs: A Fiscal Dilemma for States and the Federal Government*. The Urban Institute. December 1994. Page 6.

[5] Coughlin T. and D. Liska. "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals." *Health Affairs*. Volume 17, Number 3. May/June 1998. Page 119.

[6] California Department of Finance. *1998-99 Governor's Budget Summary: Health and Welfare*. http://www.dof.ca.gov/html/budgt8-9/H&W.html.

[7] California State Senate. AB 768 bill analysis. http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_0751-0800/ab_768_cfa_19970906_143338_sen_floor.html.

[8] The Kaiser Commission on the Future of Medicaid. *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995.* November 1997.

[9] California Department of Health Services. *List of Eligible Hospitals: Disproportionate Share Hospital Payment Program, Fiscal Year 1997/98*. October 1997.

[10] Medical Care Statistics Section, California Department of Health Services. *Annual Statistical Report: 1998 Draft Report.* Table 12.

[11] California Association of Public Hospitals and Health Systems. Phone interview: January 5, 1998.

[12] The Urban Institute. *Assessing the New Federalism: California State Report.* January 1998. Page 61.

[13] Legislative Analyst's Office. *LAO Analysis of the 1996-98 Budget Bill: Health and Social Services, Cross-Cutting Issues.* http://www.lao.ca.gov/a96ccc.html.

[14] The Urban Institute. *Assessing the New Federalism: California State Report.* January 1998. Page 63.

[15] The Urban Institute. *Assessing the New Federalism: California State Report.* January 1998. Page 64.

[16] California Association of Public Hospitals and Health Systems. *1997 Status Report of The Medi-Cal Disproportionate Share Hospital Program: Broke and Broken.* February 1997. Page 1.

[17] California Medical Assistance Commission. *Annual Report to the Legislature: 1998.* Page 16.

[18] The Urban Institute. *Assessing the New Federalism: California State Report.* January 1998. Page 65.

[19] California Medical Assistance Commission. *Annual Report to the Legislature: 1998.* Page 16.