United States General Accounting Office

GAO

Report to the Honorable Kent Conrad, U.S. Senate

January 1998

MEDICAID

Disproportionate Share Payments to State Psychiatric Hospitals

GAO/HEHS-98-52

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-276914

January 23, 1998

The Honorable Kent Conrad
United States Senate

Dear Senator Conrad:

States have been searching for ways to help finance the $172 billion Medicaid program, a jointly funded federal and state entitlement program providing medical assistance to low-income people. Beginning in the mid-1980s, states began to use so-called creative financing mechanisms, such as provider-specific taxes and voluntary contributions, which were returned to the providers in the form of increased Medicaid reimbursements, and disproportionate share hospital payments to public hospitals, which were returned to the state through intergovernmental transfers. These mechanisms both allowed states to increase the federal Medicaid contributions they received without effectively increasing their own matching funds and contributed significantly to Medicaid's more than 25-percent annual growth in 1991 and 1992.[1] To restrict the use of some of these mechanisms, the Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 that limited the sources of state matching funds. Through the Omnibus Budget Reconciliation Act of 1993, the Congress added limits on payments that could be made under the disproportionate share hospital (DSH) program to further restrict state financing mechanisms.[2]

While these legislative actions have significantly reduced the states' use of these financing mechanisms, states continue to find innovative ways to obtain additional federal funds. Some observers are now concerned that state Medicaid programs making large DSH payments to state psychiatric hospitals are benefiting state treasuries by indirectly paying some of the cost of institutional services for adults that federal law prohibits Medicaid programs from covering.[3] Because of these concerns, you asked us to follow up on our July 1997 correspondence on DSH payments to institutions for mental diseases and determine the extent to which this is

[1]For more information, see Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

[2]This program provides supplemental payments to hospitals that serve large numbers of Medicaid and other low-income patients.

[3]Medicaid has never allowed states to pay for services provided to individuals between the ages of 21 and 65 who are in institutions for mental diseases (IMD). IMDs are hospitals with more than 16 beds that specialize in psychiatric care, such as state psychiatric hospitals.

occurring.[4] Accordingly, our objectives were to determine (1) how the amount of DSH payments to state psychiatric hospitals compares with DSH payments made to other types of hospitals, (2) how the proportion of Medicaid beneficiaries in state psychiatric hospitals compares with that proportion in other hospitals, and (3) what proportion of the maximum allowable DSH payment states paid state psychiatric hospitals compared with the proportion of the maximum allowable paid to other types of hospitals.[5]

States do not routinely provide data to answer these questions to the Health Care Financing Administration (HCFA), the agency responsible for administering Medicaid at the federal level. Consequently, we visited or contacted officials in Kansas, Maryland, Michigan, New Hampshire, North Carolina, and Texas. We chose these states on the basis of our analysis of the 1993 through 1995 DSH expenditure data. We picked Michigan and Texas for site visits because those states reported high growth in mental health DSH expenditures during the period. We selected Maryland, New Hampshire, and North Carolina for site visits because their mental health DSH expenditures represented a high proportion of their total DSH expenditures. In addition, we contacted Kansas because it reported a large decline in mental health DSH expenditures. We obtained information on DSH payments made to individual hospitals in 1996 from the state Medicaid agencies and then compared them by type of hospital in each of the six states. Further, we examined related data on Medicaid utilization rates and hospital-specific maximum allowable DSH payments. Finally, we contacted headquarters and regional officials in HCFA to discuss Medicaid DSH payments and the statutes and regulations governing these payments. We performed our work between July 1997 and December 1997 in accordance with generally accepted government auditing standards.

Results in Brief

Medicaid DSH payments to state psychiatric hospitals were far larger on average than payments made to other types of local public and private hospitals in the states we contacted, enabling the states to obtain federal matching funds to indirectly cover costs of services provided to patients in IMDs that Medicaid cannot pay for directly. Overall, DSH payments to state psychiatric hospitals averaged about $29 million per hospital compared with $1.75 million for private hospitals. In four of the six states, the

[4] Medicaid: Disproportionate Share Hospital Payments to Institutions for Mental Diseases (GAO/HEHS-97-181R, July 15, 1997).

[5] The Omnibus Budget Reconciliation Act of 1993 set maximum allowable DSH payments at no more than a hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients.

average DSH payments to state psychiatric hospitals were also much larger than those to other state-owned hospitals. In the two other states, DSH payments to the other state-owned hospitals were larger than payments to state psychiatric hospitals. In all but one state, the average DSH payment per bed day was also much higher for state psychiatric hospitals than for other types of hospitals, indicating that the large DSH payments were not simply a function of hospital size. The Balanced Budget Act of 1997 limits the proportion of a state's DSH payment that can be paid to IMDS; this should reduce such payments to state psychiatric hospitals in at least some of these states.

State psychiatric hospitals receiving DSH payments in five of the six states we reviewed often served smaller proportions of Medicaid patients than other state-owned, local public, and private hospitals. For example, the 1996 average Medicaid utilization rate at Texas state psychiatric hospitals was about 3 percent, while the average rate at other types of hospitals was much higher, up to 37 percent at local public hospitals.[6] However, in one state, the state psychiatric hospital served a higher proportion of Medicaid patients than other hospitals receiving DSH payments.

The states in our review allocated DSH funds to state psychiatric hospitals at or near the maximum allowed by Medicaid rules and made DSH payments to other hospitals that were far below their limits. Each of the six states made 1996 DSH payments to its state psychiatric hospitals at more than 90 percent of the maximum allowable amount, and four of the six states paid these hospitals the maximum allowed. Other types of hospitals often received much less. For example, local public hospitals in Kansas as well as private hospitals in Michigan and North Carolina all received, on average, less than 10 percent of their allowed maximum.

Background

In 1965, Medicaid was established as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by HCFA, an agency within the Department of Health and Human Services (HHS). Within a broad legal framework, each state designs and administers its own Medicaid program. States decide how much to reimburse providers for each service and whether to cover optional services, such as eyeglasses and dental care.

[6]A hospital's Medicaid utilization rate is its number of inpatient days for Medicaid beneficiaries divided by its total number of inpatient days.

The federal and state governments share in the cost of Medicaid, with the federal government paying at least 50 percent and not more than 83 percent of a state's costs, as determined by a formula. This formula considers a state's average per capita income relative to the national per capita income and is intended to reduce differences among the states in medical care coverage to the poor and to distribute the burden of financing program benefits fairly among the states. The formula-derived match rate is called the federal medical assistance percentage. In fiscal year 1997, the federal government share averaged about 57 percent of Medicaid expenditures.

Besides making payments to medical providers for services rendered, states are required to make additional Medicaid payments (DSH payments) to hospitals that serve large numbers of Medicaid and other low-income patients. Within federal guidelines, states may designate disproportionate share hospitals but must include hospitals with high utilization rates for Medicaid or low-income patients. Hospitals must receive DSH payments if their Medicaid utilization rate is at least one standard deviation greater than the average for hospitals participating in Medicaid or if their low-income utilization rate exceeds 25 percent. States may designate other hospitals to receive DSH funding if the hospital's Medicaid utilization rate is at least 1 percent of its total bed days.

Total DSH allocations to states are limited by federal formula, and within states, payments to individual hospitals are limited to the costs of uncompensated care that hospitals provide plus the shortfall between costs and payments for care of Medicaid patients. In addition to designating certain hospitals to receive DSH payments, federal rules give states three options for setting minimum DSH payments. Within these limits, states have broad discretion when determining the size of Medicaid DSH payments to individual hospitals.

The creative financing mechanisms that states began using in the mid-1980s to maximize federal Medicaid contributions without effectively committing their own share of matching funds took various forms. One involved using provider-specific tax revenue or provider donations to fund a state's share of a later Medicaid payment to the providers. For example, hospitals might have paid $50 million in taxes or provider donations to the state. The state, in turn, made $60 million in payments to hospitals. The state received federal matching funds based on the Medicaid expenditure of $60 million. If the state had a 50-percent matching rate, it received $30 million of federal funds. Because the state received $80 million in

revenue ($50 million from hospitals and $30 million from the federal government) and made $60 million in payments, it had a net gain of $20 million. Also the hospitals received a net increase in revenues of $10 million, entirely from federal dollars.

States also benefited when they used their own funds to initiate payments to public providers. Under this financing mechanism, states generated federal matching funds by increasing payment rates for a particular group of public providers, such as nursing homes, public hospitals, or state psychiatric hospitals. However, these providers, through the use of intergovernmental transfers, returned all or the majority of federal and state funds to state treasuries.

Federal legislation in 1991 and 1993 essentially banned provider donations, required that provider taxes be broad based, limited provider taxes to 25 percent of a state's share of Medicaid expenditures, and prevented states from repaying provider taxes. Also, the legislation placed a cap on a state's total DSH payments and limited such payments to 100 percent of a hospital's unrecovered costs of serving Medicaid and uninsured patients. As these and other restrictions have been phased in, Medicaid DSH payments have dropped from a peak of $17.9 billion in 1995 to $14.7 billion in 1996. However, the legislation did not restrict states' use of intergovernmental transfers. Creative financing mechanisms involving DSH payments to public hospitals and intergovernmental transfers are still possible, although the limit for DSH payments of 100 percent of unrecovered costs constrains the hospitals from recovering more than their actual costs.

The federal government has never shared in the costs of services provided to adults in IMDs because mental health services have traditionally been considered a state and local responsibility. These hospitals may be reimbursed by Medicaid for services for patients younger than 21 or older than 64. They are also eligible for DSH payments, like other hospitals, if their Medicaid utilization rate is at least 1 percent. The majority of IMDs that receive DSH payments are state psychiatric hospitals.

States Made Larger DSH Payments to State Psychiatric Hospitals Than to Other Hospitals

Medicaid DSH payments in 1996 to state psychiatric hospitals in the six states were generally far larger than those to other types of hospitals. The states in our review devoted a significant share, from 20 to 89 percent in 1996, of their total DSH expenditures to state mental hospitals. DSH payments to state psychiatric hospitals, and other state-owned hospitals, enabled states to obtain federal Medicaid matching funds benefiting the state treasury. The Balanced Budget Act of 1997 should reduce the DSH payments to state psychiatric hospitals from 1996 levels in some of our study states, because it limits the proportion of a state's DSH spending that may be paid to state psychiatric hospitals.[7] However, the amount of the reductions will depend in part on how states use the flexibility inherent in the Medicaid program.

Four of the six states in our study made DSH payments to state psychiatric hospitals that were larger on average than payments to any other type of hospital. In Michigan and Texas, payments to state psychiatric hospitals were on average less than to other state-owned hospitals. However, in both Michigan and Texas, payments to state psychiatric hospitals still averaged far more than payments to local public and private hospitals. Table 1 shows the average 1996 DSH payment for each type of hospital in the states we reviewed.

Table 1: Average DSH Payments per Hospital in Six States, State Fiscal Year 1996

Type of hospital	Kansas	Maryland	Michigan	New Hampshire	North Carolina	Texas
State psychiatric	$12,814	$14,314	$26,774	$45,041	$36,516	$38,545
Other state-owned	1,987	36	42,834	0	18,164	57,134
Local public	64	0	1,206	0	1,453	8,213
Private	259	2,722	688	3,310	185	3,310

Note: Dollars are in thousands. Excludes hospitals not receiving DSH payments.

To determine whether the large DSH payments were a function of hospital size, we compared the average DSH payment per bed day for each type of hospital in the six study states. For five states, this ratio was greater for state psychiatric hospitals—and for other state-owned hospitals in one state—than for other types of hospitals, indicating that the difference in

[7]DSH payments to institutions for mental diseases will be limited to the lesser of 1995 mental health DSH payments or the "applicable percentage" times the state's total DSH allotment for that year. For federal fiscal years 1998-2000, the applicable percentage is the ratio of 1995 total mental health DSH payments to total DSH payments. For federal fiscal years 2001 and beyond, the applicable percentage is the lesser of the applicable percentage above, or 50 percent in 2001, 40 percent in 2002, and 33 percent for succeeding years.

average DSH payments between groups does not result from differing hospital size. For example, Kansas state psychiatric hospitals received more than $150 in DSH for each bed day, while private hospitals received about $5, and average DSH payments per bed day to other state-owned hospitals and local public hospitals were about $19 and $11, respectively. Table 2 shows the average DSH payment per inpatient bed day in 1996 for the different types of hospitals in the six states.

Table 2: Average DSH Payments per Inpatient Bed Day in Six States, State Fiscal Year 1996

Type of hospital	Kansas	Maryland	Michigan	New Hampshire	North Carolina	Texas
State psychiatric	$154	$217	$390	$756	$280	$366
Other state-owned	19	2	165	Not applicable	105	666
Local public	11	Not applicable	63	Not applicable	29	396
Private	5	35	11	155	4	76

DSH payments made to state psychiatric hospitals account for a significant portion of the total DSH payments made in these six states. In fact, three of the six allocated more than half of their total DSH spending to state psychiatric hospitals. Table 3 shows the percentage of total DSH payments made to state psychiatric hospitals in 1996.

Table 3: DSH Payments to State Psychiatric Hospitals in Six States Compared With Total DSH Payments, State Fiscal Year 1996

State	DSH payments to state psychiatric hospitals	Total DSH payment	Percent
Kansas	$51.2	$57.4	89
Maryland	114.5	152.6	75
Michigan	240.9	347.5	69
New Hampshire	45.0	137.7	33
North Carolina[a]	146.1	362.8	40
Texas	308.4	1,517.3	20

Note: Dollars in millions.

[a]Payment data for North Carolina are estimates, because final cost settlements for 1996 had not been completed at the time of our review.

DSH payments to state psychiatric hospitals benefited the state by the amount of the federal portion of the DSH payment, because the federal funds were returned to the state treasury or replaced money the state would otherwise have needed to spend for hospital operations. For example, DSH payments made to New Hampshire Hospital, a state

psychiatric hospital, are treated as board-and-care revenue to the hospital and returned to the state's general fund. The DSH payment returned to the treasury consists of both state funds spent and the federal contribution, resulting in a gain to the state treasury of the federal portion of the DSH payment, or 50 percent.

In other states, officials told us that Medicaid DSH payments to state-operated hospitals reduced, by the federal share of the DSH payments, the amount of state funds spent to operate the hospital. For example, officials from Texas told us that the availability of DSH payments to state psychiatric hospitals has allowed the state to change its financing for these hospitals. They told us that while appropriation statutes for state psychiatric hospitals provided for general state revenues to cover full hospital operations, the amount of state-appropriated funds actually spent to operate these hospitals is reduced by the federal share of the DSH payment. If the DSH payment were not available, more of the appropriated funds would actually be spent on hospital operations.

Proportion of State Psychiatric Hospitals' Bed Days for Medicaid Patients Is Smaller Than for Most Other Hospitals

State psychiatric hospitals in the six states generally served relatively fewer Medicaid patients than other hospitals while receiving larger DSH payments. Only 6 of 34 state psychiatric hospitals in the six states have a Medicaid utilization rate higher than 25 percent. However, this calculation does not include patients between ages 21 and 65 who would have been eligible for Medicaid coverage if they were not in an IMD. Some of these hospitals serve many children covered by Medicaid. States are allowed to designate other hospitals to receive DSH payments as long as they have at least 1-percent Medicaid utilization. Average Medicaid utilization rates for state psychiatric hospitals in 1996 ranged from 3.1 percent in Texas to 22.1 percent in Kansas. In three states, at least one IMD had a Medicaid utilization rate close to the 1-percent minimum necessary to qualify for DSH. For example, one of the eight state psychiatric hospitals in Texas had a 1.4-percent rate, and five other Texas state psychiatric hospitals had rates lower than 3 percent.

Other types of hospitals, with lower DSH payments, generally had higher, and in some cases much higher, Medicaid utilization rates. Other state-owned hospitals in Maryland, for example, had average Medicaid utilization rates five times as great as the average for the state's psychiatric hospitals. North Carolina private hospitals averaged 19-percent Medicaid utilization, but the state's four state psychiatric hospitals averaged less than half that rate, and the state psychiatric hospital with the highest rate

(18 percent) still fell below the private hospitals' average. Table 4 shows the average Medicaid utilization for each type of hospital for our study states in 1996.

Table 4: Average Medicaid Utilization Rates in Six States, State Fiscal Year 1996

Type of hospital	Kansas	Maryland	Michigan	New Hampshire	North Carolina	Texas
State psychiatric	22.1	13.5	16.7	17.5	9.3	3.1
Other state-owned	28.1	72.9	28.3	Not applicable	32.4	27.8
Local public	42.6	Not applicable	19.3	Not applicable	21.9	37.0
Private	22.2	37.9	26.8	6.8	19.0	27.7

Note: Figures are percentage of total bed days.

An exception to the pattern of higher Medicaid utilization rates in private hospitals is New Hampshire. There, the only state psychiatric hospital has a center for children, about 80 percent of whom qualify for Medicaid.

States Paid State Psychiatric Hospitals and Other State-Owned Hospitals a Higher Proportion of Maximum Allowable DSH Payments

State psychiatric hospitals generally received DSH payments at or near the maximum allowed by Medicaid rules, while other hospitals often received payments that were well below their maximums. Within federal limits, states targeted DSH payments to state psychiatric hospitals and in some cases to other state-owned hospitals. Local public hospitals and private hospitals generally received DSH payments at rates that were a smaller proportion of the maximum allowable. In some cases, the proportions were much smaller, as for local public hospitals in Kansas, which received only 8 percent of the maximum the state could have paid them. Table 5 shows the percentage of the maximum allowable DSH payments made to each group of hospitals for our study states in 1996.

Table 5: DSH Payments in Six States as a Percentage of Maximum Allowable, State Fiscal Year 1996

Type of hospital	Kansas	Maryland	Michigan	New Hampshire	North Carolina[a]	Texas
State psychiatric	100.0	91.0	100.0	100.0	100.0	99.7
Other state-owned	34.7	1.8	100.0	Not applicable	100.0	100.0
Local public	8.1	Not applicable	60.5	Not applicable	100.0	77.9
Private	10.7	21.0	9.4	78.1	3.4	79.0

[a]Payment data for North Carolina are estimates, because final cost settlements for 1996 had not been completed at the time of our review.

Individual hospital maximum DSH payments were established by the Omnibus Budget Reconciliation Act of 1993, which limits each hospital's DSH payment to its cost of care for uninsured and Medicaid patients, less payments received from them or on their behalf. The cost of care for patients who have insurance is not included in the determination. Similarly, state and local funds appropriated to a hospital are not included in the calculation of individual hospital limits.

DSH payments to other state-owned hospitals can provide to the state benefits similar to those of large DSH payments to state psychiatric hospitals. In some states, these hospitals used intergovernmental transfers to return their DSH funds to the state treasury. In addition, officials from North Carolina told us that local public hospitals returned the majority of their DSH payments to the state.

Conclusions

In state fiscal year 1996, state psychiatric hospitals in the six states we reviewed received between 20 and 89 percent of total Medicaid DSH payments, even though state psychiatric hospitals represented a much smaller portion of the number of hospitals in the states and even though state psychiatric hospitals often had lower Medicaid utilization rates than other hospitals. In each of the six states, payments to state psychiatric hospitals covered more than 90 percent of the maximum allowable payment to state psychiatric hospitals. These large DSH payments have enabled states to obtain federal matching funds that indirectly cover costs of services that state Medicaid programs cannot pay for directly. Implementation of restrictions on payments to IMDs in the Balanced Budget Act of 1997 should reduce some of these large payments.

Agency Comments and Our Evaluation

We provided a draft of this report to the HCFA Administrator for review and comment. HCFA officials who reviewed the report told us that the report was accurate. They pointed out that although DSH payments to IMDs enable the states to obtain federal matching funds to indirectly cover the costs of services provided to patients in IMDs that Medicaid cannot pay for directly, this is within the rules of the Medicaid program. They also suggested some technical changes to the report, and we modified the text to reflect their comments. We also discussed the information in the report on the states with officials in each state. They provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the Secretary of HHS, the Administrator of HCFA, state officials in the states we contacted, and others who are interested. We will also make copies available to others upon request. Please call me at (202) 512-7114 or Leslie G. Aronovitz at (312) 220-7600 if you or your staff have any questions about this report. Other major contributors to this report include Paul D. Alcocer, Robert T. Ferschl, Barbara A. Mulliken, and Paul T. Wagner, Jr.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Systems Issues

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested