
Health Care Federalism:

Lessons from the
Medicaid Disproportionate Share Hospital Program

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Looking Back...

Federal/state relationship over Medicaid
Disproportionate Share Hospital (DSH) payments in
early 1990s may be instructive

DSH payments authorized in 1981

Cover uncompensated care provided by hospitals
serving high shares of the poor

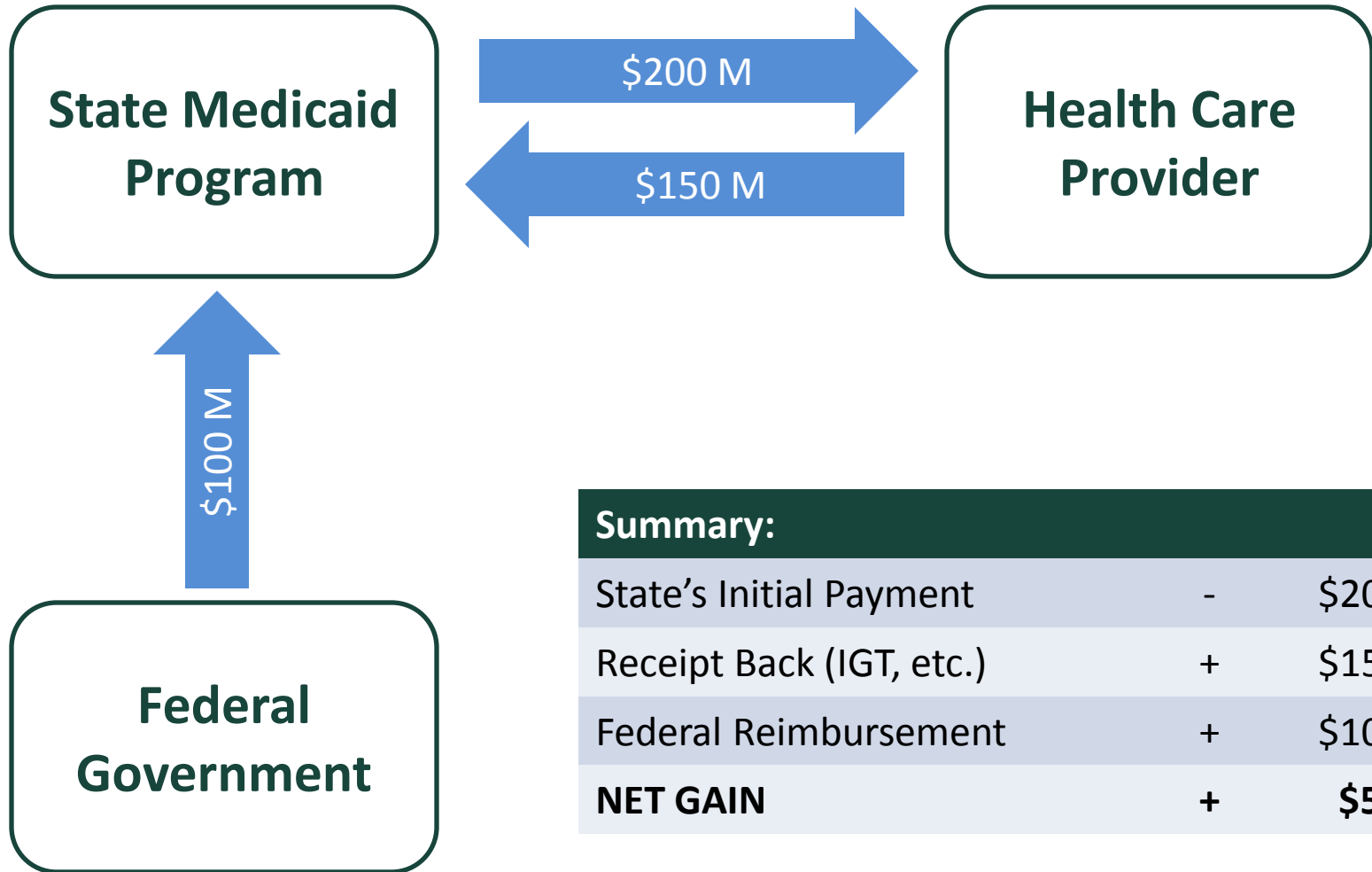
Looking Back...

Between 1989-92 DSH increase 1,600%

GAO: States using “illusory” practices to gain more federal dollars for Medicaid expenses

Linking DSH with provider taxes, donations, and IGTs

The Money Trail



Summary:

State's Initial Payment	-	\$200M
Receipt Back (IGT, etc.)	+	\$150M
Federal Reimbursement	+	\$100M
NET GAIN	+	\$50M

Congress Responds, Part 1

Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991

- Cap on DSH payments
- Banned provider donations

No practical regulation of IGTs; “burdensome” on HCFA

States React

Some states continued practice using IGTs to public hospitals and nursing homes

GAO: Michigan Case Study

- \$489M payment to UM Hospital on 10/2/1993
- Hours later, entire amount transferred back
- Triggered \$276M Federal reimbursement
- Nursing homes: \$277M payments; \$271M returned; \$155M Federal reimbursement

Congress Responds, Part 2

Committee oversight; GAO investigations

Scholarly attention

Passed OBRA of 1993, capping DSH payments to individual hospitals at the value of uncompensated care

States React

Some states begin to make large DSH payments to institutions for mental diseases (IMDs), especially state-owned psychiatric hospitals

This type of care thought to be state/local responsibility

Congress Responds, Part 3

BBA of 1997 limited DSH payments to IMDs

Required annual reports from states on DSH payment activity

Audits required by Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Implications

States may look to federal government to help relieve fiscal stress

Exploit vague or nonexistent language to increase effective federal share

Congressional response(s) slow, non-comprehensive

Difficult to measure true spending on health care

Selected References

Ku, Leighton, and Teresa A. Coughlin. 1995. “Medicaid Disproportionate Share and Other Special Financing Programs.” *Health Care Financing Review* 16(3): 27 – 54.

GAO Report 94-133, “States Use Illusory Approaches to Shift Program Costs to Federal Government”

GAO Report 98-52, “Disproportionate Share Payments to State Psychiatric Hospitals”