AN ARIZONA POLICY PRIMER

Deconstructing DSH

ARIZONA HEALTH FUTURES

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ARIZONA HEALTH FUTURES Policy Primers: *a nonpartisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

Deconstructing DSH Making sense of America's fractured, complex and contentious health care system is a daunting exercise at best. Nowhere is this more evident than in the area of health care financing, where multiple payer sources and programs combine in a tangle of rules, regulations and exceptions that can be difficult to unravel, even for the experts. For those who are charged with making broad health policy decisions, and for the general public, it is practically impenetrable.

St. Luke's Health Initiatives

A Catalyst for Community Health

In this *Arizona Health Futures Policy Primer* we deconstruct just one thread in this tangle, Disproportionate Share Hospital Payments, or **DSH**. In focusing on this important financing mechanism for what is commonly referred to as the health care "safety net," we seek to illustrate the highly elaborate – and even overwrought – cat-and-mouse game the federal government, states and local government play in allocating resources and responsibility for providing health services to our nation's low-income population.

After reviewing the history of DSH at the federal level, we outline the current situation in Arizona and suggest a number of policy questions to help frame the ongoing discussion of how health care for low-income populations should be financed in the future, especially in light of proposed changes in the federal Medicaid program.

Through the 2002 fiscal year, over $1.25 billion has been filtered through the DSH program in Arizona alone. How much of this money was intended specifically for qualified hospitals, how much of it they received and how much of it they ought to have received is open to interpretation.

What is DSH?

Disproportionate Share Hospital (DSH) payments are payments made to hospitals under the Medicaid program that "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs."[1]

The DSH program began as part of the Omnibus Budget Reconciliation Act of 1981. States were mandated to consider the special payment needs of hospitals that serve a large portion of Medicaid and uninsured patients, recognizing that these hospitals often lost money as a result of low Medicaid reimbursement rates and high levels of uncompensated care. Hospitals with large caseloads of low-income patients frequently had low private caseloads and were unable to shift the cost of uncompensated care to privately insured patients.

To address this situation, states that chose to participate in the DSH program were allowed to draw down federal dollars for additional payments to qualified hospitals, with the stipulation that state matching dollars were also provided at a rate pegged to federal financial participation (FFP) Medicaid rates.

1 Title XIX of the Social Security Act, Section 1923. The Medicare program also makes DSH payments, which total approximately $4-5 billion annually. We do not focus on Medicare DSH in this analysis.

The Federal Picture: DSH Policy & Funding

Since the original enactment of DSH in 1981, Congress has modified the DSH program on a regular basis. With each change in DSH law, states were quick to identify mechanisms under the law to maximize federal revenues – at least until Congress placed a ceiling on the funding through the Omnibus Budget Reconciliation Act (OBRA) of 1997.

In the early years, only a few states chose to participate in the DSH program, most likely because of state matching requirements. Arizona itself did not begin DSH payments until 1992 based on state legislation passed in 1991. To encourage states to join the program in the early years, Congress "sweetened the pot" by changing several key ingredients:

- Exempting DSH funds from the *Medicare upper payment limit.* This limit is the ceiling above which the federal government will not reimburse for Medicare services. Initially states were required to apply this limit to the Medicaid DSH program as well, but when few states chose to enter the program, the requirement was lifted. This exception contributed in part to the rapid growth of Medicaid DSH expenditures that began in the early 1990s.
- The development of *provider tax and donation programs.* A 1985 rule change gave states the opportunity to maximize DSH federal matching funds by allowing them to "count" donations received from private medical care providers, as well as to create provider tax plans (county taxes on medical providers, etc). These created a significant financial incentive for states. Each dollar of revenue raised from a tax or donation could generate one to four Federal Financial Participation (FFP)[2] dollars, depending upon the state's federal matching rate. In order to earn the federal dollars, the state had to spend the tax or donation revenues on their Medicaid program.
- Providing for the use of *Intergovernmental Transfers*. Because of the changes in the law, many states began using Intergovernmental Transfer (IGT) programs, which are fund exchanges between different levels of government, as the revenue source for their DSH program matching funds. Some states began to transfer funds for the DSH program from public institutions such as state psychiatric facilities, university hospitals and county or metropolitan hospitals to the state Medicaid agency. The state would then make DSH payments back to these hospitals, collecting FFP dollars in the process. The IGT mechanism provided the added advantage (over provider tax and donation programs) of preserving federal DSH dollars for state and local institutions

Sources: Teresa Coughlin; Anna Long, HHS,CMS, 2003.

During the period 1990-1996, DSH payments grew nationally from $1.4 billion to $15 billion. By 1996, DSH payments accounted for 1 of every 11 (federal and state) dollars allocated to Medicaid. How much of these funds found their way to qualified hospitals is another story.

2 Federal Financial Participation is the matching rate at which state dollars "earn" matching federal dollars. Arizona's 2003 FFP, or match rate, is 67.25% Federal and 32.75% State.

The federal government became critical of some states' use of the DSH funding, arguing that they had used DSH to decrease their Medicaid fiscal responsibilities at the expense of the federal government.

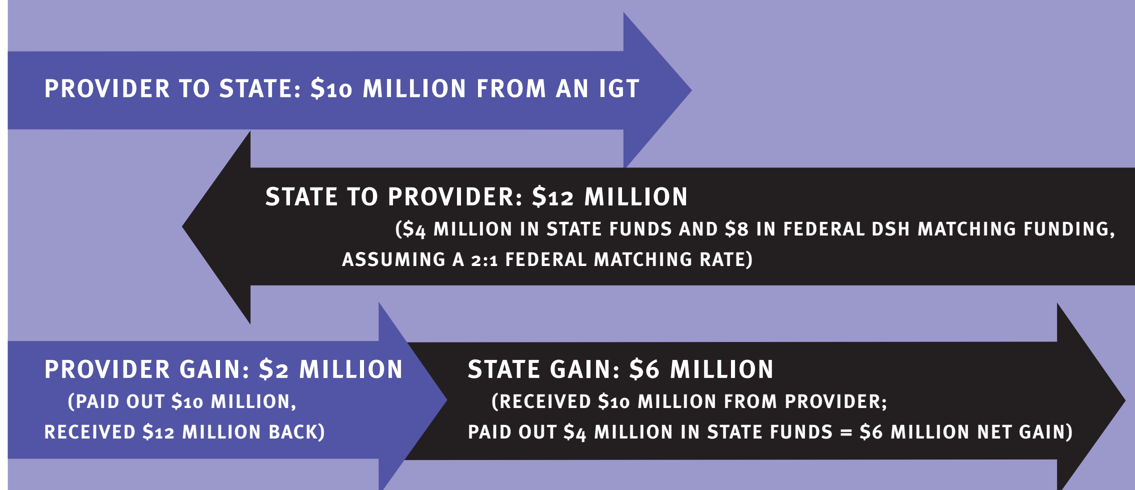
As states continued to find "creative" ways to maximize state contributions and draw down additional federal DSH dollars, the federal government became critical of some states' use of the DSH funding, arguing that they had used DSH to decrease their Medicaid fiscal responsibilities at the expense of the federal government. For their part, states argued that the DSH program was essential to maintaining the health care safety net for vulnerable populations and public facilities.

In response to this "push and pull" between the federal government and the states, after several years of creating incentives for participation, Congress began efforts in the early 90s to control DSH spending:

- **1991 THE LAW WAS CHANGED TO:**
  - End the use of provider donations.
  - Cap provider taxes at 25 percent of the state's share of Medicaid expenditures.
  - Cap DSH payments to states at roughly their 1992 levels.
- **1993 CHANGES IN OBRA PROVISIONS:**
  - Only those hospitals whose mean Medicaid Utilization Rate exceeded by at least one percent the state's mean Medicaid Utilization Rate could receive DSH payments.[3]

The **Funding Flow**

Over the life of DSH funding history, states have been able to maximize federal funds through the use of provider taxes and donations, Intergovernmental Transfers (IGT) and Certified Public Expenditures (CPE)[4]. A typical transaction might work as follows:



In this scenario, the federal government paid $8 million in DSH matching funds, but only $2 million of it was actually gained by the hospitals. For 1997 alone, a survey of states estimated that states and hospitals gained $8 billion through the DSH program. Non-state hospitals gained about $4.8 billion, and state hospitals gained about $2 billion. States themselves kept the remaining $1.2 billion in DSH residual funds.

While this flow of funds is legal under current DSH regulations, critics of the DSH system point out that the intent of the law is to channel matching federal dollars to qualified providers, and not to the state's general fund, where it could conceivably be used for other purposes.

Illustration modified from Teresa Coughlin, et. al., *Reforming the Medicaid Disproportionate Share Hospital Program.*

3 Medicaid Utilization Rate = Title XIX Days divided by all Payer Days.

4 *Certified Public Expenditures* are funds used for providing care to Medicaid or uninsured patients that have gone through a certification process by the agency providing the care.

The feds made this change because some states were making DSH payments to medical facilities that were not large Medicaid providers.

- Total DSH payments to a single hospital could not exceed the unreimbursed costs of providing inpatient care to Medicaid patients (i.e. the Medicaid shortfall) and uninsured (i.e. charity care) patients. This rule change was in response to states making DSH payments that exceeded the hospital's financial losses in serving the Medicaid and uninsured populations.

- **1996 BALANCED BUDGET ACT** – The DSH provisions in this piece of legislation included:
  - Establishing new state-specific DSH allotments for each year in the 1998-2002 time period. After 2002, federal DSH expenditures are allowed to increase by the percentage change in the Consumer Price Index, but not beyond 12 percent of each state's total annual Medicaid expenditures.
  - Limiting how much of a state's federal DSH allotment can be paid to institutions for mental diseases (IMDs) or long-term mental hospitals. By 2002, no more than 33 percent of a state's federal DSH allotment can be paid to IMDs.
  - Requiring DSH payments made on behalf of Medicaid clients enrolled in managed care to be paid directly to hospitals rather than to managed care organizations. DSH payments could no longer be included in capitation rates.
- **1997 BALANCED BUDGET ACT** – This act introduced several more expenditure cuts, including DSH cuts within the Medicaid program. Among the concerns raised:
  - A belief that payments had sometimes not been used to help safety net providers, but had been "diverted" to provide fiscal relief for state budgets instead.
  - Distribution of federal DSH payments among states was not consistent because of the way the program developed in the early part of the 1990's. For example, DSH payments per poor person (under 150 percent of poverty) in 1995 ranged from zero in some states to $1,500 in others.

By 1997, states were changing their DSH programs to comply with the revised federal laws and regulations. Under the new limits, some states found it difficult to spend their full DSH allotment. This was especially true for states with large DSH programs that were supported by IGTs, and where payments were largely directed to public hospitals.

Further, with the implementation of the managed care philosophy and practice, care began to shift from inpatient to outpatient settings. Since DSH is targeted specifically to inpatient settings, this shift reduced Medicaid revenue – and DSH dollars – to traditional safety net providers, as Medicaid patients were increasingly treated in private facilities.

Federal Policy **Summary**

The course of Federal law and policy surrounding DSH payments started with positive provisions that encouraged DSH payments. But as states responded with growing DSH expenditures – and what some claimed were "creative" ways of maximizing federal matching dollars – the Federal policy direction shifted to negative provisions that curtailed spending through restrictions and targeted spending. This kind of "cat and mouse" game has characterized federal and state fiscal relationships for decades.

Policy Changes to **Promote Growth**

1981
- DSH law passed as part of Title XIX (Medicaid law).

1989
- Excluded DSH payments from the Medicare payment ceiling.
- Tax, donation programs and IGTs are allowed for state match.

Policy Changes to **Curtail And Target Growth**

1991
- Donations are banned.
- Provider tax is capped.
- DSH payments are capped at their 1992 level.

1993
- Medicaid Utilization Rate is required as a standard.
- Prohibited a hospital from receiving DSH payments in excess of unreimbursed costs of providing care.

1996
- Established state specific allotments and capped future increases.
- Limited dollars that can be paid to mental hospitals.
- Required DSH payments to be made directly to hospitals – not through managed care organizations.

1997
- Enacted DSH budget cuts.

The Arizona Picture:
DSH Policy & Practice

In December 1991, the Arizona Legislature granted authority to the Arizona Health Care Cost Containment System (AHCCCS) to implement a DSH program. While federal law established the minimum criteria for distribution of DSH payments, states were allowed to set additional criteria *so long as they were at least as generous as the federal standards.*

For Arizona, there are four groups eligible for DSH payments. The first two are federal requirements; groups three and four are state options:

Group 1: HOSPITALS WHOSE AVERAGE MEDICAID UTILIZATION RATE EXCEEDS BY AT LEAST ONE PERCENT THE STATE'S AVERAGE MEDICAID UTILIZATION RATE.

Group 2: HOSPITALS WITH LOW-INCOME UTILIZATION RATE OF MORE THAN 25 PERCENT. This rate is defined as the sum of (a) a hospital's low-income revenue (AHCCCS, state and county revenues as a percentage of net inpatient revenue), and (b) the percentage that gross charity care revenue contributes to gross hospital revenue.

County In Lieu **Payments**

In 1992, the first year of Arizona DSH payments, the net distribution to private hospitals was estimated at $3.7 million. Public hospitals were to receive $12.4 million. However, since there were only two county hospitals (Kino Community Hospital in Pima County and Maricopa Medical Center in Maricopa County) and one state hospital (ASH), rural counties were effectively eliminated in the distribution formula, even though each county had a responsibility for indigent emergency care.

To ensure rural support for the DSH program, the Legislature authorized DSH payments to all of the rural counties, which is referred to as the "county in lieu" payment. These payments were discontinued in FY 2002 when, through the implementation of Proposition 204, counties were no longer responsible for indigent health care services.

Group 3: ACUTE CARE GENERAL HOSPITALS (psychiatric and rehabilitation facilities excluded). Qualifying conditions include (a) their Low-Income Utilization Rate is greater than the statewide average (17.2 percent for FY 2001), or (b) they provide at least one percent of the total Medicaid days across hospitals in the state. (This group is also known as the "Expanded Pool.")

Group 4: STATE AND COUNTY HOSPITALS. Kino Community Hospital, Maricopa Medical Center and the Arizona State Hospital.

Beginning with the 1997 Balanced Budget Act, Arizona's DSH allotment was $81 million dollars. This allotment has been adjusted based on the Consumer Price Index for FY 2002 to $82,214,000 and for FY 2003 to $83,448,200. These allotments are then matched with state funds at the FFP rate. (Arizona contributes approximately $1 for every $2 received from Medicaid.)

Each year the Legislature appropriates the total of the federal share and state share to the Arizona Health Care Cost Containment System Administration for DSH payments. A footnote in the general appropriations act distributes the aggregate amount to county operated hospitals, private hospitals, the Arizona State Hospital (ASH) and, until FY 2002, to the remaining counties that receive "County In Lieu Payments."

Recent DSH Payment Appropriations

Actual appropriations of DSH funding are based on the Medicaid Utilization Rate under calculations dictated in the OBRA 1993 requirements. The actual appropriations may vary since the OBRA calculations can result in less than full utilization of the DSH federal allotment. When all DSH funds are not used in one year, the funds can be rolled over in a future year as long as the OBRA limitations are followed. Finally, what is appropriated to hospitals is not necessarily what they receive in actual payment. (See flow chart on page 9.)

FISCAL YEAR	ACTUAL	COUNTY (PUBLIC) HOSPITALS, COUNTY-IN-LIEU	ASH[5]	PRIVATE HOSPITALS
1997	$141,310,900	$79,236,300 (MMC*) $17,120,100 (Kino**) $ 2,374,200 (in-lieu)	$27,106,600	$17,847,900
1998	$123,400,100	$89,200,900 (MMC) $18,109,300 (Kino) $ 2,140,400 (in-lieu)	$0	$16,089,900
1999	$125,303,000	$90,334,000 (MMC) $19,584,000 (Kino) $ 2,046,600 (in-lieu)	$0	$15,385,000
2000	$122,876,200	$68,636,100 (MMC) $15,258,200 (Kino) $ 2,015,300 (in-lieu)	$23,831,900	$15,150,000
2001	$102,773,900	$45,895,500 (MMC) $13,253,500 (Kino) $ 2,015,300 (in-lieu)	$28,474,900	$15,150,000
2002	$107,414,200	$45,895,500 (MMC) $13,253,500 (Kino) $ 0 (in lieu)	$28,474,900	$19,790,300
2003 Recommended	$156,588,700	$79,355,000 (MMC) $23,799,200 (Kino)	$28,474,900	$26,959,600
2004 Recommended	$136,866,800	$82,244,200 (MMC) $ 0 (Kino)[6]	$28,474,900	$26,147,700

5 Arizona State Hospital. ASH did not receive DSH funding in 1998 and 1999 because the hospital lost its Medicare certification status. It regained it in 1999, and funds flowed again in 2000.

6 Kino may revert to private hospital status in FY 2004 and, depending on that decision, could conceivably no longer be eligible for DSH funding under public hospital status.

*MMC = Maricopa Medical Center

**Kino = Kino Community Hospital

ADDITIONAL LEGISLATIVE ACTIONS that have impacted the net gain to the State General Fund include:

- In 1992, the Legislature designated $10 million of DSH payments as property tax relief that would have been part of the net gain to the State General Fund.
- In 1994, Maricopa County was experiencing a financial crisis. The Legislature allowed the county to withhold approximately $9 million in sales tax revenue as a rollover in the repayment from 1994 to 1995. Since the net gain to the State General Fund comes through the IGTs with Maricopa and Pima counties, the state appropriates the full gross payment to each county and then receives the difference between the gross payment and the net distribution through sales tax payments to the state.
- In 1995, Maricopa County paid the state back. This was referred to as a "rollover recovery."
- Also in 1995, the state began using DSH as a mechanism to increase the net gain to the State General Fund by making higher DSH payments to ASH. Since these increased payments were not needed for hospital operations, millions of dollars reverted to the State General Fund at the end of the fiscal year. From 1995 through 1997, $44 million was paid to ASH and returned to the State General Fund.

Net Gain to the **State General Fund**

Arizona, like many other states, allocated DSH payments through IGT Agreements that resulted in increased net gains to the State General Fund. From FY 1992 to FY 2002, the total net gain to the State General Fund has been $356,151,000.

YEAR	NET GAIN TO THE GENERAL FUND
1992	$15,465,600
1993	$25,727,000
1994	$20,516,700
1995	$41,563,300
1996	$34,640,700
1997	$37,716,200
1998	$33,325,700
1999	$45,098,200
2000	$32,598,500
2001	$19,192,900
2002	$50,306,200
2003 - Projected	$74,955,800

Source: Schedule 100, Distribution of Disproportionate Share Hospital payments, Fiscal Years 1992 - 2001

How Net Gain Works

Net gain to the State General Fund works this way:

- The state allocates its annual DSH allotment (both federal and state dollars) to private hospitals, county public hospitals (Kino and MMC), ASH and, until 2002, county-in-lieu.
- Federal and state DSH dollars for the two county hospitals flow to Maricopa and Pima counties through an IGT agreement. The county share of the transaction privilege (sales) tax is then *reduced* (as part of the Health Omnibus Reconciliation Bill each year) in the amount that is *above* the hospitals' DSH allocation.[7]
- The result is a net gain to the State General Fund. While the State paid the DSH funding to the counties, it retained through the withholding of transaction privilege tax the amount above the DSH allocation.
- In the case of ASH, the funding essentially passes through ASH and reverts back to the general fund, since ASH operations are funded through state appropriation in the first place.

The Impact of Proposition 204 on DSH[8]

The passage of Proposition 204 expanded eligibility to the AHCCCS program for individuals with annual incomes up to 100 percent of the Federal Poverty Level (FPL). As a condition of the federal waiver to implement Proposition 204, Arizona is subject to federal budget neutrality. In order to maximize federal funds available for the expanded Medicaid population and still meet the budget neutrality requirement, in 2001 the Arizona Legislature chose to drastically reduce DSH revenues, maintaining only the funding necessary for payments to private hospitals. As a part of the negotiation to obtain the Proposition 204 federal waiver, counties and ASH would no longer receive DSH funds.

When Arizona proposed to give up the public hospital share of DSH (approximately $76 million), it was with the understanding that the federal government would allow individuals eligible for the State Emergency Services (SES) program to be eligible for Medicaid under Proposition 204. However, this eligibility transfer was not approved. In addition, subsequent to the passage of enabling legislation for Proposition 204, Arizona's federal Medicaid waivers did allow the shifting of some costs to Title XXI (KidsCare). During this same time period, the downturn in the economy was creating significant economic pressure and the need to maximize revenues.

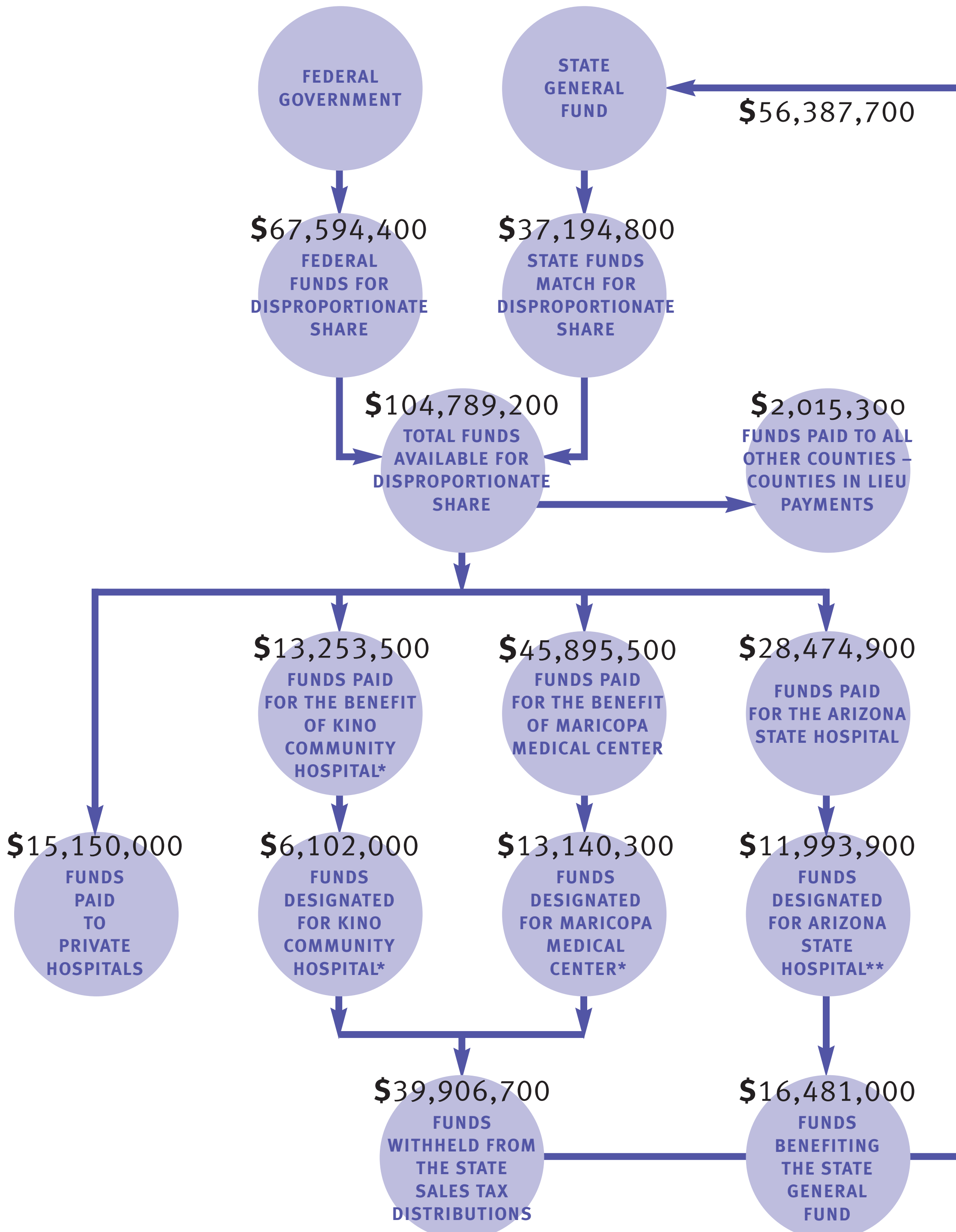
As a result of these contributing factors, the public hospitals were brought back into the DSH funding pool. Since it was no longer necessary for the state to give up DSH payments in order to stay budget neutral, Arizona's DSH allotment remained whole at $81 million, and public hospitals remained part of DSH payment methodology. Both county hospitals received a net gain in FY 2003.

7 The actual allocation of funds to the two public hospitals is based on an agreement between the State and the counties in the early 1990s, when the state was experiencing budget difficulties and sought the counties' assistance in leveraging new sources of revenue. While the conditions giving rise to that agreement have arguably changed since that time, the agreement itself has apparently not.

8 Proposition 204: Step by Step, St. Luke's Health Initiatives.

Flow of 2001 Disproportionate Share Hospital Payments

THE ACCOMPANYING FUNDING FLOW CHART DEMONSTRATES HOW DSH FUNDING FLOWS FROM THE STATE THROUGH COUNTIES AND ASH AND RESULTS IN A NET GAIN TO THE STATE GENERAL FUND.



In Summary:

Net Gain to General Fund
$19,192,900

Private Hospitals
$15,150,000

Maricopa Medical Center
$13,140,300

Arizona State Hospital
$11,993,900

Kino Community Hospital
$6,102,000

Other Counties
$2,015,300

Source: Citizens Task Force on the County Health Care System; April 1, 2003 (Updated with information from the Governor's Office of Strategic Planning and Budgeting).

* Kino Community Hospital and Maricopa Medical Center are county operated facilities.The funds paid to the counties for the hospital through disproportionate share are intended to offset the subsidies paid by the counties to the hospitals. This money may or may not flow through to the hospital for the disproportionate number of uncompensated care cases they have.

** The Arizona State Hospital (ASH) is technically funded by the State of Arizona General Fund.

Pending Policy Considerations

Some critics have publicly stated that if MIHS had been receiving its full intended share of DSH payments since 1992, the health system would not now be in a financial crisis, and would not have a pressing need to create a special taxing district.

2003 Bush Administration Medicaid Proposal[9]

The administration of President George W. Bush proposes revisions to the Medicaid program that would establish a new state option under Medicaid and the State Children's Health Insurance Program (SCHIP). This "block grant" proposal would combine federal Medicaid and DSH payments into two lump-sum allotments – one for acute care and one for long-term care. States would be permitted to transfer up to 10 percent between allotments.

Under the proposal, DSH would not be allocated separately but would be considered part of administrative costs, which are limited to 15 percent of the total. States would receive higher payments from the federal government for the first seven years of the program, and payments would be reduced in years 8-10 to make the overall effort budget neutral to the federal government over the full 10-year period.

Essentially, hospitals that are now eligible for supplemental DSH federal funds would be required to compete with other providers to obtain compensation from their state's Medicaid block grant. On the positive side, states would have increased flexibility in deciding how to allocate Medicaid funds without applying for special federal waivers, as well as receive additional Medicaid appropriations in the early years of the program. On the negative side, total funding is reduced in future years and does not take into account state economic conditions and growth rates. This is especially problematic for a high growth state like Arizona.

Maricopa County Proposed Health Care District

The Maricopa County Citizens Task Force on the County Health System was convened to develop recommendations regarding the future of the Maricopa Integrated Health System (MIHS). The Task Force, in reviewing the current financial situation facing MIHS, identified five causes of MIHS's current fiscal plight, including "the diversion of federal and state Disproportionate Share Hospital Program funds ($50 million annually) away from MIHS into the State's General Fund." Describing the system as "run on a shoestring–with compassion, grit and resolve," the Task Force recommended the establishment of a special health care district.

Specific to DSH payments, the Task Force recommended: "efforts toward (a) increasing payment to Maricopa Integrated Health Systems (MIHS) of Disproportionate Share Hospital Program funds paid as a result of uncompensated services provided to the public by MIHS; and (b) evaluating the inequities now existing, and working with the State to ensure that federal funds continue to be paid to Arizona."[10]

Legislation was passed at the end of the 2003 session to create the Maricopa Health Care District (HB 2530), which will require approval by voters. With regard to DSH payments, the legislation includes the authority to make disproportionate share payments to "hospitals owned or leased by a special health care district."

9 National Conference of State Legislatures; FACT Sheet; State Health Care Partnership Allotment.

10 The phrase "inequities now existing" refers to the difference between what MIHS is "intended" to receive under the DSH appropriation and what they actually receive after the State retains part of the County's tax-sharing revenue. Some critics have publicly stated that if MIHS had been receiving its full intended share of DSH payments since 1992, the health system would not now be in a financial crisis, and would not have a pressing need to create a special taxing district.

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The Future: Policy Choices

The history of the development of DSH payments, both nationally and in Arizona, contains lessons and quandaries for how we should finance and administer health care in the future. Essentially, we have made access to health care a de facto public good, but we have done so in a heavily privatized, inefficient and fragmented system. This creates a continuing friction between the federal government and state governments, and between state governments, local governments and providers on who should pick up the tab, and in what proportion.

1. **WHO IS RESPONSIBLE FOR PAYING FOR HEALTH CARE?** Currently, 40 percent of health care costs are borne through private insurance, 15 percent from individual out-of-pocket, and 45 percent from public sources (Medicaid, Medicare, etc.). Health economists estimate that public funding is actually closer to 60 percent when employer tax deductions for health insurance are factored in. With costs predicted to continue to rise and with an aging population accustomed to receiving expensive care, it's clear that the present system is unsustainable without agreement on both *how* we divide the payment pie and *what* we are willing to cover on the public side.
2. **WHAT PRINCIPLES SHOULD INFORM THE BALANCE BETWEEN FEDERAL, STATE AND LOCAL RESPONSIBILITY FOR HEALTH CARE?** With fiscal deficits ballooning at all governmental levels, it's not surprising to witness devolution to the states on the federal side and demands for greater federal financial (but not regulatory) involvement on the state side. In order to arrive at the proper balance, policy makers will need to weigh the principles of fairness, efficiency, flexibility and accountability in a tighter matrix than they do today.
3. **WHAT IS THE TRADEOFF BETWEEN FLEXIBILITY AND ACCOUNTABILITY?** Arizona and other states have had the flexibility over the past decade to revert DSH payments back to the general fund, where they can potentially be allocated to other needs and priorities determined by the exigencies of the moment. This is accountable to the letter of the law, but many would argue that it is not accountable to its intent and spirit. *In a word, should all DSH dollars go directly to health care providers rather than be diverted to the general fund?*
4. **DOES DSH POLICY IMPLY A DOUBLE STANDARD FOR THE ARIZONA LEGISLATURE?** In the past, the Legislature has occasionally reprimanded state officials and departments for allegedly spending state funds for purposes other than those intended through their appropriation. The issue is whether the Legislature has a different standard of intent and use when the money is not their own, but the federal government's.
5. **ARE HOSPITALS DISADVANTAGED UNDER THE ARIZONA DSH APPROPRIATION PROCESS?** Under Arizona's DSH funding mechanisms, some might argue that the state is incentivized to "pass" money through the counties under an IGT because it can then draw down additional federal matching dollars. The state is not incentivized to let the money flow directly to the hospitals because it doesn't generate additional matching funds. To the degree that particular hospitals require public funding to offset increasing services for indigent and charity care, and to the degree that DSH dollars flow to the general fund and not to the hospitals directly for those services, they could be said to be at a disadvantage.
6. **DOES ARIZONA'S DSH ALLOCATION METHODOLOGY REPRESENT GOOD PUBLIC POLICY?** This might be rephrased as whether Arizona's approach to DSH payments represents public policy at all, in the sense that public policy ought to be fully disclosed and crafted in open view of the public. The sheer complexity of DSH regulations and requirements, and the labyrinth-like process that reverts DSH dollars to the State's General Fund, make it next to impossible for citizens to discern either the advantages or disadvantages to the allocation formula; the vested interests various parties might have in retaining or changing the current scheme; and how the allocation formula impacts the larger picture of health care financing in Arizona for low income populations.
7. **WHAT WILL BE THE IMPACT OF BUDGET NEUTRALITY ON THE NEED FOR FUTURE DSH FUNDS OR OTHER FUNDING SOURCES?** Arizona continues to operate under a federal Medicaid budget neutrality requirement that program changes will not cause an increase in the need for federal matching funds. With pressure to add services and populations to Medicaid – and with pressing needs in other dimensions of the state budget – the issue is whether Arizona will need to come up with future DSH funds or some other funding source to meet this requirement.
8. **HOW SHOULD ARIZONA REGARD PROPOSED CHANGES IN THE FEDERAL MEDICAID PROGRAM?** The answer to this question depends on whether one believes states already have too much flexibility with DSH and other parts of Medicaid, or not enough; and whether increased funding in the early years of the program is sufficient enticement to leave the state vulnerable in later years as funding is capped and needs are potentially greater. Block grants move flexibility and accountability to the state level, but they can be tempting targets for local policy makers who are under intense pressure to use "discretionary" dollars to respond to the latest pressing need. The issue is whether health care for the poor might suffer as a result.

Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on vulnerable populations and building the capacity of communities to help themselves.

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www.slhi.org

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve the health of all Arizonans, especially those in need.

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