



Medicaid DSH Funds: Essential Support for the Nation's Health Safety Net

The Medicaid disproportionate share hospital (DSH) payment adjustment was created in 1981 to help ensure that Americans have adequate access to health care. The goal of this adjustment was to ensure the financial viability of safety net hospitals that shoulder a disproportionate burden of caring for the poor and uninsured.¹ By FY 2006, spending on the Medicaid DSH program totaled \$17.15 billion—\$9.65 billion of this total is federal spending, while the \$7.5 billion non-federal share is provided by state and local governmental entities.²

As is generally true of Medicaid, states have considerable discretion in designing their DSH programs. As a result, states have targeted DSH payments to hospitals serving a range of important safety net needs, including (but not limited to) services provided to Medicaid enrollees and the uninsured. In fact, uninsured care is only one of many intended uses of Medicaid DSH payments; DSH funding is also intended to: 1) cover financial losses resulting from caring for Medicaid patients; 2) ensure that safety net facilities are able

to deliver essential community-wide health care services; and 3) support physician training.

How Are Medicaid DSH Funds Used?

Of the \$9.65 billion in federal DSH spending, \$7.6 billion is used by safety net hospitals for a variety of purposes as described below. The remainder of federal DSH spending supports institutions for mental disease (IMDs) or state psychiatric hospitals.

1. DSH HELPS HOSPITALS COVER A PORTION OF MEDICAID LOSSES

Medicaid DSH funding helps providers cover the costs of treating Medicaid patients. This additional payment is necessary to enhance historically low Medicaid payment levels and ensure that Medicaid patients can receive the full range of services that are necessary to facilitate their care. These include many “wraparound” services such as transportation, social work, patient navigation and language assistance, as well as other services that are not

typically covered by private insurance. In creating the DSH program, Congress intended to assist safety net providers—hospitals that typically incur higher costs and have fewer private-paying patients—ensure access to services for Medicaid and uninsured patients in their communities.

Current DSH funding levels have not kept pace with increasing Medicaid losses, as both the number of patients eligible for Medicaid and the overall costs of serving those individuals have risen. Nationwide, hospitals lost \$11.3 billion in 2006 in providing care to Medicaid patients—an increase of over 330 percent since 2000 (see Figure 1).³ Meanwhile, DSH spending increased by only 10 percent over the same period, and when adjusted for inflation, decreased by 16.6 percent.⁴ The growing losses on Medicaid pose a particular burden on hospitals that care for a large number of Medicaid and uninsured patients. Recently, this has proven to be particularly challenging in Massachusetts, following implementation of statewide health reform. In Massachusetts, safety net providers are paid significantly less than the cost of caring for both Medicaid and Commonwealth Care patients (the new public insurance program). Because DSH funds were utilized to finance, in part, the expansion of health insurance in Massachusetts, they

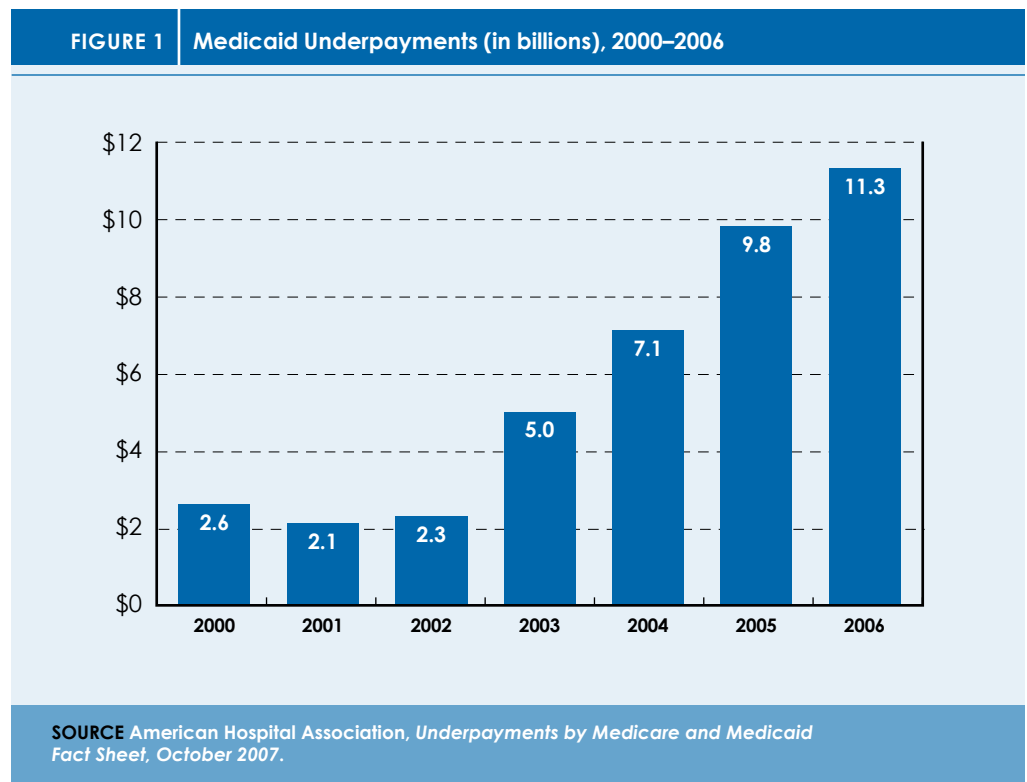
are no longer available to supplement insufficient Medicaid payment rates.

2. DSH SUPPORTS ESSENTIAL COMMUNITY-WIDE HEALTH SERVICES

Medicaid DSH payments also fund many otherwise unreimbursed—or unprofitable—health care services that safety net health systems provide to their communities. DSH funds work to provide financial stability to safety net providers. Without the stabilizing support of DSH funds, safety net hospitals' total operating margin would have been -5.16 percent in 2006. This stability allows safety net hospitals to provide trauma and burn services, surge capacity and emergency preparedness activities. Safety net hospitals play a key role in making sure these services are available in their communities—in the major U.S. cities, safety net hospitals operate 40 percent of all Level I trauma centers; staff 50 percent of all burn beds; and treat nearly 25 percent of all emergency room patients. Additionally, safety net hospitals are on standby to respond to natural and manmade disasters, often playing a key role in state emergency preparedness plans and regional emergency preparedness coordination. This role, and the ability of the safety net to create surge capacity, proved critical during the September 11th terrorist attacks, Hurricanes Katrina and Rita, and the California wildfires.

3. DSH HELPS SUPPORT PHYSICIAN TRAINING AT TEACHING HOSPITALS

More often than not, safety net hospitals are also teaching hospitals—in fact, NAPH member hospitals train over



15,000 physicians and dentists each year. Medicaid DSH payments are critical to teaching hospitals, as they help defray some of the costs incurred in treating a high volume of uninsured and Medicaid patients. These payments enable hospitals to continue their mission of ensuring a high quality and adequate physician workforce for the future. Currently, the Medicaid program allows states the flexibility to support physician training; however, states vary significantly in their level of support. In 2005, according to the Association of American Medical Colleges (AAMC), three states provided no funding for physician training via the Medicaid program; remaining state funding levels ranged from \$260,000 to \$1,175,000,000. States have the flexibility to make graduate medical

education (GME) payments via their Medicaid programs, and a portion of DSH funding covers the unreimbursed costs of physician training for Medicaid and uninsured patients.

4. DSH SUPPORTS—BUT DOES NOT ENTIRELY COVER—THE COST OF UNINSURED CARE

DSH payments are the only Medicaid funding stream through which states are explicitly allowed to reimburse providers for care to the uninsured. However, DSH funds do not cover all the costs of caring for the uninsured. Federal caps on DSH payments have resulted in little growth in state DSH allotments, despite the significant rise in costs and the number of uninsured Americans (see Figure 2). In 2006, 90 NAPH hospitals, collectively, provided over \$6.4 billion in uncompensated

care (measured in costs). Medicaid DSH payments to these hospitals totaled only \$3.3 billion.

DSH Spending Varies from State to State

DSH payments—and what they fund—vary from state to state. In large part, state variation in DSH is driven by variation in federal DSH allotments—the ten states with the highest DSH expenditures account for over 72 percent of the \$17.15 billion of nationwide

Medicaid DSH spending.⁵ However, this variation is not based on current patient needs, but rather historical spending levels.

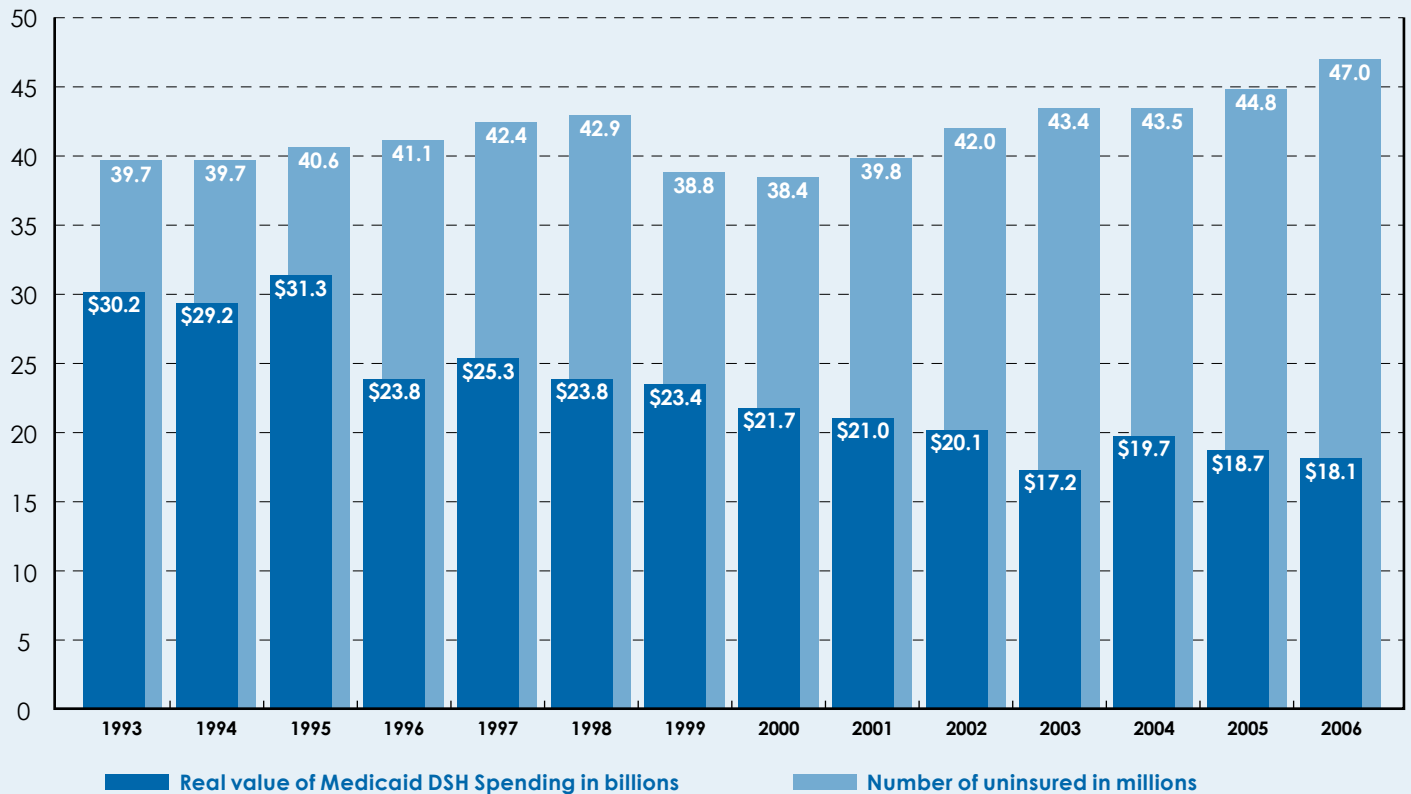
Figure 3 (page 4) depicts how spending varies across the country per Medicaid enrollee and the uninsured. A state's total Medicaid DSH spending and provider payment rates together influence the share of DSH that must be used to cover Medicaid losses. Additionally, in cases where DSH allotments and Medicaid payment rates are low, DSH funds may not be sufficient to stabilize

safety net providers, allowing them to fill unique and critical roles, such as the provision of trauma and burn services, surge capacity and emergency preparedness activities.

DSH Funding and the Health Reform Dialogue

A clear understanding of how Medicaid DSH payments are used is critically important as the dialogue on health reform begins. While many assume that DSH funds are solely dedicated

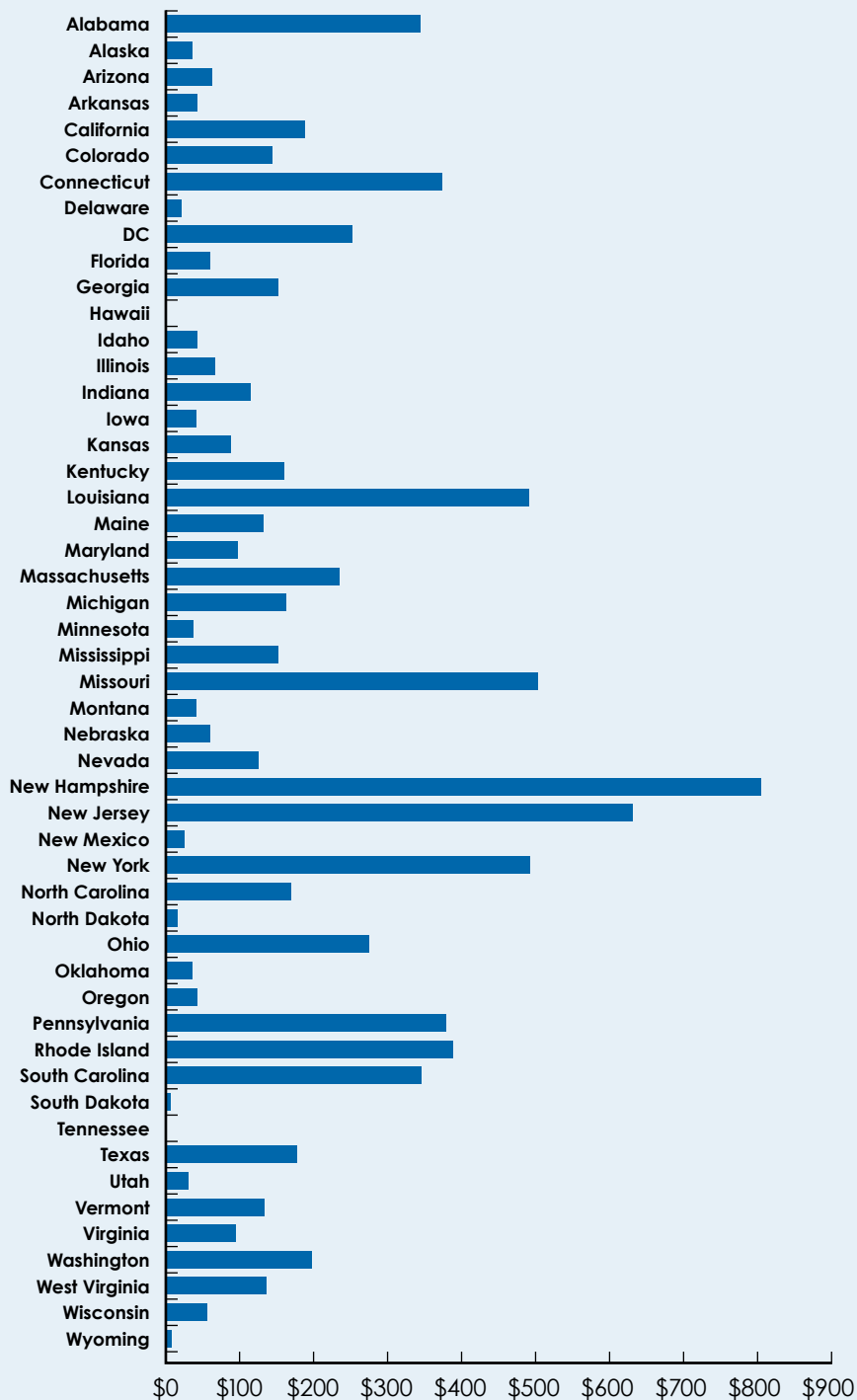
FIGURE 2 Real Value of Medicaid DSH Spending Compared with Number of Uninsured in U.S. Population, 1993–2006



SOURCE NAPH analysis of Medicaid DSH spending data from the Urban Institute, CMS-64 and GAO-08-614; U.S. Census Bureau uninsured data; U.S. Bureau of Labor Statistics consumer price index data.

FIGURE 3

Medicaid DSH Spending per Medicaid Enrollee and Uninsured Individual, 2006



SOURCE GAO-08-614 for 2006 DSH spending data. Kaiser Family Foundation's statehealthfacts.org for 2005 Medicaid enrollee data and 2006 uninsured data.

to caring for uninsured patients, this is only one focus of the Medicaid DSH program. It is necessary to assess the gains realized as a result of the Medicaid DSH program—regardless of the program’s structure—and ensure that the public benefits that result from the DSH program continue in a newly reformed system. If you have questions about this issue, or would like more information, contact the National Association of Public Hospitals and Health Systems. ■

Notes

1. Social Security Act (SSA) § 1902(a)(13)(A).
2. Government Accountability Office, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, May 2008 at 15.
3. American Hospital Association, *Underpayments by Medicare and Medicaid Fact Sheet*, October 2007 at 3.
4. NAPH analysis of data from CMS-64 and Government Accountability Office, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, May 2008 at 15.
5. *Id.* at 15.