National Association of Public Hospitals and Health Systems

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

The Medicaid disproportionate share hospital (DSH) payment adjustment was created in 1981 to help ensure Americans have adequate access to health care via a financially sound safety net hospital system. Safety net hospitals shoulder a disproportionate share of caring for the poor and uninsured, and their financial viability depends on the Medicaid DSH program[1]. By fiscal year 2010, spending on the Medicaid DSH program totaled $17.58 billion—$9.93 billion of this total was federal spending, while the $7.65 billion nonfederal share was provided by state and local governmental entities[2].

As is generally true of Medicaid, states have considerable discretion in designing their DSH program. As a result, states have targeted DSH payments to hospitals serving a range of important safety net needs, including (but not limited to) those providing uncompensated services to Medicaid patients or the uninsured. In fact, uncompensated care is only one of many intended uses of Medicaid DSH payments. DSH funding is also intended to ensure safety net facilities are able to deliver essential communitywide health care services and support physician training.

How Are Medicaid DSH Funds Used?

The vast majority of federal DSH spending is used by safety net hospitals for a variety of purposes, as described below. The remainder supports institutions for mental disease or state psychiatric hospitals.

1. 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 the number of uninsured Americans and the cost of caring for them. In 2010, 87 NAPH hospitals, collectively, incurred more than $8.4 billion in uncompensated care costs. However, Medicaid DSH payments to these hospitals totaled only $4.0 billion.

Although the Affordable Care Act (ACA) expanded coverage to millions, NAPH members expect to continue to provide billions of dollars of uncom-

NAPH represents about 200 of the nation's largest metropolitan safety net health systems, which fill a persistent gap in care access by providing high-volumes of uncompensated care to low-income, uninsured, and vulnerable populations. In fact, NAPH members represent just 2 percent of acute care hospitals nationally, yet provide 20 percent of all hospital-based uncompensated care. In addition to providing top-level trauma care, burn care, neonatal intensive care and other essential community services, and training more than 19,000 physicians and dentists annually, these health systems help newly uninsured patients and those newly eligible for public coverage programs navigate the health system to get the care they need.

Going forward, even with expanded coverage, safety net services made possible by the Medicaid DSH program will still need support in order to sustain public benefits in a newly reformed system.

pensated care, especially in light of the Supreme Court's ruling that made the ACA's Medicaid expansion voluntary for states. The Congressional Budget Office estimates that this decision will result in 6 million more uninsured Americans than previously estimated[3]. With a higher number of remaining uninsured patients, NAPH members will continue to see a disproportionate share in uncompensated care burden.

2. 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 Medicaid patients receive the full range of services necessary to facilitate their care. These services include "wraparound" assistance such as transportation, social work, patient navigation, and translation, as well as other services not typically covered by private insurance. In creating the DSH program, Congress intended to assist safety net providers—which typically incur higher costs and have fewer private-paying patients—in guaranteeing access to services for Medicaid and uninsured patients in their communities.

3. DSH supports essential community-wide health services.

Medicaid DSH payments also offer the financial stability safety net providers need to deliver many otherwise unreimbursed—or unprofitable—health care services to their communities. Without the stabilizing support of DSH funds, NAPH member hospitals' total operating margin would have been -6.1 percent in 2010. With this support, safety net hospitals can provide trauma and burn services and maintain 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 10 largest U.S. cities, safety net hospitals operate 37 percent of all level I trauma centers, staff 57 percent of all burn beds, and treat nearly 24 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.

4. DSH helps support physician training at teaching hospitals.

Most safety net hospitals are also teaching hospitals—in fact, NAPH member hospitals train more than 19,000 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 to ensure a high quality and adequate physician workforce for the future.

DSH Funding and the Health Reform Dialogue

A clear understanding of how Medicaid DSH payments are used is critically important as implementation of the ACA—and its mandated DSH reductions—continues. While many assume DSH funds are solely dedicated to caring for uninsured patients, this focus is only one of the Medicaid DSH program's many aims. Going forward, even with expanded coverage, safety net services made possible by the Medicaid DSH program will still need support in order to sustain public benefits in a newly reformed system. ■

If you have questions about this issue, or would like more information, contact Xiaoyi Huang (xhuang@naph.org) at NAPH.

[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 15, 2008, http://www.gao.gov/new.items/d08614.pdf.

[3] Congressional Budget Office. (March 2010). Letter to the Speaker of the House of Representatives Nancy Pelosi on cost estimate of H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf; Congressional Budget Office. (July 2012). Estimates for the insurance coverage provisions of the Affordable Care Act updated for the recent Supreme Court decision. Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.