

The Need to Raise the Hospital-Specific Medicaid Disproportionate Share Upper Limit for Pennsylvania's Safety-Net Hospitals

Our Position

The Safety-Net Association of Pennsylvania urges the federal government to increase the upper limit for Medicaid DSH payments to safety-net hospitals from the current level of 100 percent of unreimbursed Medicaid and uncompensated care costs to 175 percent of those costs. This would enable the state to direct more appropriate Medicaid reimbursement to safety-net hospitals that play the greatest role in caring for the poor and uninsured in Pennsylvania – and to do so without spending any more federal money for this purpose than has already been budgeted by the federal government.

Background

The Medicaid Disproportionate Share Hospital Program (DSH) limits how much individual private hospitals may receive in Medicaid DSH payments to no more than 100 percent of hospitals' unreimbursed costs for providing care to Medicaid recipients and the uninsured. This limit, commonly referred to as the Medicaid hospital-specific disproportionate share upper limit, applies only to private hospitals. Public hospitals, on the other hand, currently may receive as much as 175 percent of the costs associated with Medicaid and uninsured patients in Medicaid DSH payments. No deviation from this policy is allowed even in states that do not have public hospitals and that therefore rely on private safety-net hospitals to care for the poor.

Upper Limits, Public Hospitals, and Intergovernmental Transfers

The Medicaid DSH program was created in the early 1980s to provide financial relief to hospitals that serve large proportions of poor patients. The rationale for this approach was that providing this supplemental support would help maintain access to care for the poor, including Medicaid recipients and the uninsured. The enabling legislation called on states to "take into account the situations of hospitals which serve a disproportionate number of low-income patients with special needs" when they set their Medicaid inpatient hospital rates. Medicaid DSH payments became the mechanism for supplementing the income of hospitals that care for especially large proportions of poor patients – that is, Medicaid recipients and the uninsured.

As noted previously, public and private hospitals have different Medicaid DSH upper limits: for private hospitals, the upper limit is 100 percent of their costs for providing care to Medicaid recipients and the uninsured; for public hospitals, it is 175 percent of those costs. States also have a federally imposed aggregate Medicaid DSH cap – a limit on how much they can spend on Medicaid DSH payments for all hospitals state-wide.

A major benefit of having a higher upper limit for states with public hospitals is that many of these states fund part of their own share of Medicaid through what are known as intergovernmental transfers. Through this approach, public hospitals transfer significant sums of money to their state Medicaid office, which then receives

federal Medicaid matching funds and returns the original funds, plus additional funds in the form of Medicaid DSH payments, to the public hospitals from which they received the money in the first place. Having a higher upper limit gives public hospitals more room to maneuver within the upper limit, enabling them to use intergovernmental transfers to increase federal funding for state Medicaid programs. In theory, private hospitals do not need higher limits because they cannot perform intergovernmental transfers and do not need more maneuvering room.

Public hospitals, and the states that host them, have taken considerable advantage of this Medicaid funding tool. According to a 1997 survey of forty states, nineteen percent of Medicaid DSH funds – nearly half of the states' contribution to Medicaid – came through intergovernmental transfers. States that do not have public hospitals cannot avail themselves of the use of intergovernmental transfers and therefore must fund a greater portion of their share of their Medicaid programs through other state funds, such as tax revenue. This gives states with public hospitals a better tool for drawing down more federal financial participation, allowing state officials, if they so choose, to cover more people, offer more benefits, and provide better reimbursement to providers.

Another important benefit of the 175 percent limit for public hospitals is that it enables their state Medicaid programs to direct additional resources to them. Public hospitals provide enormous amounts of uncompensated care and clearly need this additional government help, and the 175 percent limit provides the vehicle for delivering this supplemental assistance.

In states like Pennsylvania that do not have public hospitals, responsibility for caring for the uninsured is not nearly as concentrated. At the same time, however, it is not evenly spread throughout the state: because of where they are located, a clearly defined group of hospitals – Pennsylvania's safety-net hospitals – provide significantly greater proportions of care to the poor and the uninsured than other hospitals. These hospitals, however, do not benefit from a special, federally sponsored mechanism for ensuring that they receive additional financial help for the additional role they play in constituting their state's health care safety net. Instead, they are prevented, by law, from receiving Medicaid DSH payments exceeding 100 percent of their unreimbursed costs of providing care to Medicaid recipients and the uninsured.

The Case for Raising the Hospital-Specific Upper Limit for Safety-Net Hospitals in Pennsylvania

There are four primary reasons why the federal government should raise the hospital-specific upper limit for Pennsylvania's private safety-net hospitals to the 175 percent level enjoyed by states with public hospitals.

1. *Medicaid DSH payments currently do not recognize all Medicaid-related costs.* Many of the costs that private safety-net hospitals incur when treating Medicaid recipients and the uninsured are not reflected in Medicaid payments; the process through which costs are allocated does not necessarily capture all Medicaid costs. The allocation method used assumes that the cost of treating Medicaid patients is the same as other patients – which many experts do not believe is true. Easing the 100 percent upper limit would allow more appropriate reimbursement to hospitals for those costs.
2. *Medicaid DSH payments that only help safety-net hospitals cover 100 percent of their unreimbursed costs of caring for Medicaid patients and the uninsured are inadequate.* Because of payer cutbacks over the years, hospitals are constantly cutting costs – and no hospitals do this more often, and more dramatically, than safety-net hospitals. Hospitals with more favorable payer mixes – that is, those with more privately insured patients – have more and better opportunities to receive reimbursement that exceeds their costs. These hospitals use this additional money to invest in capital improvements, acquire new health care technology, and maintain higher staffing levels. If safety-net hospitals only recover their costs but do no more, they cannot make such investments, which detracts from their ability to provide the highest quality of care to their at-risk patients and also destroys their ability to attract the

limited number of privately insured patients in their communities. Hospitals that do no more than recover their costs are operating under a death sentence: they can make do for a time, but inevitably, they must succumb to the combination of the overwhelming financial pressures they endure and their inability to remain competitive as providers of quality care. A number of Pennsylvania's safety-net hospitals have disappeared under these circumstances in recent years and others currently are in the midst of bankruptcy proceedings or moving in that direction.

3. *Raising the Medicaid DSH upper limit for safety-net hospitals would enable Pennsylvania to improve its own Medicaid program using its own funds.* Intergovernmental transfers are a financing technique used by many states to fund greater portions of their own Medicaid programs at federal expense; Pennsylvania does not seek an opportunity to make greater use of intergovernmental transfers. Instead, it needs the flexibility to put more Medicaid resources into the hands of the safety-net hospitals that provide the greatest proportion of care to low-income, uninsured, and underinsured Pennsylvanians. Today, Pennsylvania's Medicaid program compensates hospitals for approximately eighty percent of the cost of caring for Medicaid recipients. For hospitals that serve low proportions of Medicaid patients, this is adequate compensation; for safety-net hospitals, however, it is not. The state needs to do more for safety-net hospitals, and the appropriate mechanism for this is Medicaid DSH payments; the current upper limit of 100 percent, however, impedes the state's ability to use this tool to maximum effectiveness. Pennsylvania's distribution of tobacco settlement funds illustrates the problem that this lack of flexibility poses for state policy-makers: the current hospital-specific limit prevents the state from distributing enough tobacco settlement money to the hospitals with the greatest need. Increasing the Medicaid DSH hospital-specific upper limit to 175 percent would enable the state to make better use of its own money – and to do so without additional cost to the federal government.
4. *Many other states have this extra measure of flexibility; Pennsylvania should have it, too – especially since such a change would not cost the federal government more money.* Increasing the hospital-specific Medicaid DSH upper limit for Pennsylvania's safety-net hospitals from 100 percent to 175 percent would give the state a degree of flexibility that many other states already enjoy - the flexibility to determine where the need is greatest and to focus its resources there. Pennsylvania does not need a change in federal Medicaid regulations to enable it to do more intergovernmental transfers: it needs the ability to reimburse safety-net hospitals adequately and distribute its Medicaid money in a manner that meets the clear public policy objective of preserving the health care safety-net for poor, uninsured, and underinsured Pennsylvanians. Raising only the hospital-specific Medicaid DSH upper limit, and only for safety-net hospitals – while leaving the state's aggregate Medicaid DSH limit untouched – also would ensure that even with the possible reallocation of Medicaid funds within the state, the federal government would not spend even one dollar more on Medicaid in Pennsylvania than it already has budgeted for that purpose. While Pennsylvania does not have public hospitals, it does have a core group of forty-eight safety-net hospitals that collectively fulfill much the same role as public hospitals: they care for especially large proportions of poor and uninsured patients. The commonwealth needs the same flexibility for directing additional Medicaid resources to these safety-net hospitals as other states do to direct additional resources to their public hospitals.

For these reasons, the Safety-Net Association of Pennsylvania urges the federal government to raise the hospital-specific upper limit for Medicaid DSH payments for Pennsylvania's private safety-net hospitals from the current 100 percent to 175 percent of the unreimbursed costs of caring for Medicaid recipients and the uninsured. Pennsylvania's safety-net hospitals should not be placed at a disadvantage because the state has chosen to entrust its health care safety net – and the health and well-being of most of its two million Medicaid recipients and uninsured residents – to a core group of private, mission-driven safety-net hospitals.

About the Safety-Net Association of Pennsylvania

The Safety-Net Association of Pennsylvania represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of the commonwealth. Safety-net hospitals are the twenty-five percent of hospitals in Pennsylvania that care for the highest combined proportion of uninsured patients, Medical Assistance recipients, and Medicare SSI recipients and that therefore constitute the state's health care safety net. As a result of the patients they serve, safety-net hospitals face a significant, continuing, disproportionate challenge to their financial health. Today, there are forty-eight safety-net hospitals in Pennsylvania out of 192 acute-care hospitals in the state overall.

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For further information about the Safety-Net Association of Pennsylvania and the views expressed in this document, please contact Charles DeBrunner, president, at (717) 234-6970.