# DSH Hospitals: Still Caring for the Poor

BY FELICIEN "FISH" BROWN

Peering down on members of Congress as they pass through Statuary Hall in the Capitol building in Washington, DC, is the towering figure of Mother Joseph of the Sisters of Providence. A founder of schools, orphanages, and hospitals in the Northwest in the mid-1800s and an undaunted advocate for the poor, Mother Joseph often spent months on end begging in mining camps for the funds needed to keep her hospitals going. On one begging trip to Denver, her train was stopped by masked gunmen demanding passengers' belongings. After the baggage had been piled up, Mother Joseph had the audacity to say to one of the robbers, "My boy, please give me my bag." Astounded by her action, the bandit carried the bag to her with her $200 of donations inside. "Thank you, God bless you, my boy," said Mother Joseph.[1] And the hospitals had the money needed to keep going.

Catholic hospitals have come a long way since Mother Joseph but they still have the same mission of service to the poor. In fact, a large number of Catholic hospitals continue in their role as "safety net providers," offering care to a disproportionate share of uninsured, low-income patients without the ability to pay. Fortunately over the last decade, the Medicare and Medicaid programs have recognized the financial burden on these hospitals and now give supplemental payments to disproportionate share hospitals (DSH). Increasingly, however, these DSH payments are under attack. The Balanced Budget Act of 1997 reduced Medicare DSH payments by 5 percent over the next few years, and some in Congress are calling for deeper cuts.

The Bipartisan Commission on the Future of Medicare is considering recommending the removal of DSH payments from the program altogether in an effort to improve Medicare's long-term solvency. Proponents of this approach say that federal funding for disproportionate share hospitals should flow from general appropriations, not Medicare. The "social costs" of caring for the uninsured ought not to come from a Medicare program reformed to act more like a private insurer, they say. This argument would be more convincing if one did not know that, were DSH needs to be funded by general appropriations rather than Medicare, they would have to compete with other government needs such as transportation, education, and defense—and, as a result of such competition, would face severe cutbacks.

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## DSH Hospitals Are a "Safety Net"

What is the purpose of Medicare DSH payments, and why are they still needed?

In 1986, Congress added the DSH adjustment to Medicare's inpatient prospective payment system (PPS) as a way of approximating the extra costs to hospitals of treating high volumes of low-income patients. Research showed that such hospitals incurred a higher cost per case than those with lower volumes did. Moreover, such costs were beyond the control of the hospital. Low-income or indigent patients tended to be sicker once hospitalized, often because they were unable to get adequate routine care or early medical intervention. Congress also had become increasingly concerned that, without additional payments, hospitals treating disproportionate numbers of low-income patients would be in jeopardy of closing, which would mean diminished access to care for low-income Medicare beneficiaries and other patients. In 1997, about 38 percent of hospitals paid under the prospective payment system received DSH payments.[2]

Most DSH hospitals are in urban areas and often the only source of medical care for the poor, who are often uninsured. However, a significant number of these "safety-net" institutions exist in rural areas as well. In addition to their large number of low-income patients, safety-net hospitals often treat a high percentage of Medicare and Medicaid patients. This means that they depend heavily on Medicare and Medicaid for patient revenues. It also means that Medicare

DSH payments are an integral part of the overall revenue structure of safety-net hospitals. Catholic hospitals alone received $503 million in Medicare DSH payments last year.

Safety-net hospitals will have to rely more on Medicare DSH payments to cover the costs of low-income patients as commercial insurers increasingly compete on price by ratcheting down hospital reimbursement rates or lengths of stay. As a result, the ability to cost-shift the burden of paying for indigent care to privately insured patients will steadily decline. As the ability to cost-shift evaporates, however, some safety-net hospitals may have no choice but to reduce their commitment to serving the poor. Researchers have determined that this is already occurring. For example, the Prospective Payment Assessment Commission found that erosion of funds from private payers is strongly associated with reductions in hospital loads of uncompensated care.[3]

Further contributing to the scarcity of dollars to support hospital care for the low-income is the growth of Medicare managed care. Hospitals are losing a percentage of their overall DSH payments because managed care plans that enroll Medicare beneficiaries generally are not passing DSH adjustments on to hospitals. This problem will worsen with the expanding enrollment of beneficiaries in the Medicare+Choice program. A fairer alternative would be for Medicare to "carve out" DSH payments from the capitation amounts paid to Medicare+Choice health plans and instead pay them directly to hospitals that incur the costs of providing services to the poor.

## Preserve DSH Payments

The shrinking pool of dollars to pay for hospital services for the nation's low-income populations poses a major policy dilemma. To remain competitive in a price-sensitive insurance market, private insurers are increasingly less likely to subsidize the healthcare of the poor. On the other hand, the long-term survival of Medicare argues against allowing its DSH obligations to grow unchecked. To ensure continued access to hospital care for the low-income and elderly, a broader base of funding may eventually be needed to support DSH payments. One option is a shared responsibility model in which all payers contribute to a dedicated financing base for funding services provided for the public good, such as care for the low-income.

In the absence of such a shared responsibility structure, however, reductions in Medicare's commitment to DSH would be premature and potentially crippling. If Medicare DSH payments cease to be a source of dedicated funding, the healthcare safety net will surely no longer be able to support the weight of its obligations. Alternatively, assisting safety-net hospitals to discharge their larger social responsibilities by continuing Medicare DSH will guarantee that beneficiaries, who often rely on these facilities as their only source of care, have a dependable source of care.

Of course, the best approach to ensuring access to healthcare for the poor is to extend health coverage to all Americans. Yet until that goal is achieved, the federal government will need to play an extensive role in supporting hospitals and other providers of care to the uninsured—now 43.6 million people and growing. Medicare DSH payments are an essential element in funding for safety-net providers. If Mother Joseph were alive today, she would likely be in Washington doing what needed to be done to ensure continued Medicare DSH funding for Catholic and other hospitals serving low-income beneficiaries and their families. □

### NOTES

1. *A Call to Care*, The Catholic Health Association, St. Louis, 1996, pp. 63-68.
2. Medicare Payment Advisory Commission, *Selected Medicare Payment Policies*, Washington, DC, October 1997.
3. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress*, Washington, DC, June 1996, p. 48.

## LAW

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requirements and the reimbursement policies and procedures of MCOs. Hospitals should not be punished by MCOs because they have faithfully complied with federal law.

Logically and strategically, these statutory provisions should be included in the patients' rights legislation that the president has made a top priority for the 106th Congress. The provision was included in last year's legislation, and it is the most likely package to be passed into law in the next Congress.

### Conundrum in the ER

System and hospital legal counsel should study the new guidance provided by OIG and HCFA on a hospital's duty under EMTALA. They should also consider filing comments with OIG and HCFA to explain how this issue can arise in the real operations of a healthcare facility. Hospitals risk significant penalties if they abide by contractual provisions requiring prior authorization before providing individuals presenting at the hospital with an appropriate medical screening examination. Hospitals should not have to face a difficult emergency room conundrum: abiding by federal law and losing reimbursement, on one hand, or honoring contractual provisions and violating EMTALA, on the other. Congress can and should clarify this situation. □

### NOTES

1. Leigh M. Chiles, "Summers v. Baptist Medical Center Arkadelphia: A 'Disparate' Application of EMTALA's Terms," *Arkansas Law Review and Bar Association Journal*, vol. 559, 1997.
2. 42 U.S.C. Section 1395dd (a).
3. 42 U.S.C. Section 1395dd(b), (c).
4. 42 U.S.C. Section 1395dd(d)(1)(A), (B).
5. 42 U.S.C. Section 1395dd(d)(2).
6. OIG and HCFA, *Solicitation of Comments on the OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute*, December 2, 1998, p. 3.
7. *Solicitation of Comments*.
8. *Solicitation of Comments*, p. 4.
9. See S. 1890, Patients' Bill of Rights Act of 1998, Section 101 (105th Cong. 2nd Session); S. 2330, Patients' Bill of Rights Act, Section 721 (105th Cong. 2nd Session).

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