Safety-net hospitals have long relied on a patchwork of financial subsidies to support their mission of caring for any patient regardless of their ability to pay. Although several public policies are intended to support this mission, the centerpiece is the Medicaid disproportionate share hospital (DSH) payment program, which began in 1981 and was built around the understanding that a small subset of hospitals provides the majority of uncompensated care and that state and federal governments should help these institutions bear those costs.

Despite its intentions, the DSH payment program has often been subject to gaming in ways that have detracted from its goals of supporting the safety net. The 1990s saw unprecedented growth in DSH payments due to “fiscal shenanigans,” in which states requested large payment allotments from the federal government, but only allocated a portion of those payments to safety-net hospitals while using the rest to support other state activities. Although Congress passed legislation to limit these behaviors, as of 2016, some states still request funding from the federal government above the uncompensated care levels reported by their hospitals.

Effective targeting of DSH payments, which now total more than $20 billion annually, is not just important for bookkeeping. Prior work has shown that when DSH payments reach the hospitals that need them the most, inpatient outcomes improve. In this way, diverting DSH payments away from their intended purpose may reduce the quality of care for the patients who stand the most to benefit from them. Revisiting the design and implementation of the DSH program thus represents a key policy lever for improving health equity in the US by improving support for the hospitals and health systems that serve low-income communities. Remedying these policy issues has a renewed urgency given these hospitals also bore a disproportionate burden of caring for patients during the COVID-19 pandemic.

We identify 4 opportunities for states and the federal government to realign DSH payments with their original intent to improve access to care for Medicaid beneficiaries and uninsured individuals by improving the financial viability of safety-net hospitals.

**Better Targeting**

First, states could better target existing DSH funds to support hospitals that provide relatively high levels of uncompensated care. The DSH payment program is operated as a joint state-federal partnership in which states have a remarkable degree of flexibility in deciding how payments are allocated to hospitals and other health care organizations. Some states allocate a nonzero amount of DSH payments to nearly all hospitals, while others target the majority of funds to a small subset. In some ways, these allocation decisions reflect differences in uninsured rates across states given the heterogeneity in insurance coverage following implementation of the Affordable Care Act. However, recent work has shown that 32% of DSH payments were allocated to hospitals with levels of uncompensated care provision below the median in their state. In this way, the current system for DSH payment allocation may be undermining its intended goals.

These misallocations can be remedied. Several states have pools of unspent DSH payments that should be distributed to hospitals that play a substantiative role in caring for Medicaid beneficiaries and the uninsured. To inform improved approaches to DSH allocation, state and federal governments could strengthen auditing procedures to ensure that DSH payments are reaching the hospitals.
intended by statute, which include those that disproportionately serve Medicaid-insured patients or provide uncompensated care.

States could also test redistributing DSH payments from hospitals that provide little uncompensated care to those that provide higher amounts. The Centers for Medicare & Medicaid Services have already begun to implement redistributive policies in other settings, as with the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model, in which ACOs that disproportionately serve dual-eligible enrollees will receive a payment bump derived from reductions in payments made to those that serve few of these enrollees.

Defining Safety-Net Needs Differently

Second, states could move away from targeting DSH funds primarily with health care utilization-based measures—such as the proportion of inpatient care delivered to Medicaid beneficiaries—given that these measures have been shown to systematically underallocate funds to communities that face structural barriers to care. Conditional on receiving the same level of DSH funding, hospitals serving minoritized communities have much higher rates of uncompensated care and unaddressed population health needs than those serving nonminoritized communities.\(^4\) To address this issue, DSH payment formulas could be partially tied to the provision of essential community services as defined by the Medicaid and CHIP Payment and Access Commission to support the health needs of low-income, uninsured populations,\(^2\) including obstetric, inpatient psychiatric, and trauma care.

Reducing Redundancy

Third, states and the federal government could work together to address redundancy among the so-called supplemental payment programs—which, in addition to the Medicaid DSH program, includes the Medicare DSH program, among others—that all share the goal of supporting uncompensated hospital care but do so through different mechanisms. The extent to which hospitals currently claim funds from different supplemental payment pools is unclear. A single mechanism to support this mission, along with enhanced federal and state auditing efforts, could address redundancy and improve targeting. For example, in 2015, California proposed combining DSH payments with other supplemental payments to create a global budget program that would better align care delivery for low-income populations in the state. Preliminary evidence has shown that this reform substantially improved access to care.\(^5\)

Fundamental Reform

Fourth, Congress could fundamentally reform the DSH program to reflect the fact that the majority of health care is now delivered in the outpatient, rather than inpatient, setting. Access to outpatient care is relatively low for Medicaid beneficiaries, which has partially been attributed to low payment rates, although evidence for the association between Medicaid payment and outpatient access to care has been mixed.\(^6,7\) Unused or mistargeted DSH funds could be reallocated as a subsidy to organizations and clinicians providing outpatient services to incentivize primary care and specialist physician participation in the Medicaid program.

Conclusions

The problems that have plagued the DSH payment program are emblematic of broader structural issues related to safety-net health care financing. Many of these issues stem from a central problem of slippage or policy creep, in that originally well-targeted financing schemes end up losing focus over time, expanding to include more and more stakeholders and participants such that funding is no
longer well targeted to the entities that the policy was designed to support. Reforming Medicaid DSH policy is politically complicated given the intertwined interests of state and federal legislators, hospital systems, medical groups, and advocacy organizations. Importantly, the DSH program represents only a single lever by which policy makers might consider improving the viability of safety-net hospitals—broader efforts to enhance access to insurance, including encouraging all states to expand Medicaid eligibility under the Affordable Care Act or improving the affordability of subsidized coverage on state insurance marketplaces, would directly reduce hospitals’ uncompensated care. Yet, expansions of insurance coverage would not obviate the need for a subsidy because many people—including those with undocumented immigration status—will likely remain ineligible for government programs. Better targeting of DSH funds to hospitals and other organizations serving substantive roles in the safety net thus represents a key opportunity for states and the federal government to invest in their financial viability and thereby improve health equity in the US.

ARTICLE INFORMATION
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