

Profiles of Disproportionate Share Hospitals

As part of its statutory obligation to study Medicaid payments to disproportionate share hospitals (DSH), MACPAC has sought to understand the financial health of these hospitals and their role in serving Medicaid patients. While quantitative analyses of utilization, payment, and hospital costs have been the foundation of our analyses, we know that such data do not tell the whole story. To develop a richer and more nuanced picture of the role of DSH hospitals in different markets and communities, the Commission contracted with the Urban Institute to profile seven DSH hospitals. Through interviews with hospital executives, we sought to shed light on the different types of institutions across the country that receive DSH payments and the relationship between DSH and other sources of hospital funding. These interviews were conducted during the summer and fall of 2016.

These profiles accompany MACPAC's analyses of DSH allotments and payments included in the Commission's March 2017 [Report to Congress on Medicaid and CHIP](#). Although we cannot draw strong conclusions from the experience of the seven profiled hospitals, the profiles, supplemented with additional information collected from Medicare cost reports, Medicaid DSH audits, and other sources, illustrate both the different circumstances of these institutions and the importance of DSH funds to them.

Below we present the key themes from our interviews:

- DSH hospitals operate in a wide variety of state and market contexts;
- DSH hospitals are often part of health systems that provide an array of outpatient services;
- state and market contexts affect how hospitals use DSH funding;
- state DSH payment policy is dynamic and subject to change based on a variety of factors; and
- hospitals respond to changes in DSH policy.

Each of the hospitals listed below is profiled in a separate fact sheet:

- Parkland Hospital in Dallas, Texas, a 770-bed county-owned hospital that is part of the larger Parkland Health and Hospital System. It is the primary teaching hospital for the University of Texas Southwestern Medical Center.
- MetroHealth Hospital in Cleveland, Ohio, a 397-bed county-owned hospital that is part of an integrated health system with more than 20 sites. The system serves as a teaching hospital for Case Western Reserve University.
- Santa Clara Valley Medical Center in San Jose, California, a 574-bed county-owned hospital that is part of the Santa Clara Valley Health and Hospital System. Santa Clara Valley Medical Center is a teaching



hospital that has its own residency program as well as a long-standing affiliation with Stanford University Medical School.

- Vidant Medical Center in Greenville, North Carolina, a 909-bed non-profit hospital that is the flagship facility for Vidant Health System, a regional system that serves 29 counties in eastern North Carolina. Vidant Medical Center is the only hospital in Greenville and is the primary teaching hospital for East Carolina University's Brody School of Medicine.
- Henry Ford Hospital in Detroit, Michigan, a 491-bed non-profit hospital that is the flagship facility of the Henry Ford Health System, which is composed of seven hospitals and one of the nation's largest group practices, the Henry Ford Medical Group. Henry Ford Hospital is also the primary teaching hospital for Wayne State University.
- Northeastern Vermont Regional Hospital in St. Johnsbury, Vermont, a 25-bed non-profit critical access hospital in rural Vermont. Northeastern Vermont Regional Hospital is the only hospital within 40 miles of St. Johnsbury, Vermont.
- Connecticut Children's Medical Center in Hartford, Connecticut, a 187-bed non-profit children's hospital and the primary pediatric teaching hospital for the University of Connecticut School of Medicine. It is the only freestanding children's hospital in the state.

Hospital Characteristics

Compared to other hospitals nationally, the hospitals that we profiled had above average Medicaid and low-income utilization rates and higher levels of uncompensated care in 2014, the year of the most recent available data (Table 1). However, the reliance of the profiled hospitals on DSH payments varied widely: their DSH payments ranged from 3 percent to 36 percent of total Medicaid payments in 2012. Many hospitals also received large non-DSH supplemental payments in addition to DSH funding.

Key Themes

DSH hospitals operate in a wide variety of state and market contexts

The hospitals we profiled operate in different states and market contexts. Key areas of difference include state Medicaid expansion decisions, state Medicaid payment rates, and relationships to other hospitals in their local markets.

Hospitals in states that expanded Medicaid to adults under age 65 with incomes at or below 138 percent of the federal poverty level under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) reported lower levels of unpaid costs of care for uninsured individuals in their Medicare cost reports. For example, MetroHealth Medical Center in Ohio and Santa Clara Valley Medical Center in California are both public hospitals whose patient mix includes a high share of low-income patients. In



2014, after their states expanded Medicaid, these hospitals reported lower levels of bad debt and charity care than before the expansion, commensurate with other hospitals in their regions. By contrast, Parkland Hospital, a public hospital in Texas, a state that has not expanded Medicaid, continued to report high levels of uncompensated care as a share of its operating expenses in 2014 (33 percent), which was more than twice as high as other hospitals in its region.

Executives described how state Medicaid payment policies, including the level of base rates, affected their hospital's Medicaid shortfall, which is the difference between Medicaid payments and the cost of providing services to Medicaid-enrolled patients. For example, Vidant Medical Center reported receiving cost-based Medicaid reimbursement and no Medicaid shortfall, while Northeastern Vermont Regional Hospital reported that Medicaid payments only cover about half of the hospital's Medicaid costs.

The three large public hospitals that we profiled (Parkland Hospital, MetroHealth Medical Center, and Santa Clara Valley Medical Center) are in urban markets with many other hospitals; the others are the sole provider in their markets. For example, Vidant Medical Center in Greenville, North Carolina, is the sole provider in its urban market and many of its surrounding counties, and Northeastern Vermont Regional Hospital is the sole provider in a geographically remote area. While the large public hospitals we profiled serve a high share of low-income patients in otherwise high-income markets, both Vidant Medical Center and Northeastern Vermont Regional Hospital serve a high share of low-income patients because they are in regions with lower per capita income overall.

Connecticut Children's Medical Center is in an urban setting with many other hospitals but is the only freestanding children's hospital in the state and therefore has less competition for the services it provides. Connecticut Children's Medical Center, like many children's hospitals, reports high Medicaid utilization rates because Medicaid covers a higher share of children than adults.

DSH hospitals are often part of health systems that provide an array of outpatient services

All but one of the DSH hospitals that we profiled were part of larger health systems that provided extensive outpatient care and other services in their communities. In 2016, for example, Parkland Hospital provided 20 times as many outpatient clinic visits as inpatient hospital stays. Although Northeastern Vermont Regional Hospital is not part of a health system and provides fewer outpatient visits, it recently partnered with rural health clinics, federally qualified health centers, a designated mental health agency, and various social service providers to form the Caledonia Southern Essex Accountable Health Community.

Being part of a health system can affect a hospital's overall finances. For example, Henry Ford Hospital reported that the suburban hospitals in its system attract more commercially insured patients, which helps offset losses from the health system's flagship hospital in Detroit. In addition, MetroHealth Medical Center described how it recently acquired a physician group with a larger share of patients with commercial coverage with the goal of increasing the portion of privately insured patients in its payer mix.



TABLE 1. Summary Statistics for Profiled Hospitals, 2012 and 2014

Hospital	Location	Hospital type	Deemed DSH status	Medicaid utilization rate, 2014	Low-income utilization rate, 2014	Uncompensated care as a share of hospital operating expenses, 2014	DSH payments, 2012 (millions)	DSH as a share of Medicaid revenue, 2012	DSH and non-DSH supplemental payments as a share of Medicaid revenue, 2012
Parkland	Dallas, TX	Short-term	Deemed	25%	49%	33%	\$191.2	36%	54%
MetroHealth	Cleveland, OH	Short-term	Deemed	56	35	5	33.5	12	21
Santa Clara Valley	San Jose, CA	Short-term	Deemed	68	81	1	197.2	32	36
Vidant	Greenville, NC	Short-term	Deemed	30	18	4	22.7	8	16
Henry Ford	Detroit, MI	Short-term	Not deemed	28	13	6	8.6	3	30
Northeastern Vermont Regional	St. Johnsbury, VT	Critical access	Not deemed	22	15	3	1.3	13	13
Connecticut Children's	Hartford, CT	Children's	Deemed	56	37	2	10.1	10	10
National averages									
All DSH hospitals				21%	14%	4%		14%	26%
All hospitals				19	11	4		N/A	N/A

Notes: DSH is disproportionate share hospital. N/A indicates that data are not available. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. The Medicaid inpatient utilization rate is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid. The low-income utilization rate is a measure of Medicaid and charity care utilization. Medicare cost reports define uncompensated care as charity care and bad debt.

Source: MACPAC, 2016, analysis of 2014 Medicare cost reports and 2012 DSH audit data.



State and market contexts affect how hospitals use DSH funding

DSH funding is flexible, and executives at the seven profiled hospitals reported using DSH funds directly and indirectly for different purposes, including:

- offsetting the hospital’s uncompensated care costs for Medicaid-enrolled and uninsured patients;
- supporting the development of programs for low-income patients, such as programs to address infant mortality, substance use disorders, and social determinants of health; and
- supporting the financial stability of their overall health system, including the hospital’s ability to employ physicians and maintain access to care in the outpatient setting.

In some cases, the hospital’s market context appeared to shape hospital executives’ views about the role of DSH payments for their institution. For example, executives from Northeastern Vermont Regional Hospital and Vidant Medical Center, two hospitals that were the sole providers in their regions, described using DSH funds to support access to care for services that were not otherwise available in their region (such as birthing services at Northeastern Vermont Regional Hospital and trauma, emergency room, and behavioral health services at Vidant Medical Center). Executives at hospitals that were one of many hospitals in their urban markets noted that DSH payments allowed them to provide low-income patients with access to services that other hospitals in the same market did not provide.

State DSH payment policy is dynamic and subject to change based on a variety of factors

Three of the seven DSH hospitals that we profiled reported recent changes in their states’ DSH payment policies that lowered their DSH payments:

- Parkland Hospital executives reported that Texas’s 2014 changes to its DSH targeting policy to make more privately owned hospitals eligible for DSH payments resulted in a drop in net DSH payments to Parkland, which is publicly owned. The hospitals net DSH payments fell from \$72 million in 2015 to \$62 million in 2016 (a 14 percent decline).
- MetroHealth Hospital executives reported that its DSH payments fell from \$33 million in 2012 to \$11.7 million in 2015 (a 60 percent decline) because of a change in Ohio’s formula for distributing DSH payments and because MetroHealth’s total amount of uncompensated care fell as a result of Ohio’s Medicaid expansion. In 2015, Ohio developed a new methodology for distributing DSH payments that de-emphasized hospital unpaid costs of care for uninsured individuals.
- Connecticut Children’s Hospital executives reported that their DSH payments were specified as a line item in the state budget and fluctuated from year to year based on budget constraints—from a low of \$10 million in 2012 to a high of \$20 million in 2015, and most recently \$12.5 million in 2016.

Hospitals respond to changes in DSH policies

Hospitals that experienced recent reductions in DSH payments as a result of changes to state DSH policies responded in different ways. At Parkland Hospital, executives reported that they were seeking additional non-DSH supplemental payments through Texas’s Section 1115 demonstration to help make up for the



loss of DSH funding. At MetroHealth Hospital, hospitals reported that they may need to consider strategies to offset lost revenue by increasing their share of commercially insured patients. Executives at both hospitals said that they might need to cut services or staff if DSH funding is further reduced.

In contrast to the other hospitals we profiled, executives at Santa Clara Valley Medical Center reported that they were providing additional services as a result of an increase in DSH payments under Medi-Cal 2020, California's new Section 1115 demonstration. The demonstration allows the state to distribute DSH funds as a global payment to 21 designated public hospitals.

Under the terms of the global payment program (GPP), DSH funding is delinked from hospital uncompensated care costs and hospitals receive incentives to invest in outpatient care that can reduce inpatient costs for uninsured patients. Hospital executives noted that the GPP helped support clinic services for uninsured patients that DSH did not pay for previously, but also expressed concern about whether the hospital would meet its targets and earn full GPP payment, because GPP payments are not guaranteed and must be earned.

Methods and Data Sources

To select hospitals for inclusion in the project, hospitals that received DSH payments in 2012 (according to state DSH audits) were first categorized by hospital type, ownership, location (rural or urban), teaching status, and deemed DSH status. Then a four-step process was used to identify potential study hospitals. We selected hospitals that met the following criteria:

- they represented combinations of characteristics common to hospitals that receive DSH payments nationally (according to the categories we identified);
- they had complete 2012–2014 Medicare cost report data and were in a state that submitted a 2012 DSH audit;
- their locations would allow us to examine a variety of state Medicaid expansion choices, geographic locations, and strategies for financing the non-federal share of DSH; and,
- they received DSH payments that contributed significantly to their finances (i.e., DSH payment amounts comprised a relatively large percentage of uncompensated care cost without exceeding it).

Using these criteria, we identified target hospitals and alternate hospitals for recruitment. The original goal was to recruit one for-profit hospital, four non-profits, and three public hospitals. Further, we wanted one of the eight study hospitals to be an institution for mental diseases (IMD) and one to be a critical access hospital; the remainder would be short-term. America's Essential Hospitals, the Children's Hospital Association, and the Catholic Hospital Association also assisted us by identifying member hospitals that met these criteria. In addition, the associations followed up with selected hospitals, indicating their support for the project once a member hospital had been invited.

We contacted the chief executive officers (CEOs) and chief financial officers (CFOs) of the eight original target hospitals via e-mail, inviting them to participate in the study. The e-mail invitation stated the purpose of the study and asked the hospital's CFO to participate in a 90-minute interview and the



hospital's CEO to review a profile of their hospital, which the Urban Institute would draft using interview information and publicly available data such as Medicare cost reports. Prospective hospitals were sent a template displaying the types of information that would be included in the hospital profile. At least three follow-up attempts were made.

Several waves of recruitment were required to secure hospital participation. Hospitals that declined did not always give a reason, but some said there was too much time involved, and one said that their hospital and state were in the process of resolving an issue with the Centers for Medicare & Medicaid Services (CMS) pertaining to their DSH payments and that the hospital did not want to “muddy the waters” by participating in this study. Despite assistance from the National Association of Psychiatric Health Systems and the National Association of State Mental Health Program Directors in recruiting an IMD, we were ultimately unsuccessful in doing so.

Interviews and Profiles

The Urban Institute conducted 12 interviews with executives from 7 hospitals during the summer and fall of 2016; each interview lasted 60 to 90 minutes. Interviewees included five hospital CEOs, one hospital system president, and six CFOs. Some interviewees were joined by other hospital employees, such as reimbursement or government relations staff, for part or all of the interview. With permission from the interviewees, interviews were audio-recorded and detailed notes were taken. Interview questions were customized for each hospital based on the background information we compiled on the hospital, its community, and its state to produce a preliminary profile (Table 2). Questions focused on the hospital and its community's characteristics, the hospital's Medicaid base and supplemental payments (DSH and non-DSH), its use of DSH payments, and its financial situation. Hospital executives were also asked for their opinions on how Medicaid DSH payments might be better targeted.

After the interviews were completed, gaps in the notes were filled in using the audio recordings. Interview information was added to our preliminary data to draft each hospital's profile. Each draft profile was reviewed by MACPAC and then by the hospital itself for accuracy. Where there were gaps, additional information was requested from the hospital at the time of review. Hospital feedback was incorporated into each profile.

TABLE 2. Data Sources Used to Develop Disproportionate Share Hospital Profiles, 2016

Data source	Time frame	Organization	Details extracted
Medicare cost reports	2011–2014	MACPAC	Hospital, HRR, state DSH payment, Medicaid payment and other financial information
DSH audit data	2011–2012	MACPAC	Hospital, HRR, state DSH payment, Medicaid payment and other financial information



TABLE 2. (continued)

Data source	Time frame	Organization	Details extracted
American Community Survey	2012–2014	U.S. Census Bureau	State and county characteristics, demographics, health insurance enrollment
County health ranking data	2016	Robert Wood Johnson Foundation	County health characteristics
State Medicaid expansion status and type	As of October, 2016	Kaiser Family Foundation	State Medicaid expansion status and type
<i>MACStats: Medicaid and CHIP Data Book</i>	2015	MACPAC	DSH distribution strategy
U.S. Government Accountability Office (GAO) analysis of state-reported data	2012	GAO	Predominant DSH financing method
MACPAC Medicaid inpatient payment compendium data	2014	MACPAC	Medicaid payment methodology

Notes: HRR is hospital referral region. DSH is disproportionate share hospital. Some profiles included additional information provided by the hospital or found online (e.g., financial reports).

Source: MACPAC, 2016 and Urban Institute, 2016, analysis of selected disproportionate share hospital data.

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