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Piling It On DSH Providers' Plate: Why PPACA's Eyes Are Bigger Than Its Stomach

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I. INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (PPACA) is the most comprehensive reform of the American healthcare system since the enactment of Medicare in 1965.[1] Passed in the midst of rising unemployment rates and unprecedented bankruptcies from medical debt, the PPACA aims to provide more Americans with access to health care by expanding public and private health insurance coverage eligibility, especially to low-income individuals. Historically, this population has been served by a system of healthcare providers known as the "safety-net" that often undertake substantial financial losses to provide free or deeply discounted care to these deserving, yet underserved communities.[2] This essential element of the healthcare infrastructure already struggles to meet the current needs of the uninsured and low-income populations it serves and after full implementation of PPACA in 2014, that mission may very well become impossible due to financial constraints affecting the states, the federal government, and the facilities themselves.[3]

On its face, the PPACA tries to relieve some of the safety-net's burden by enabling these individuals to access health insurance through government sponsored and private

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1. *See generally* Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (consolidated with the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, Tit. X (2010)).
2. *See Infra* Part II (discussing the role of the safety-net).
3. *See Infra* Part II (highlighting the financial problems safety-net provided are facing).

options.[4] Viewed singularly, the provisions that expand Medicaid and create an individual mandate are commendable ideas, at least in theory.[5] When viewed in conjunction with the reimbursement reductions and supplemental funding cuts, however, the provisions that expand insurance coverage fail to create a financially sustainable trajectory for the hospitals and physicians that are expected to serve as the point of access for the remaining uninsured, the newly insured, and those still left in the safety-net. Under an intense resources strain, these facilities will be forced to make difficult decisions with harsh consequences for their communities. In light of these conflicting provisions, the PPACA may ultimately harm the populations the legislation meant to protect.

This article looks at the role of safety-net hospitals within the current health care system, and argues that certain conflicting provisions of PPACA threaten their long-term viability. First, this article will look at the importance of the Medicare and Medicaid Disproportionate Share (DSH) payments as a resource for safety-net hospitals to help supplement the cost of providing health care to low-income and uninsured populations.[6] Second, this article explains how PPACA intends to scale back or essentially eliminate those payments.[7] Third, it examines this funding reduction in tandem with the Medicaid eligibility expansion, individual mandate, and provider reimbursement rate adjustments to expose the gaps and resource constraints created by PPACA.[8] Lastly, this article concludes that once the reform is fully implemented, safety-net systems will become financially unsustainable, despite a pervasive residual need for such providers.[9]

II. DEFINING THE SAFETY-NET AND THE ROLE OF HOSPITALS

Safety-net hospitals by definition provide a large proportion of the inpatient care delivered to the uninsured.[10] By organizational structure, most safety-net hospitals are either not-for-profit corporations or public entities, operated either directly by the state or local government or by a separate government entity, such as a board of directors,

4. *See Infra* Part V (explaining the Medicaid expansion and Individual mandate provisions).
5. *Id.*
6. *Infra* Part II.
7. *Infra* Part III.
8. *Infra* Part IV.
9. *Infra* Part V & VI.
10. Michael Spivey & Arthur L. Kellermann, *Rescuing the Safety Net*, 360 NEW ENGL. J. MED. 2598, 2598 (Jun. 18, 2009), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp0900728.

entrusted with full governance authority.[11] Most are also eligible for exemption from federal income taxes, conditioned upon the provision of "community benefits," and serving patients regardless of ability to pay, especially Medicare and Medicaid beneficiaries, is one such example of a community benefit.[12]

Safety-net providers' contribution is typically quantified as a financial burden measured by the amount of uncompensated care incurred by treating the uninsured.[13] Consequently, these facilities are typically located where the uninsured reside, in depressed rural communities and inner cities.[14] Due to the skyrocketing healthcare costs and growing numbers of uninsured Americans as a result of rising unemployment rates, safety-net hospitals face mounting pressure to provide more for their communities despite falling reimbursement rates and revenue shortages.[15] Nationally, the unemployment rate is nine percent,[16] an unprecedented 50.7 million Americans are uninsured,[17] and the percentage of people living in poverty is currently 14.3 percent and rising.[18] Traditionally, the Medicaid program has been the mechanism for insuring low-income populations.[19] Unfortunately, this mechanism is riddled with coverage gaps and most

11. *Id*. Of the 3,900 nonfederal, short-term, acute-care general hospitals in the United States in 2003, approximately 62% were not-for-profit and 20% were public, government-owned. Statement of David M. Walker, Comptroller General of the United States before the House Committee on Ways and Means, United States Government Accountability Office, *Nonprofit, For-Profit, And Government Hospitals* (May 26, 2005).

12. While not explicitly required, the Internal Revenue Services considers treating Medicare and Medicaid patients as a form of community benefits for federal income tax exemption purposes. *See* Rev. Rul. 69-545, 1969-2 C.B. 117 *and* Rev. Rul. 83-157, 1982-2 C.B. 94 (stressing the significance of serving Medicare and Medicaid beneficiaries as evidence that a hospital is operated exclusively for the benefit of the community). But *see* Brief for Illinois Hospital Association Amici Curiae Supporting Appellants at 10, Provena Covenant Med. Ctr. v. Dep't of Revenue, 925 N.E. 2d 1131 (Ill. 2010) (No. 107328) [herein after IHA *Provena* Brief] (discussing how the average Illinois hospital depends on Medicare and Medicaid for more than half of its revenue from patient care, but highlights the fact that both programs reimburse for less than the cost of services which creates what is known as the Medicare/Medicaid "shortfall").

13. Calculated as the sum of free care, for which the hospital does not expect payment, and bad debt, or uncollectable outstanding patient charges. Joel Weissman, *The Trouble with Uncompensated Hospital Care*, 352 NEW ENGL. J. MED. 1171, 1171 (Mar. 24, 2005).

14. Spivey & Kellermann, *supra* note 10, at 2598.

15. *See infra* notes 78-82 (discussing recently stayed Medicare reimbursement cuts and PPACA provisions to reduce reimbursement to fund itself).

16. U.S. DEP'T OF LABOR - BUREAU OF LABOR STATISTICS, *Labor Force Statistics from the Current Population Survey - Series ID: LNS14000000: Seasonal Unemployment Rate*, (Feb. 21, 2011), http://data.bls.gov/cgi-bin/surveymost.

17. Richard Wolf, *Number of Uninsured Americans Rises to 50.7 Million*, USA TODAY, Sept. 17, 2010, http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm (citing to data from the U.S. Census Bureau).

18. *Id.*

19. Sara Rosenbaum, *A "Customary and Necessary" Program—Medicaid and Health Reform*, 362 NEW ENGL. J. MED. 1952, 1952 (May 27, 2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1003890 (describing the eligibility requirements before reform as "tied to both low income and demographic characteristics that are vestiges of federal cash-welfare

unemployed or low-income individuals remain uninsured.[20] As a result, most rely on uncompensated care via hospitals' emergency departments, a costlier point of access, as their primary provider of health care.[21] Tax-exempt hospitals, specifically, have historically offered some of these services to eligible individuals free of charge as charity care, but in an era of negative operating budgets, charity care has become a controversial and arguably waning practice.[22]

Beyond serving populations severely limited in the ability to pay for medical services, safety-net hospitals are facing all of the same financial burdens present in the healthcare system at large. First, the vast majority of the paying patients at safety-net hospitals are Medicaid and Medicare beneficiaries—programs that reimburse hospitals at less than the

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programs designed to benefit the disabled, the aged, and extremely poor "dependent" minor children and their parents"). In Fiscal Year 2009, the US government's total Medicaid spending equaled $366,471,017,061. Kaiser Family Found., *Illinois: Medicaid Spending*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/profileind.jsp?sub=47&rgn=15&cat=4 (last visited May 2, 2011).

20. *See* SAMANTHA ARTIGA, KAISER COMM'N ON MEDICAID AND THE UNINSURED, KEY FACTS: WHERE ARE STATES TODAY?, PUBL'N NO. 7993, 1 (Dec. 2009), http://www.kff.org/medicaid/upload/7993.pdf (discussing that the states are only mandated to cover children, pregnant women, elderly and disabled, and parents of eligible children, but that nondisabled, nonparents can be covered at the discretion of the state). Illinois currently extends coverage to parents through 191% of the federal poverty level, beyond federal requirements, but does not offer coverage or premium assistance for nondisabled, nonparent individuals. Kaiser Family Found., *Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by Scope of Benefit Package, January 2011*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/profileind.jsp?rep=54&cat=4&rgn=15 (last visited May 2, 2011).

21. Weissman, *supra* note 13, at 1172; STEVEN R. MACHLIN, MED. EXPENDITURE PANEL SURVEY STATISTICAL BRIEF NO. 111: EXPENSES FOR A HOSPITAL EMERGENCY ROOM VISIT, 2003 (Jan. 2006), http://www.meps.ahrq.gov/mepsweb/data_files/publications/st111/stat111.pdf (calculating that the average expenditure for an emergency room visit was $560 in 2003, and generally emergency room visits were more expensive than other ambulatory visits for outpatient services or services rendered in an office-based setting). For more information on the dynamic between the uninsured and hospital emergency departments, see JULIE PARADISE & CEDRIC DARK, KAISER COMM'N ON MEDICAID AND THE UNINSURED, POLICY BRIEF: EMERGENCY DEPARTMENTS UNDER GROWING PRESSURES, PUB. NO. 7960 (Aug. 2009), http://www.kff.org/uninsured/upload/7960.pdf [hereinafter EMERGENCY DEPARTMENT POLICY BRIEF].

22. State and Federal governments have increased focus on these organizations, questioning the merit of granting tax exemptions when limited free care is being provided in return. *See e.g.*, Provena Med. Ctr. v. Dep't of Revenue, 925 N.E. 2d 1131 (Ill. 2010) (Illinois Supreme Court upheld the Department's decision to deny a property tax exemption, but only a plurality reasoned that the hospital's total charity care in 2002, which equaled less than one percent of patient revenues, was *de minimus* and thus did not constitute charitable use of the property) *and* Pub. L. No. 111-148, § 9007 (2010) (PPACA's requirements for hospitals seeking tax exemptions: 1) perform a community assessment every three years which is to be used to develop and adopt an implementation strategy to meet the needs of the community as highlighted by the study 2) develop financial assistance and emergency care policies that clearly explain the eligibility criteria, characterization of care as free or discounted, calculation procedures for charges, method of applying aid, measures to make the community aware of the financial assistance policy, and the hospital's plan in the event of nonpayment including collection processes, and 3) submit audited financial statements and Form 990 Schedule H, which now includes information regarding community benefits and charity care.) *See also*, Kris A. Moussette & Matthew O. Page, *President Signs PPACA—New § 501(c)(3) Requirements for Charitable Hospital*, EDWARDS ANGELL PALMER & DODGE, (Apr. 20, 2010) http://www.eapdhealthcarereform.com/presidentsignsppaca/ (describing PPACA new requirements on not for profit, tax-exempt hospitals).

cost of the services provided.[23] Not including losses incurred due to unpaid patient bills and charity care, this means the hospital's expenses exceed revenues for a vast majority of services rendered, resulting in a negative operating margin.[24] Second, due to a larger and less healthy aging population,[25] hospitals are experiencing increased acuity levels.[26] Lastly, the unstable financial market and uncertainty surrounding health care reform has driven many healthcare lenders from the market, leaving capital for facility improvements and equipment replacements scarce.[27] In the face of all these financial restraints, disproportionate share payments have been an important resource to supplement the bottom line of hospitals that bear a heavier burden of costs from treating higher numbers of Medicare, Medicaid, and uninsured patients.

III. MEDICARE AND MEDICAID DISPROPORTIONATE SHARE PAYMENTS

The Social Security Act, out of necessity, authorized Disproportionate Share (DSH) payments in the early 1980's.[28] In 1981, Congress allowed states to decouple Medicare

23. Reimbursement data from 2007 that shows that for every dollar spent on Medicare and Medicaid patients, .91¢ and .88¢, respectively, were recovered. This translated into a shortfall of $21.5 billion for Medicare patients and $10.4 billion for Medicaid patients in one year. Brief of the American Hospital Association Amici Curiae Supporting Provena Covenant Medical Center at 7, Provena Covenant Medical Center v. Dep't of Revenue, 925 N.E. 2d 1131 (Ill. 2010) (No. 107328) [hereinafter AHA *Provena* Brief].

24. Spivey & Kellermann, *supra* note 10, at 2598 (explaining that the average operating margin for safety-net hospitals is -3.0%).

25. The US Census Bureau reports that in 2009, approximately twenty-four percent of the population or 72 million people, were older than fifty-five years old. US CENSUS BUREAU, CURRENT POPULATION SURVEY: ANNUAL SOCIAL ECONOMIC SUPPLEMENT 2009, POPULATION BY AGE AND SEX: 2009, BOTH SEXES, Table 1 (Dec. 2010), *available at* http://www.census.gov/population/socdemo/age/2009_older_table1.csv. *See also* John Pletz, *The Graying of Chicago*, 34 CRAIN'S CHIC. BUS., no. 6, Feb. 7, 2011, *available at* http://www.chicagobusiness.com/article/20110205/ISSUE01/302059982/crains-special-report-the-graying-of-chicago#axzz1EcwpccJK (describing the effect of the aging baby boomer generation on Chicago, and predicting more than 2 million Chicagoans begin turning sixty-five this year).

26. Scott B. David & Phillip J. Robinson, *Health Care Providers Under Pressure: Making the Most of Challenging Times*, 37 HEALTH CARE FIN., no. 2, 2010, at 49, 49. Higher acuity levels increase the demand for hospital staff, increasing labor costs, in addition to the fact that services to patients with a high acuity are costlier. *See generally*, Mark W. Stanton, *Hospital Nursing Staff and Quality of Care*, RES. IN ACTION (Agency for Healthcare Research and Quality) Mar. 2004, *available at* http://www.ahrq.gov/research/nursestaffing/nursestaff.pdf (discussing how increased patient acuity is demanding a more qualified nursing staff, within the greater focus of the nurse shortage situation).

27. David & Robinson, *supra* note 26, at 53 (noting that financially strong systems can access tax-exempt bonds, but weaker ones cannot, and traditional lending—which does not have the benefit of tax-free interest rates—is an option, but banks are mandating very strict terms and covenants). *See e.g.*, Mary A. Clark, *Rebuilding The Past: Health Care Reform In Post-Katrina Louisiana*, 35 J. HEALTH POL. POL'Y & L. 743, 747-48 (Oct. 2010) (describing the dilapidated condition of Charity Hospital, Louisiana's second largest safety-net (the largest in New Orleans) hospital in the state, before it was completely destroyed by Hurricane Katrina. Also explains the city's scramble for capital and deliberations to decide whether to refurbish it or demolish and rebuild the facility all together both before and after the hurricane).

28. *See generally* 42 U.S.C. §§ 1395ww *et seq*., 1396r-4 (setting forth the definition and formulas for Medicare and Medicaid DSH Payments, respectively). For a comprehendible overview of how these two

and Medicaid payments and recognizing the consequences this would have on facilities providing care to larger Medicaid populations, encouraged states to make supplemental payments to those facilities.[29] The Omnibus Budget Reconciliation Act of 1985 explicitly created an additional payment for hospitals that served a "significantly disproportionate share of low-income patients" through October 1, 1988.[30] In 1987, Congress increased the DSH percentage adjustment and extended the payments through 1990.[31] Under this regulatory scheme, states had to put up the money for the payments first, and the federal government would then match that amount.[32] Unfortunately in 1991, because of state abuse of the DSH payments,[33] Congress capped federal DSH funds at twelve percent of annual expenditures, based on published state allotments for 1992.[34] States responded by making payouts to select hospitals in excess of the cost of uncompensated care, instead of an equitable distribution, and managed to recover most of the money from the federal government.[35] Since then Congress restricts states from making DSH payments in excess of unreimbursed costs, and allows the Centers for Medicare and Medicaid (CMS) to scrutinize the DSH system on a state-by-state basis.[36] The way DSH payments functions today, states have a lot of discretion over which

different payments relate to each other and the aforementioned statutes, see Cooper Univ. Hosp. v. Sebelius, 686 F. Supp. 2d 483, 484-487 (D.N.J. 2009).

29. Spivey & Kellermann, *supra* note 10, at 2598-99.

30. Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9105(a), 100 Stat. 158 (1986) (amending 42 U.S.C. 1395ww(d)(5) adding paragraph (F)(i)).

31. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4003(b), 101 Stat. 1330-46 (1987) (amending 42 U.S.C. 1395ww(d)(5)(B)); the adjustment to the Prospective Payment System (PPS), through which CMS reimburses providers for Medicaid services, basically self-funded the DSH payments by lowering the diagnosis related group ("DRG") rate paid to all hospitals. Recognizing that most teaching hospitals would qualify as DSH providers, the indirect medical education adjustment was also decreased. Ass'n of Am. Med. Colleges, *Medicare Disproportionate Share (DSH) Payments*, AAMC.ORG, https://www.aamc.org/advocacy/medicare/155102/dsh.html (last visited May 2, 2011). For actual statutory language amending the PPS, see Pub. L. No. 100-203, § 4003(a) (amending 42 U.S.C. 1395ww(d)(5)(B)(ii)).

32. Spivey & Kellermann, *supra* note 10, at 2599.

33. Budget experts figured out that if states required the DSH hospitals to contribute to the state's required share, the state could draw down a larger federal matching payment. The hospitals were reimbursed at least their contributions, but states kept most of the federal funds, sometimes even turning around and using them to draw down a larger federal Medicaid payment. Spivey & Kellermann, *supra* note 10, at 2599; *see also* CHRISTIE PROVOST PETERS, NAT. HEALTH POL'Y FORUM, THE BASICS: MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS 4-5 (2009) http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf [hereinafter THE BASICS] As an effect of this abuse, Federal DSH payments increased from $1.4 billion to $15 billion between 1990 and 1996. Spivey & Kellermann, *supra* note 10, at 2599.

34. THE BASICS, *supra* note 33, at 5 (explaining that the problem with this cap is that basing the state allotments—above which federal funding was not available—was inadequate for future years, and also resulted in a system that favored states that had been taking advantage of the system prior to the new cap).

35. Spivey & Kellermann, *supra* note 10, at 2599.

36. *Id*. at 2600 (noting CMS has concluded that "recycling," the practice of drawing excessive federal funds, has essentially stopped as of 2006).

facilities qualify as DSH providers,[37] but the actual amount of the payment is calculated with a formula dictated by the statute.

Medicare and Medicaid DSH payments are calculated separately, but there is some overlap. Medicare DSH payments can be calculated in one of two ways. The first determines eligibility based on a disproportionate patient percentage (DPP) threshold.[38] CMS uses a complex formula, taking into account the DPP figure to determine the states DSH adjustment for the fiscal year.[39] Alternatively, an exception applies to hospitals known as "pickle hospitals" that meet certain statutory criteria[40] where the statute specifically provides the amount of the adjustment for those "exception" facilities.[41] Medicaid DSH payments are subject to more state discretion, provided the statutory minimum criteria for eligibility is met.[42] States are required to provide at least the amount calculated under the Medicare DSH formula, or can apply a distribution method that calculates an amount proportional to increases in the hospital's low-income utilization rate.[43] In recent years, DSH caps have been put in place to reduce federal

37. Subject to the federal threshold of a 1% Medicaid utilization rate. Spivey & Kellermann, *supra* note 10, at 2600; THE BASICS, *supra* note 33, at 3. Of some concern, thirty-seven states have chosen to make DSH payments to hospitals providing Medicaid and charity care below the federal threshold since 1993. Spivey & Kellermann, *supra* note 10, at 2600.

38. The DDP is the sum of two percentages. The first percentage divides Medicare/Medicare Advantage inpatient days (attributable to patients entitled to both Medicare Part A and Supplemental Security Income) by Total Medicare Days. The second percentage divides the total number of Medicaid, Non-Medicare Days by total patient days. CTRS. FOR MEDICARE & MEDICAID SERVICES, FACT SHEET: MEDICARE DISPROPORTIONATE SHARE HOSPITAL, 1 (Jul. 2009) http://146.123.140.205/MLNProducts/downloads/2009_mdsh.pdf [hereinafter CMS FACT SHEET].

39. The application of the formula is contestable and subject to judicial review under certain circumstances, and the issue has recently been before the courts. *See e.g.*, Baystate Med. Ctr. v. Leavitt, 587 F. Supp. 2d 37 (D.D.C. 2008) (holding in Baystate's favor in part, ordering Leavitt, the Secretary of Health and Human Services, to recalculate the SSI fraction [a component of the Medicare DSH formula] and to pay Baystate any monies due in accordance with the new calculation) *and* Auburn Regional Med. Ctr. v. Sebelius, 686 F. Supp. 2d 55 (D.D.C. 2010) (holding the court did not have jurisdiction to review a Provider Reimbursement Review Board's decision to dismiss seventeen Medicare provider's untimely administrative appeals, requesting recalculation of DSH payments).

40. CMS FACT SHEET, *supra* note 38, at 2-3. The exemption applies to hospitals located in urban areas, with at least one hundred beds that can demonstrate that more than 30% of total net inpatient care revenues come from state and local government sources for indigent care, other than Medicare and Medicaid. Omnibus Budget Reconciliation Act of 1985, § 9105. However, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended the criteria to allow urban hospitals with fewer than one hundred bed and rural hospitals with fewer than five hundred beds to be eligible. *Id.*

41. Pickle hospitals receive a thirty-five percent increase in Medicaid operating payments, and a capital DSH adjustment of 14.16%. H.R. REP. NO. 108-391, at 663 (2003) (Comm. Report to Accompany H.R. 1).

42. THE BASICS, *supra* note 33, at 3. Medicaid Inpatient Utilization rate is at least one standard deviation in excess of the mean for all hospitals in the state or the facility's low-income utilization rate exceeds twenty-five percent. All eligible facilities must have a Medicaid utilization rate of *at least* one percent. For example, Wisconsin only designates hospitals meeting the federal minimum criteria as DSH providers, while New York designates nearly all hospitals. *Id.*

43. *Id.* The amount cannot exceed the total cost of providing inpatient and outpatient services to

spending, with exceptions for certain rural and urban hospitals.[44]

Under certain conditions, states have used DSH payments to expand Medicaid coverage rather than directly reimburse for uncompensated care.[45] Generally, most facilities still rely on DSH payments to supplement financial losses resulting from providing care to the uninsured and low-income populations. In terms of bottom-lines, the National Association of Public Hospitals and Health Systems found that without the stabilizing effects of DSH payments, safety-net hospitals' operating margins would have been -5.6 percent in 2006.[46] In fact, as part of the American Recovery and Reinvestment Act of 2009, the federal government infused DSH payments to mitigate some of the effects of the global recession, recognizing the vital role these facilities play in providing essential health care to Americans, especially in the hardest of economic times.[47] From any perspective, these payments are vital to keeping safety-net hospitals financially afloat.

Medicaid and uninsured patient. As an oversight measure, states must submit to the Secretary of Health and Human Services a detailed annual report and an independent, certified audit of DSH payments to hospitals.

44. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 402 places a 12% cap on DSH payments to hospitals, except urban hospitals with more than one hundred beds, rural hospitals with more than five hundred beds, and Rural Referral Centers and Medicare Dependent Hospitals (per § 5003 of the Deficit Reduction of 2005, starting Oct. 1, 2006). Pub. L. No. 108-173, § 402, 117 Stat. 2066 (2003). *See also* CENTERS FOR MEDICARE AND MEDICAID, CMS LEGISLATIVE SUMMARY OF H.R. 1 MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 PUB. L. 108-173, 54-55 (Ap. 15, 2004) (summarizing the 12% cap, and noting that it does not apply to Pickle hospitals) and CMS FACT SHEET, *supra* note 38, at 2. For an example of how the DPP is calculated and the 12% cap is applied, see *Id.* at 2.

45. *See e.g.*, *Medicaid Waivers and Demonstrations List: Details for Massachusetts MassHealth 1115*, CENTERS FOR MEDICAID AND MEDICARE SERVICES (last updated Feb. 23, 2010), http://www.cms.gov/medicaidstwaivprogdemopgi/mwdl/itemdetail.asp?itemid=CMS042959 (and accompanying pdf's) (describing the state sponsored universal coverage plan implemented in Massachusetts, for which DSH funds were diverted in an effort to fund the coverage expansion). *But see*, Spivey & Kellermann, *supra* note 10, at 2600 (describing how Tennessee redirected DSH funds to expand Medicaid, and within months safety-net hospitals curtailed or virtually eliminated vital programs, causing Tennessee to reinstate the DSH program).

46. Nat. Ass'n of Pub. Hops. & Health Sys., *Medicaid DSH Funds: Essential Support for the Nation's Health Safety Net*, ISSUE BRIEF Mar. 2009, at 2, *available at* http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Medicaid-and-DSH/Medicaid-DSH-Funds.aspx?FT=.pdf.
Compare supra note 24 (stating that the average operating margin for safety-net hospitals (with the DSH payments) is -3.0%).

47. Illinois received an increase of approximately $5,265,333 in DSH allotment under the Act. *Disproportionate Share Hospitals (DSH) Allotments for Fiscal Year 2009*, HHS.GOV (last revised Mar. 17, 2009), http://www.hhs.gov/recovery/cms/dshstates.html; Kaiser Family Found., *Illinois: Disproportionate Share Hospitals (DSH) Allotments under the American Recovery and Reinvestment Act (ARRA) FY 2010*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.kff.org/profileind.jsp?ind=678&cat=4&rgn=15 (last visited May 2, 2011) (calculates Illinois' increase at $10,703,308).

IV. PPACA'S MEDICARE AND MEDICAID DISPROPORTIONATE SHARE PAYMENT REDUCTIONS

Despite the importance of DSH payments to safety-net facilities, the PPACA actually reduces both Medicare and Medicaid DSH payments starting in 2014.[48] As a starting point, in 2009, the federal government paid out approximately eleven million dollars in Medicaid DSH payments and ten million dollars in Medicare DSH payments.[49] Medicare DSH payments will experience the most dramatic reduction, dropping by seventy-five percent for fiscal year 2014.[50] Subsequent payments are based on three statutory factors relating to the size of the uninsured population under age sixty-five, as well as the amount of uncompensated care provided and the amount the hospital would have received had PPACA not reduced payments.[51] These factors are determined by the Secretary of Health and Human Services, and not subject to judicial or administrative review.[52] Medicaid DSH payments, on the other hand, will experience less dramatic cuts in an attempt to equitably distribute these reductions.[53] State allotments are decreased based on a new formula that imposes the largest reduction on the states with the smallest uninsured populations, and takes into account the importance of DSH payments to neutralize states' budget calculations for expanding Medicaid coverage.[54] Medicaid DSH payments are reduced by five hundred million dollars in 2014, with the maximum reduction of $5.6 billion occurring in fiscal year 2019.[55] The reduction in Medicaid DSH

48. Pub. L. No. 111-148, §§ 2551, 3133 (2010) (assuming its own success, future DSH payments cut by prescribed percentages, and then recalculated based on the size of the uninsured population post-2014 when the Medicaid expansion and Individual mandate take effect). *See infra* Section V (discussing why other provisions will actually still create a need for the safety net).

49. HEALTH & MED. POL'Y RES. GROUP, *Health Care Reform Impact in Illinois: Safety Net Hospitals*, May 2010, http://hmprg.org/wp-content/uploads/2010/05/Health-Reform-Workforce-factsheet-Final1.pdf [hereinafter *Illinois Impact*]. Illinois received approximately two hundred and fifteen million dollars for seventy-one hospitals in thirty cities. *Id.*

50. Pub. L. No. 111-148 § 3133(2) (as revised by Pub. L. No. 111-152, § 1104). The Congressional Research Service actually hails the Medicare DSH payment reduction as one of the largest cost savings provisions, citing to Congressional Budget Office predictions that it will decrease federal expenditures by $22 billion. PATRICIA A. DAVIS, ET. AL., CONG. RES. SERVICE, R41196, MEDICARE PROVISIONS IN PPACA (P.L. 111-148) at 3 (2010), *available at* http://opencrs.com/document/11-148/2010-04-21/ (click to download report for pdf).

51. Pub. L. No. 111-148 § 3133(2)(A)-(C).

52. *Compare* § 3133(c) (limiting judicial and administrative review) *with supra* note 39 (discussing cases where facilities have challenged the calculation of DSH payments).

53. Pub. L. No. 111-148 §2551(a)(2) (as replaced by Pub. L. No. 111-152 §1203(2)).

54. *Id.*; *Illinois Impact*, *supra* note 49 (pointing out that HHS must still develop a method for executing this provision, and ensuring the neediest states get the most funds). *See supra* note 34 (explaining the abuse before state allotments were put into place, and why equitable distribution of the reductions is even an issue).

55. Pub. L. No. 111-148 §2551 (as replaced by Pub. L. No. 111-152 §1203(2)); *Illinois Impact*, *supra* note 49.

payments are supposed to be offset by increased reimbursements to Medicare levels,[56] and indirectly countered by reducing the number of uninsured through the Medicaid expansion.[57] The idea behind reducing DSH payments is that covering an additional thirty-two million and effectively insuring ninety-five percent of Americans will dramatically reduce uncompensated care costs to a level undeserving of supplemental funding; however, other provisions of PPACA thwart this goal, rendering the safety-net anything but obsolete.[58]

V. OTHER PROVISIONS OF PPACA STRETCHING THE SAFETY-NET BEYOND SUSTAINABILITY

If PPACA went according to plan, then the DSH payment reductions may be a justified and fiscally efficient decision. Realistically speaking, the debate surrounding funding highlights the potential consequences of PPACA when limited state and federal resources are stretched too thin. The following subsections examine three PPACA provisions that will consume large amounts of federal and state dollars, but could end up costing the safety-net even more.

Coverage Gaps Created By Expanding Medicaid Eligibility and the Individual Mandate

One of the provisions of PPACA having the most impact on the safety-net is Section 2001, which brings all Americans under age sixty-five with income below 133 percent of the federal poverty level underneath the Medicaid umbrella starting January 1, 2014.[59]

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56. *Illinois Impact*, *supra* note 49.

57. *But see e.g.*, *Illinois Impact*, *supra* note 49 (discussing how Massachusetts' state sponsored universal health insurance program still left 2.6% of the population uninsured, but DSH payments were used to fund the coverage expansion, leaving hospitals with less revenue to care for the uninsured).

58. *See also*, Mark A. Hall, *Rethinking the Safety Net Access for The Uninsured*, 364 NEW ENGL. J. MED. 7, 8-9 (Dec. 29, 2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1011502 (arguing that the new uninsured population that will arise post-reform is evidence of the need to sustain the safety-net and describing the new uninsured population as: those falling into short term coverage gaps, those not subject to the individual mandate penalty because insurance is still unaffordable, in excess of eight percent of income, and the unaccounted for undocumented immigrant populations).

59. Pub. L. No. 111-148, § 2001(a) (2010). While the statute dictates 133%, new income counting rules for determining Medicaid eligibility specify a reduction of 5% of FPL from individuals income, which effectively raises new income eligibility threshold to 138% FPL. EVELYNE BAUMRUCKER & BERNADETTE FERNANDEZ, CONG. RES. SERVICE, 7-5700, GENERAL DISTRIBUTION MEMORANDUM: VARIATION IN ANALYSES OF PPACA'S FISCAL IMPACT ON STATES 8 n.11 (2010), *available at* http://healthreform.kff.org/~/media/Files/KHS/Scan/CRS%20State%20Impact%20of%20PPACA.pdf [herein after CRS MEMO]. Brian Blase, *Obamacare and Medicaid: Expanding a Broken Entitlement and Busting State Budgets*, WEBMEMO BY HERITAGE FOUND.,1, (Jan. 19, 2011), http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Medicaid-Expanding-a-Broken-Entitlement-and-Busting-State-Budgets (last visited May 2, 2011) [hereinafter WEBMEMO] (translating the

Most notably, this expansion applies to all individuals, including non-disabled, non-parents, that traditionally have been excluded from the program. For the safety-net system, this ideally translates into less uninsured patients, and guarantees at least some nominal reimbursement for services. Yet, a closer look at this provision and its application in conjunction with the individual minimum coverage mandate[60] reveals how the ideal might not become the reality.

First, newly eligible Medicaid beneficiaries will only be entitled to minimum essential benefits as defined by Section 1302(b) of PPACA, not full Medicaid benefits.[61] The federal government will pay for one hundred percent of the cost of these services provided to the "new eligibles" until 2016, then the federal share will decrease to ninety percent by 2020, leaving states to determine how to fund the remaining ten percent.[62] Second, before the expansion takes effect, states are prohibited from constricting current Medicaid eligibility requirements to save money,[63] with one major exception. If the state reports a budget deficit, the eligibility requirements for non-pregnant, nondisabled individuals above 133 percent of the federal poverty line, currently covered by a state program, can be restricted.[64] Considering that the vast majority of states are experiencing budget deficits, or at least tremendous strain, these individuals are most at risk of being uninsured until 2014,[65] if PPACA is fully implemented.[66] These individuals, as

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percentage into dollar value income: 138% FPL is the equivalent of $33,000 for a family of four, excluding any welfare benefits).

60. Pub. L. No. 111-148, § 1501(b) (2010).

61. These benefits are to be defined by the Secretary of Health and Human Services, but must include at least: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services, including oral and vision care. Pub. L. No. 111-148, § 1302(b) (2010) (emphasis added).

62. Pub. L. No. 111-148, § 2001(a) (as replaced by § 1201(1)(B) of Pub. L. No. 111-152).

63. § 2001(b)(1); WEBMEMO, *supra* note 59, at 1 (explaining that the maintenance of effort ("MOE") requirement is a condition of receiving federal funds, and the current eligibility levels are actually frozen at July 1, 2008 levels as a condition of receiving funds under the American Recovery and Reinvestment Act of 2009).

64. § 2001(b)(3) (entitled nonapplication); WEBMEMO, *supra* note 59, at 3 n.12. Some predict that states will scale back eligibility for individual over the expanded 133% federal threshold once the MOE expires in 2014, and instead shift this population into the state exchange for coverage where federal subsidies are available to them. CRS MEMO, *supra* note 59, at 5.

65. There are currently forty-four states and the District of Columbia reporting budget shortfalls for the 2012 fiscal year. Elizabeth McNichol et. al, *States Continue to Feel Recession's Impact*, CTR. ON BUDGET & POL'Y PRIORITIES, http://www.cbpp.org/files/9-8-08sfp.pdf.

66. Constitutional challenges to PPACA have already arisen. The Medicaid expansion has been challenged as a "customary and necessary" feature of state governments, and because the bill offers no alternative to participation as prescribed, the states argue that Congress "converts what [has] been a voluntary

discussed above, are already largely excluded from safety-net coverage, relying on the emergency room as a "primary care provider" because it is the most available point of access for individuals without coverage.

The third issue speaks to an existing system failure that is neither solved by PPACA nor will cease to be a problem: determining who is eligible and for which programs. The individuals targeted by the Medicaid expansion, could already be eligible in several states for Medicaid, but because of poor identification and recruitment mechanisms, are not actually enrolled. State participation rates nationwide vary, but no state has enrolled more than eighty percent of their citizens eligible for government-sponsored health insurance.[67] In fact, the national average is 61.7 percent for eligible individuals enrolled.[68] The PPACA assumes that sixteen million people in the current coverage gap will become enrolled automatically.[69] Yet, it fails to take into account the twelve million people currently eligible, but not in Medicaid, who will likely apply or face a penalty once PPACA's individual mandate takes effect.[70] This leads to the second part of the problem: who is eligible for which program. The portion of the population on the cusp between Medicaid eligibility and federal subsidies to purchase individual coverage poses

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federal-state partnership into a compulsory top-down federal program in which the discretion of [states] has been removed." Rosenbaum, *supra* note 19, at 1954. *See also* Commonwealth of Virginia *ex rel* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va., 2010) (holding that the Commonwealth had standing and the issue was ripe for judicial review, and denied a motion to dismiss because the Commonwealth's claim that the individual mandate, § 1501, exceeds Congress' constitutional power under the Commerce Clause, the Necessary and Proper Clause, and the General Welfare Clause had merit); *13 Attorney Generals Sue on Health Care Bill*, BOSTON GLOBE (Mar. 24, 2010), *available at* http://www.boston.com/news/health/articles/2010/03/24/13_attorneys_general_sue_on_health_care_bill/?rss_id=%20Boston.com+—+Health+news (detailing the lawsuit was filed in Pensacola ten minutes after President Obama signed PPACA into law, challenging the constitutionality of the individual mandate).

67. Massachusetts, with a state-sponsored universal health insurance program, is the only state with an eighty percent participation rate, but the District of Columbia does boast an eight-eight percent enrollment rate. Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion—The Soft Underbelly of Health Reform*, 363 NEW ENGL. J. MED. 2085, 2086 (Nov. 25 ,2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1010866.

68. Sommers & Epstein, *supra* note 67, at 2085. Varying participation rates among states is one of the more prominent factors in determining PPACA's impact on state budgets. PPACA encourages states to "improve outreach, streamline enrollment, and coordinate with exchanges" but each state's financial situation will dictates its ability and willingness to maximize Medicaid enrollment. CRS MEMO, *supra* note 59, at 8.

69. PPACA proposes another thirty-two million Americans will gain access to coverage because of the reform: sixteen million from the Medicaid expansion and sixteen million from the individual mandate and access to coverage through state exchanges. Health Care, CONGRESSIONAL BUDGET OFFICE, http://www.cbo.gov/publications/collections/health.cfm (last visited May 2, 2011) and Sommers & Epstein, *supra* note 67, at 2085.

70. WEBMEMO, 59, at 1. Sommers and Epstein hypothesize that for CBO estimates to be correct, and sixteen million more people be enrolled in Medicaid, participation rates among eligible individuals (without private insurance) will need to be at eighty percent, as opposed to this 61.7% national average. Sommers & Epstein, *supra* note 67, at 2086. For select states' Medicaid enrollment increase predictions, see CRS MEMO,

a conflict of interest between the state and federal governments. The states want to render these individuals eligible for federal subsidies to stay those costs,[71] while the federal government would prefer to see these individuals enrolled in the Medicaid program, of which states share some of the costs.[72] Either way, the fact that eligible individuals are not currently enrolled in the appropriate program, easily draws the conclusion that this borderline population will end up caught in the political crosshairs instead of having health insurance, as PPACA intended.[73] This reality alone speaks to the ongoing necessity of a safety-net system post-reform.

Reimbursement Rate Increased and Decreased

In an effort to make the Medicaid program more appealing for providers, the PPACA increased reimbursement rates for 2013 and 2014, to Medicare levels, for primary care services.[74] The federal government will pay this increase until January 1, 2015, after which states must fund the increase or cut rates.[75] If state budgets cannot sustain the increased reimbursement rates, states may have to potentially contend with an exodus of many primary care service physicians from the ranks of the Medicaid program if rates are ultimately reduced.[76] Financially, reimbursement rates, along with benefit scale-backs, are the most logical way for states to sustain the level of coverage mandated by PPACA, but the logical consequence is decreased access to primary care services for beneficiaries and increased presentation to the emergency room.[77]

Aside from the Medicaid reimbursement dilemma PPACA creates, safety-net facilities and Medicare providers recently dodged a twenty-three percent Medicare reimbursement rate cut when Congress renewed the wage index set under the Medicare Drug, Improvement, and Modernization Act of 2003.[78] The rate cut, intended to be a cost

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supra note 59, at Appendix.

71. For one such prediction, see *supra* note 64 and accompanying text.

72. WEBMEMO, 59, at 3.

73. *But see* Hall, *supra* note 58, at 9 (suggesting safety-net facilities can serve as points of origin to determine eligibility status).

74. Pub. L. No. 111-148 § 1202(a)(1) (2010).

75. Rosenbaum, *supra* note 19, at 1953; WEBMEMO, *supra* note 59, at 2.

76. WEBMEMO, *supra* note 59, at 3.

77. *Id.*

78. Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309 § 102, 124 Stat. 3285 (2010). *See also* Physician Payment and Therapy Relief Act of 2010, H.R. 5712, 111th Cong. (2nd Sess. 2010) *available at* http://www.gpo.gov/fdsys/pkg/BILLS-111hr5712enr/pdf/BILLS-111hr5712enr.pdf (initially staying the rate cuts for one month and providing a 2.2% increase for physicians) *and* David Loder & Mitchell Goldman, *U.S. Healthcare Reform Updates*, MONDAQ (Feb. 10, 2011).

savings mechanism, is only stayed through the end of 2011, at which point legislative action is required for any further extension.[79] Such action is unlikely given that the PPACA authorizes more than five hundred billion dollars in Medicare funding and reimbursement cuts in order to finance the law.[80] These reimbursement reductions alone, some predict, will cause more than seven hundred hospitals to become unprofitable.[81] If providers pull out of these programs, as is predicted, even those covered by the safety-net programs will be left with hospitals' emergency rooms as their only access point for care.[82]

VI. CONCLUSION

With all of the exceptional strides made to increase access and insure more Americans under the PPACA, it is quite alarming to realize that once the program expansions and reimbursement fluctuations start drawing from the same limited pool of state and federal resources those strides may be a lot smaller and less effective than anyone had hoped. As explained above, state are likely to scale back coverage and benefits, leaving the safety-net as the "health care of last resort" for those individuals marginalized by the system through political pushback[83] or intentional statutory omission.[84] When hospitals are

79. *House Could Delay Medicare Rate Cuts,* CNN, Nov. 29, 2010, *available at* http://www.cnn.com/2010/POLITICS/11/29/medicare.doctor.payments/index.html (explaining rate cuts have been blocked eight time in the last ten years).

80. *Camp Opening Statement: Hearing on the Health Care Law's Impact on the Medicare Program and its Beneficiaries*, COMMITTEE ON WAYS AND MEANS (Feb. 10, 2011) [hereinafter *Camp Opening Statement*] (""". . .there are more than one half-trillion dollars in cuts to Medicare that have been made in an effort to finance the law. Those changes include massive cuts to hospitals, cuts to home health agencies, cuts to skilled nursing facilities, and cuts to hospice providers. The concern of many on the committee is the impact of this law and the potential to either lose access to health care services or be forced to pay more for the services they need.").

81. *Camp Opening Statement*, *supra* note 80 (citing to Medicare actuaries predictions).

82. *See Emergency Department Policy Brief, supra* note **Error! Bookmark not defined.** (observing the effects of the recession and uninsured-ness on safety-net hospital emergency departments). *See generally,* Judith S. Gavaler & David H. Van Thiel, *The Non-Emergency in the Emergency Room*, 72 No.1 J. NAT. MED. ASS'N 33, 33 (1980), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2537390/pdf/jnma00033-0035.pdf (already identifying that low-income and uninsured as using the emergency room for nonemergency medical care because of the lack of a personal physician).

83. *See supra* Part V (discussing how states will try to shift individuals to the exchanges where federal subsidies are available and less state resources are necessary). *See, e.g., The Fiscal Consequences of the Health Care Law: Hearing Before the H. Comm. on the Budget*, (Jan, 26, 2011) (statement of Dennis G. Smith, Secretary of Wisconsin Dep't of Health Services, (transcript available at http://budget.house.gov/UploadedFiles/dsmith012611.pdf) (explaining that Wisconsin can save $579.4 million between 2014 and 2019 by shifting individuals out of Medicaid to the state exchange with federal tax credits).

84. The bill specifically prohibits undocumented aliens from purchasing coverage on the state exchanges, regardless of whether they can afford coverage with or without a federal subsidy. CHRIS L. PETERSON & THOMAS GABE' CONG. RES. SERVICE, R41137, HEALTH INSURANCE PREMIUM CREDITS UNDER PPACA (P.L. 111-148) 1-2 (2010),

faced with financial struggle and no means of increasing revenue, their only option is to cutback on services, facilities, or staff.[85] The community then suffers because the unprofitable, yet vital services are usually the most at risk to be scaled back or eliminated.[86]

Understandably, the impact of PPACA is yet to be seen,[87] but a more appropriate course of action may be to delay the scale back of vital resources to these entities currently partnering with the government to provide for the most vulnerable Americans. Too many "what if's?" remain unanswered to compromise an already fragile network of health care providers for the poor, yet the government's resolve is to ask for "even more, for even less."

available at http://healthreform.kff.org/~/media/Files/KHS/docfinder/crspremiumcredits.pdf.

85. *See* Julie Appleby, *Hospitals Hurt by Slumping Economy Put Off Projects*, USA TODAY, Jan. 22, 2009 *available at* http://www.usatoday.com/news/health/2009-01-22-hospitals_N.htm?POE=click-refer ("As a result of the economic crunch, 45% of hospitals have postponed upcoming improvement projects and 13% have halted expansions already underway" as reported by a survey of 639 hospitals.").

86. For examples, see AHA *Provena* Brief, *supra* note 23, at 30 (referencing "subsidized health service" such as emergency and trauma care, neonatal intensive care units, community health clinics and immunization programs) and IHA *Provena* Brief, *supra* note 12, at 6 (providing examples of unprofitable, yet vital community services, such as emergency departments, trauma and burn centers, neonatal intensive care units, and community care units).

87. Even the Congressional Budget Office predicts "limited" success, citing wasteful spending and fundamental reorganization as impediments to PPACA's fully effectuated success. Douglas W. Elmendorf, Director of the Cong. Budget Office, Economic Effects of the March Legislation, Presentation at the Schaeffer Center of the University of Southern California (Oct. 22, 2010), *available at* http://www.cbo.gov/ftpdocs/119xx/doc11945/USC10-22-10.pdf.