CHAPTER 1

Overview of Medicaid Policy on Disproportionate Share Hospital Payments

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Key Points

- State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid and other low-income patients.
- States began making DSH payments in 1981, when Medicaid payments to hospitals were de-linked from Medicare payments. Congress first established federal limits on DSH spending in 1991, following a period of rapid growth in DSH spending.
- Under current law, DSH payments to individual hospitals cannot exceed each hospital's uncompensated care, which includes the shortfall (if any) between Medicaid payments and the cost of providing services to Medicaid patients as well as the unpaid costs of care for the uninsured.
- State DSH spending is also limited by federal allotments, which vary by state, ranging from less than $10 million to more than $1 billion. The current variation in state DSH allotments stems from the variation that existed in state DSH spending in 1992.
- In 2014, Medicaid made a total of $18 billion ($8 billion in state funds and $10 billion in federal funds) in DSH payments to hospitals.
- About half of all U.S. hospitals receive DSH payments. Some states make DSH payments to almost all of the hospitals in the state, and other states make DSH payments to only one or two hospitals.
- In 2011, about one-third of DSH hospitals qualified as deemed DSH hospitals, meaning that they were required to receive DSH payments because they served a particularly high share of low-income patients. These deemed DSH hospitals received about two-thirds of all DSH payments nationally, but reported negative operating margins even after DSH payments.
- Under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), Congress established a schedule for reducing federal DSH allotments to account for an anticipated decrease in uncompensated care as a result of an increase in the number of people with insurance. Originally set to go into effect beginning in fiscal year (FY) 2014, the reductions are now scheduled to begin in FY 2018 at $2 billion and increase to $8 billion by FY 2025.

CHAPTER 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid and other low-income patients. State DSH payments are limited by annual federal DSH allotments, which vary widely by state. DSH payments to hospitals are also limited by the total amount of uncompensated care that hospitals provide to Medicaid patients and the uninsured. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) includes reductions to federal DSH allotments under the assumption that increased health care coverage would lead to reductions in hospital uncompensated care. With the onset of these reductions currently scheduled for fiscal year (FY) 2018, Congress has instructed the Commission to report annually on Medicaid DSH policy issues.

We begin this report with a description of the history of and context for Medicaid DSH payments. First we outline the evolution of DSH payment policy, including the enactment of state- and hospital-specific limits. Then we discuss variation in DSH allotments and spending among states and describe the types of hospitals that receive DSH payments. We end with an overview of the reductions in DSH allotments enacted under the ACA.

The History of Medicaid DSH Payment Policy

States began making Medicaid DSH payments in 1981, when Medicaid hospital payments were de-linked from Medicare payment levels. Beginning with Medicaid's enactment in 1965, states were required to mirror Medicare's hospital payment policies in order to pay hospitals' reasonable costs for Medicaid services. In 1981, states were given broader discretion over hospital payment when Congress amended the Social Security Act (the Act) to remove the requirement to pay hospitals according to Medicare cost principles. Because of concerns that state flexibility to reduce hospital payments might threaten hospitals serving large numbers of Medicaid and uninsured patients, Congress also directed state Medicaid agencies to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs" (§ 1902(a)(13)(A)(iv) of the Act).

States were initially slow to make DSH payments. As a result, Congress clarified in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) that Medicaid's hospital payment limitations did not apply to DSH payments. Then, in 1987, Congress required states to make DSH payments to certain hospitals that serve the highest share of low-income patients, which were referred to as deemed DSH hospitals (§ 1923(b) of the Act).

Prior to these congressional actions, a 1985 federal regulation permitted states to use both public and private donations as sources of non-federal Medicaid financing. In 1987, policy guidance from the federal government indicated that taxes that were imposed only on Medicaid providers could also be used to finance Medicaid (Matherlee 2002). The combination of the lack of limits on DSH payments and the flexibility in raising the non-federal share of payments was soon followed by substantial growth in DSH spending. The total amount of DSH payments increased from $1.3 billion in 1990 to $17.7 billion in 1992 (Holahan et al. 1998).

As DSH spending increased, federal policymakers grew concerned over both the level of DSH spending and the possibility that some states were misusing DSH funds by making large DSH payments to hospitals operated by state or local governments that were then transferred back to the state and used for other purposes. Congress acted to address these concerns: In 1991, it enacted national and state-specific caps on the amount of federal funds that could be used to make DSH payments, and in 1993 it created hospital-specific DSH payment limits equal to the actual cost of uncompensated care for hospital services provided to Medicaid and uninsured patients.

State allotments

The caps on the federal DSH funds that are available to each state are referred to as allotments, and the amount of each state's allotment is calculated

BOX 1-1. Glossary of Key Medicaid Disproportionate Share Hospital (DSH) Terminology

- **State DSH allotment**—The total amount of federal funds available to a state for Medicaid DSH payments. If a state does not spend the full amount of its allotment in a given year, the unspent portion is not paid to the state and does not carry over to future years. Allotments are determined annually and are generally equal to the lower of the prior year's allotment adjusted for inflation or 12 percent of the state's total Medicaid benefit spending (§ 1923(f) of the Social Security Act (the Act)).
- **Low-DSH state**—A state with fiscal year (FY) 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000, including a special exception to include Hawaii (§ 1923(f)(5) and § 1923(f)(6) of the Act).
- **DSH hospital**—A hospital that receives DSH payments and meets the minimum statutory requirements to be eligible for DSH payments: a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions).
- **Deemed DSH hospital**—A DSH hospital with a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate that exceeds 25 percent. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Act).
- **Medicaid DSH audit**—A statutorily required audit of a hospital's uncompensated care costs to ensure that Medicaid DSH payments do not exceed the hospital-specific DSH limit.
- **Hospital-specific DSH limit**—The total amount of uncompensated care for which a hospital may receive Medicaid DSH payment, equal to the sum of Medicaid shortfall and unpaid costs of care for the uninsured for allowable inpatient and outpatient costs.
- **Medicaid shortfall**—The difference between a hospital's costs of serving Medicaid patients and the total amount of Medicaid payment received for those services (under both fee for service and managed care, excluding DSH payments).
- **Unpaid costs of care for the uninsured**—The difference between a hospital's costs to serve individuals without health coverage and the total amount of payment received for those services.

according to statutory requirements and published annually in the *Federal Register*. Allotments were initially established for FY 1993 and were generally based on each state's 1992 DSH spending (P.L. 102-234).

Congress has acted on several occasions to make incremental adjustments to state DSH allotments, but the 1992 DSH spending amounts still serve as the basis for most state allotments today, meaning the states that spent the most in 1992 now have the largest allotments and the states that spent the least in 1992 now have the smallest allotments.

At first, the original legislation implementing caps on federal DSH funds allowed the allotments for the lowest spending states to grow annually while holding allotments for the highest spending states unchanged. The Balanced Budget Act of 1997 (P.L. 105-33) temporarily replaced the calculated allotments with fixed allotments, specified in statute, which reduced total DSH allotments by about half. The fixed allotments were in place from FY 1998 through FY 2000. Following this period of fixed allotments, state allotments were again calculated based on the prior year's allotment, starting from the FY 2000 allotment as the baseline.[1] Beginning in 2000, recognizing that some states still had much lower DSH allotments than others, Congress enacted special rules allowing the allotments for so-called low-DSH states to grow more quickly through FY 2008.

Congress has also provided several temporary increases in state DSH allotments in response to state fiscal pressures, most recently in 2009 during the recession. Since then, the only other changes in state DSH allotments have been adjustments for inflation.[2] (See Appendix 1A for a timeline of key legislation affecting Medicaid DSH payment policy.)

Hospital-specific limits

In 1993, shortly after establishing the state DSH allotments, Congress also established hospital-specific limits for DSH payments (P.L. 103-166). These limits were based on a hospital's overall uncompensated care for low-income patients, defined as the sum of Medicaid shortfall and unpaid costs of care for the uninsured for DSH-allowable services.[3] Specifically, states cannot pay a hospital more than the hospital's cost of inpatient and outpatient services to Medicaid and uninsured patients minus payments received by or on behalf of Medicaid (including supplemental payments) and from uninsured individuals.[4] Costs associated with physician services and hospital-based clinics do not count toward the hospital-specific limit.[5]

DSH reporting and audits

In 2003, Congress added statutory requirements for states to submit annual reports and, separately, to submit for each hospital an annual independent certified audit of DSH payments (P.L. 108-173). The annual reports for each DSH hospital must include the following: the hospital-specific DSH limit, the Medicaid inpatient utilization rate, the low-income utilization rate, the state-defined DSH qualification criteria, and all Medicaid payments (including fee-for-service, managed care, and non-DSH supplemental payments) (§ 1923(j) of the Act and 42 CFR 447.299). The annual independent audits must certify that each DSH hospital qualifies for payment, that DSH payments do not exceed allowable uncompensated care costs, and that the hospital accurately reported payments, spending, and utilization.

The Centers for Medicare & Medicaid Services (CMS) finalized DSH audit regulations in 2008, and the first set of DSH audit reports were submitted in 2010 for state plan rate years (SPRYs) 2005–2007.[6] SPRYs 2005–2010 were designated transition years to allow CMS, states, hospitals, and auditors time to develop and refine their procedures without financial penalties. Beginning with the reports for SPRY 2011, which were due to CMS by December 31, 2014, DSH payments that exceed hospital-specific limits will be considered overpayments and states will be required either to return the federal share or, if specified in the state plan, to redistribute it to other hospitals that are below their limits (CMS 2008). CMS regulations permit states to

submit DSH audits approximately three years after a state plan rate year ends so that all claims can be included and audits can be completed. CMS posts DSH audit data on its website after its review, typically about five years after a state plan rate year ends.

State distribution of DSH payments

As mentioned previously, federal statute specifies that hospitals must receive DSH payments if they meet the minimum requirements for DSH hospitals and also meet one of the following criteria for deemed DSH hospitals:[7]

- they have a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments; or
- they have a low-income utilization rate in excess of 25 percent.

However, states may also make DSH payments to other hospitals as long as they have a Medicaid inpatient utilization rate of at least 1 percent and, with certain exceptions, at least two obstetricians with staff privileges that treat Medicaid enrollees.

This flexibility results in a wide variety of hospitals being designated as DSH hospitals.

State DSH payment methodologies are specified within their Medicaid state plans, which are reviewed and approved by CMS. Federal statute requires that payments to DSH hospitals must be determined using one of the following methodologies:

- the Medicare DSH adjustment methodology;
- a methodology that increases DSH payments in proportion to the extent that a hospital's Medicaid inpatient utilization exceeds one standard deviation above the mean; or,
- a methodology that varies by hospital type (such as teaching hospitals, children's hospitals, etc.) and that applies equally to all hospitals of each type and is reasonably related to Medicaid and low-income utilization.

DSH payments are subject to hospital-specific limits based on a hospital's overall uncompensated care costs for low-income patients. Federal statute also limits the amount of DSH payments that each state can make to institutions for mental diseases or other mental health facilities (Box 1-2).

BOX 1-2. Disproportionate Share Hospital (DSH) Payments to Institutions for Mental Diseases

States may make DSH payments to institutions for mental diseases (IMDs), which are defined by the Social Security Act (the Act) as hospitals, nursing facilities, or other institutions of more than 16 beds that primarily serve individuals with mental diseases (§ 1905(i) of the Act). Because IMDs cannot receive Medicaid payment for individuals age 21–64 (§ 1905(a)(B) of the Act), IMD services provided to Medicaid enrollees in this age range are classified as unpaid costs of care for the uninsured, a type of uncompensated care that is eligible for DSH funding.

The amount of a state's federal DSH funds available for IMDs is limited. Each state's IMD limit is the lesser amount of either the DSH allotment the state paid to IMDs and other mental health facilities in fiscal year (FY) 1995 or 33 percent of the state's FY 1995 DSH allotment.

In 2011, IMDs accounted for 6 percent of DSH hospitals but received 18 percent of DSH payments ($3 billion). Delaware and Maine made DSH payments exclusively to IMDs in 2011, and six states made more than half of their DSH payments to IMDs.

However, states have broad flexibility within these requirements in determining the amount of DSH payments that are made to each provider. There is no minimum DSH payment that must be made to DSH hospitals (including deemed DSH hospitals).

Current State DSH Allotments and Spending

State DSH allotments

A total of $11.7 billion in federal funds ($20.7 billion in state and federal funds combined) was allotted to states for DSH payments in FY 2014 (CMS 2014). Large disparities in allotments persist today despite past legislation intended to reduce them. State allotments in FY 2014 ranged from about $10 million or less in four states (Wyoming, Delaware, North Dakota, and Hawaii) to over $1 billion in three states (California, New York, and Texas) (CMS 2014). In 2014, 17 states were classified as low-DSH states and had average DSH allotments of $30 million, while the remaining 34 states had average DSH allotments of $337 million. (State allotments are given in TABLE 2A-1.)

DSH spending by state

In FY 2014, states spent a total of $10.2 billion in federal funds on DSH payments ($18.1 billion in state and federal funds combined). The amount of DSH expenditures and the percentage of Medicaid spending that DSH payments account for vary widely among states. DSH spending as a percentage of Medicaid service spending ranged from less than 1 percent to 16 percent (Figure 1-1). Ten states account for more than two-thirds of total DSH spending. Seven of these ten (California, Texas, Michigan, New Jersey, New York, Ohio, and Pennsylvania) are also among the top ten in total Medicaid service spending. The other three (Missouri, Louisiana, and South Carolina), rank 19th, 23rd, and 27th respectively in Medicaid service spending. Nationally, DSH spending accounted for 3.9 percent of total Medicaid service spending in FY 2014.

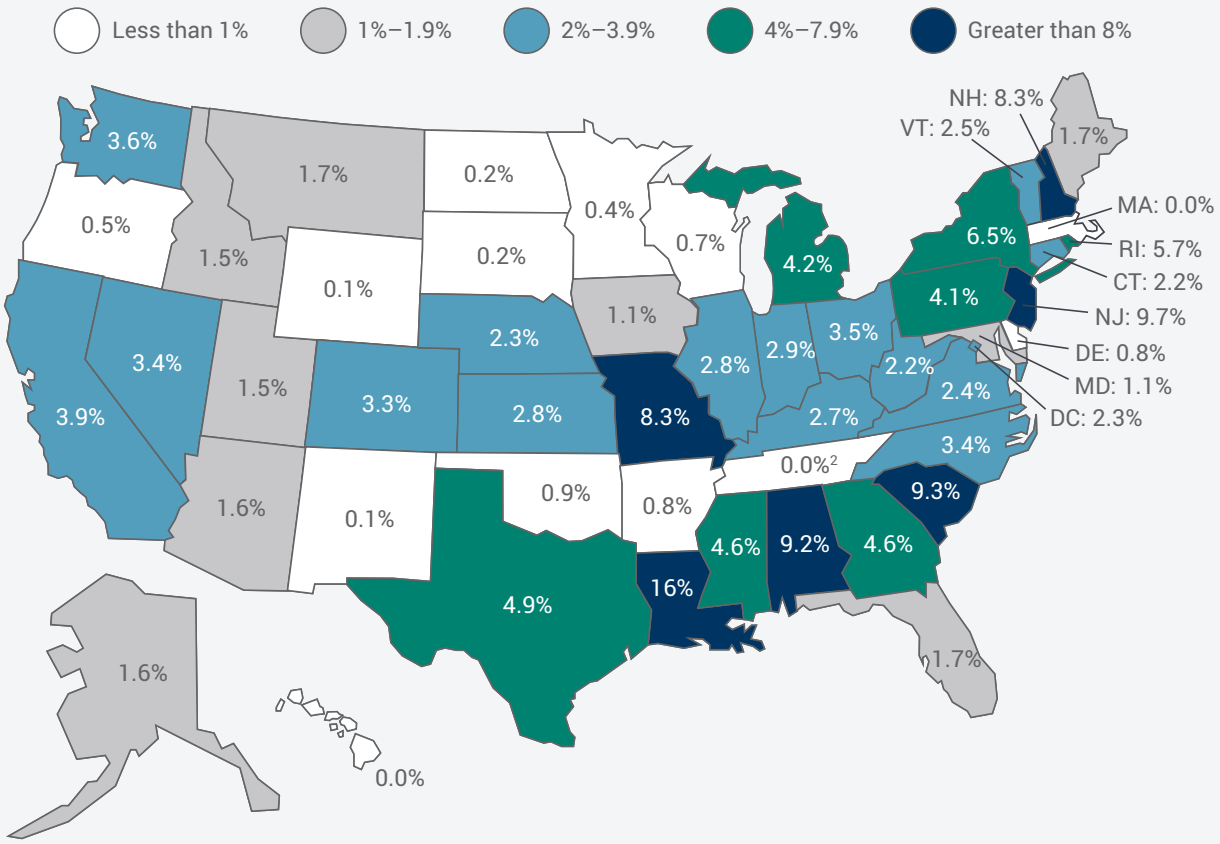
Historically, some states do not spend their full DSH allotments. As of November 2015, $1.2 billion in federal DSH allotments for FY 2012 were unspent ($2.1 billion in state and federal funds combined). Four states accounted for half of unspent DSH allotments in FY 2012.[8] Because states must provide state matching funds to draw down DSH payments at the same matching rate as other Medicaid service expenditures, some states may choose to apply their state funding to other types of Medicaid payments. Although other Medicaid payments are not limited by federal allotments, regular Medicaid hospital payments are subject to different rules that may limit the ability of states to make the same amount of Medicaid payments to hospitals without using DSH funding.[9]

DSH spending by hospital type

About half of all U.S. hospitals received DSH payments in 2011. The majority of DSH payments were made to short-term acute care hospitals and public hospitals (Table 1-1). However, all hospital types received at least some DSH payments in 2011.

The share of hospitals that receive DSH payments varies widely from state to state (Figure 1-2). For example, in 2011, 10 states provided DSH payments to less than 20 percent of hospitals, while 11 states provided DSH payments to more than 80 percent of hospitals in their state. In general, states with larger DSH allotments make DSH payments to a greater proportion of hospitals, but there are exceptions. In 2011, the 17 low-DSH states made DSH payments to an average of 32 percent of the hospitals in their respective states, but Minnesota, Montana, and Utah made DSH payments to more than 60 percent of their hospitals. Those states not classified as low-DSH states (33 states and the District of Columbia) made DSH payments to an average of 49 percent of the hospitals in their respective states, but California, Maine, and

FIGURE 1-1. State DSH Spending as a Share of Total Medicaid Medical Assistance Expenditures, FY 2014



Notes: DSH is disproportionate share hospital. FY is fiscal year. FMR is Financial Management Report.

[1] Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for the state's safety-net care pool instead.

[2] Tennessee did not have a DSH allotment for FY 2014 but has a DSH allotment for subsequent fiscal years.

Source: MACPAC 2015 analysis of CMS-64 FMR net expenditure data as of February 25, 2015.

Massachusetts made DSH payments to fewer than 20 percent of their hospitals.

In 2011, about 40 percent of DSH spending went to hospitals that were in the highest decile of Medicaid or low-income utilization (Figure 1-3). During the same period, about 17 percent of DSH payments went to hospitals with Medicaid inpatient utilization that was at or below the 50th percentile, and about 27 percent of DSH payments went to hospitals with low-income utilization rates at or below the 50th percentile.

Medicaid DSH Payments in Relation to Other Sources of Hospital Financing

In addition to Medicaid DSH payments, many hospitals receive other types of federal funding that offset operating costs (Table 1-2). Because we lack hospital-specific data, we were not able to measure the extent to which Medicaid DSH hospitals receive these other sources of funding.

TABLE 1-1. Distribution of DSH Spending by Hospital Type, SPRY 2011

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as percent of all hospitals	
Hospital type				
Short-term acute care hospitals	1,891	3,426	55%	$ 13,143.0
Critical access hospitals	558	1,321	42	291.9
Psychiatric hospitals	174	494	35	2,848.2
Long-term hospitals	34	443	8	62.0
Rehabilitation hospitals	35	228	15	10.6
Children's hospitals	51	88	58	291.9
Hospital ownership				
For-profit	447	1,683	27	682.7
Non-profit	1,521	2,973	51	5,253.8
Public	775	1,344	58	10,711.1
Total	**2,743**	**6,000**	**46%**	**$ 16,647.6**

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Total DSH spending includes state and federal funds. Excludes 90 DSH hospitals that did not submit 2011 Medicare cost reports.

Source: MACPAC 2015 analysis of 2011 Medicare cost reports and 2011 as-filed Medicaid DSH audits.

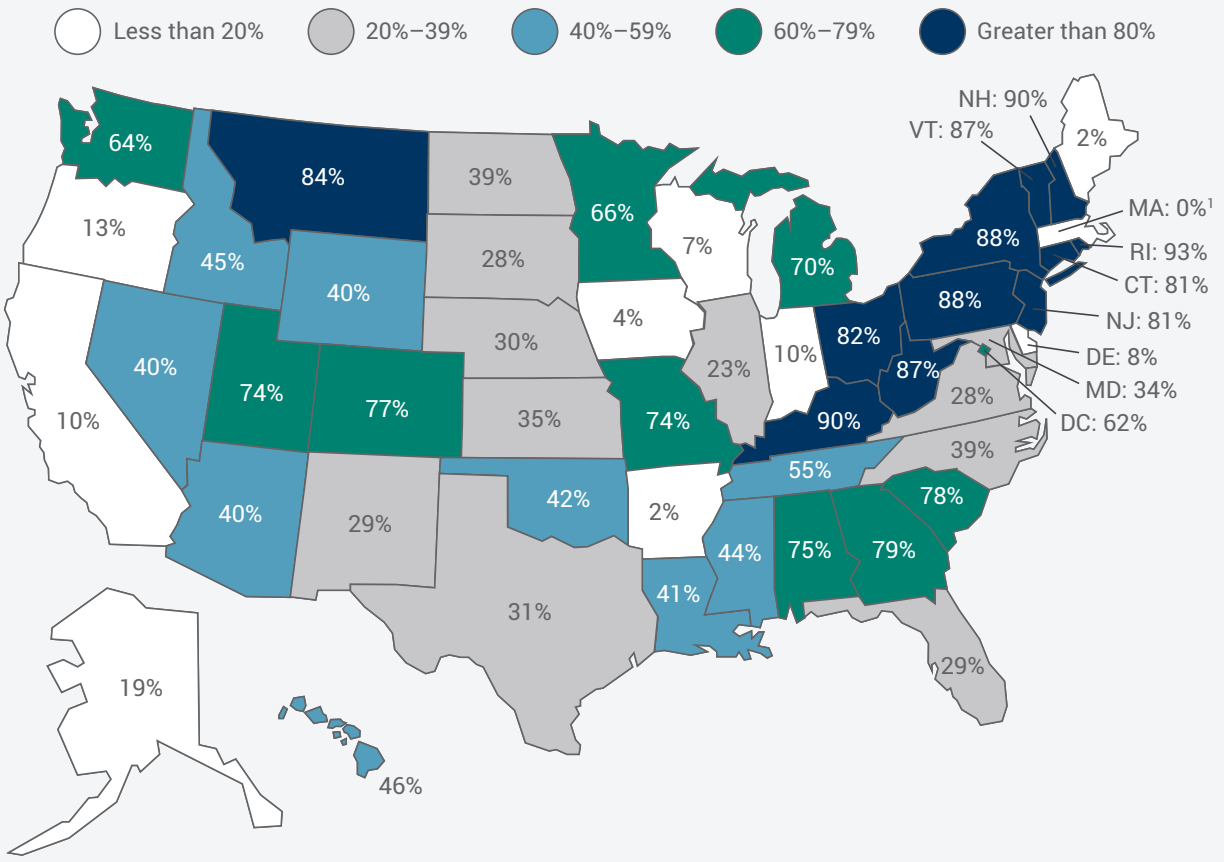
Relationship of Medicaid DSH payments to other Medicaid payments

Within the Medicaid program, states can make non-DSH supplemental payments to hospitals, and do so primarily through the upper payment limit (UPL) rules for fee-for-service Medicaid.[10] In 2013, total spending (state and federal funds combined) on hospital non-DSH supplemental payments totaled $20.6 billion (MACPAC 2014). In 2011, more than two-thirds of DSH hospitals received other Medicaid supplemental payments; we do not know how many non-DSH hospitals receive these payments because states do not report that information.

Under current Medicaid payment rules, states can increase Medicaid payment to hospitals through fee-for-service rate increases, either applying increases for all providers or by establishing different rates for a targeted subset of providers, such as DSH hospitals. States also have options to increase payment rates through managed care by requiring managed care plans to pay according to minimum fee schedules, flexibility that CMS has proposed to codify in its proposed managed care rule (CMS 2015b).

A key difference between DSH payments and Medicaid payments for services is that DSH payments are intended to offset hospitals' uncompensated care costs, including its costs for serving individuals without insurance. DSH payments are not subject to the UPL rules that apply to fee-for-service Medicaid payments and can be made outside of managed care arrangements. Compared to regular Medicaid payments for services, which are based on Medicaid utilization, DSH payments can be targeted based on uncompensated care costs, which include care for the uninsured.

FIGURE 1-2. Share of Hospitals Receiving DSH Payments by State, SPRY 2011



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year.

[1] Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for the state's safety-net care pool instead.

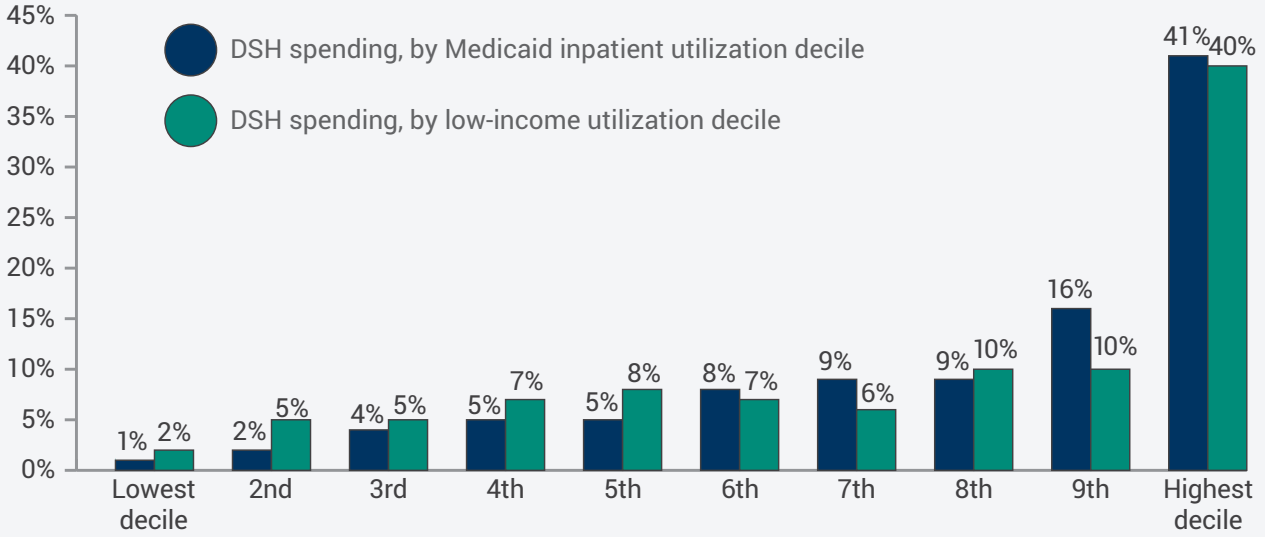
Source: MACPAC 2015 analysis of 2011 Medicare cost reports and 2011 as-filed Medicaid DSH audits.

Relationship of Medicaid DSH payments to Medicare DSH payments

Many Medicaid DSH hospitals also receive Medicare DSH payments, which totaled approximately $12.1 billion in 2013 (CMS 2015a). Unlike Medicaid DSH payments, which vary by state, Medicare DSH payments are based on a standard national formula. Historically, Medicare DSH payments were based solely on a hospital's Medicaid and Supplemental Security Income (SSI) patient utilization, but beginning in 2014, the ACA required that most Medicare DSH payments be based on a hospital's uncompensated care relative to other Medicare DSH hospitals. In addition, the ACA linked the total amount of funding for Medicare DSH payments to the uninsured rate. As a result, Medicare DSH payments are projected to decrease to $9.8 billion in 2016 (CMS 2015a).

Medicare also makes other types of payment adjustments to hospitals; although these adjustments are not directly related to uncompensated care, they still affect a hospital's overall financial viability. For example, in 2013, Medicare made $5.8 billion in indirect medical

FIGURE 1-3. Distribution of DSH Spending on Hospitals by Decile of Medicaid and Low-Income Utilization, 2011



Notes: DSH is disproportionate share hospital. Excludes psychiatric hospitals. Medicaid inpatient utilization rates in this analysis exclude services provided to dually eligible and other Medicaid enrollees for which Medicaid was not the primary payer, which are part of the definition of Medicaid inpatient utilization used for Medicaid DSH purposes. Low-income utilization includes services provided to Medicaid and uninsured patients (as measured by charity care charges).

Source: MACPAC 2015 analysis of 2011 Medicare cost reports and 2011 as-filed Medicaid DSH audits.

TABLE 1-2. Selected Supplemental Funding and Other Support for Hospitals, 2013 (billions)

Type of support	Federal spending	State spending	Other support	Proportion of U.S. hospitals receiving funding (estimate)
Medicaid				
Medicaid DSH payments	$ 9.3	$ 7.1	–	48%
Non-DSH supplemental payments[1]	12.0	8.6	–	–[2]
Medicare				
Medicare DSH payments[3]	12.1	–	–	44
Other support				
Non-profit tax exemptions[4] (federal, state, and local)	–	–	24.6	49
Total	**$ 33.4**	**$ 15.7**	**$ 24.6**	**–**

Notes: DSH is disproportionate share hospital.

[1] Medicaid non-DSH supplemental payments include upper payment limit payments, Section 1115 waiver supplemental payments, and graduate medical education payments.

[2] In 2010, two-thirds of DSH hospitals received a total of $9.4 billion in non-DSH supplemental payments. Data are not available for 2013.

[3] Beginning in 2014, Medicare DSH payments were reduced based on the expectation of a decline in the uninsured rate. In 2016, Medicare DSH payments are expected to total $9.8 billion.

[4] Data on non-profit tax exemptions are from 2011.

– Dash means data not available or not applicable.

Sources: MACPAC 2014, CMS 2015a, Rosenbaum et al. 2015.

TABLE 1-3. Characteristics of and Spending by Deemed and Non-Deemed DSH Hospitals, SPRY 2011

Hospital characteristics	DSH hospitals			DSH spending		
	Number of hospitals			Total spending (millions)		
	Deemed DSH hospitals	All DSH hospitals	Deemed as percent of total	Deemed DSH hospitals	All DSH hospitals	Deemed as percent of total
Hospital type						
Short-term acute care hospitals	472	1,891	25%	$ 7,622.8	$ 13,143.0	58%
Critical access hospitals	112	558	20	86.4	291.9	30
Psychiatric hospitals	139	174	80	2,558.3	2,848.2	90
Long-term hospitals	19	34	56	45.1	62.0	73
Rehabilitation hospitals	6	35	17	1.6	10.6	15
Children's hospitals	50	51	98	291.8	291.9	100
Hospital ownership						
For-profit	137	447	31	254.3	682.7	37
Non-profit	368	1,521	24	1,917.0	5,253.8	36
Public	293	775	38	8,434.7	10,711.1	79
Total	**798**	**2,743**	**29%**	**$ 10,606.0**	**$ 16,647.6**	**64%**

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Excludes 90 hospitals that did not submit 2011 Medicare cost reports. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. For further discussion of the methodology and limitations, see Appendix 3A.

Source: MACPAC 2015 analysis of 2011 Medicare cost reports and 2011 as-filed Medicaid DSH audits.

education payments to offset the higher costs of care of teaching hospitals. In addition, critical access hospitals, which are not eligible for Medicare DSH payments, receive higher base Medicare payment rates to offset their operating costs (MedPAC 2015).[11] Medicare also includes adjustments related to hospital uncompensated care in its pricing for Medicare Advantage plans, and there is some evidence to suggest that Medicare Advantage plans may pass these higher rates on to hospitals (Berenson et al. 2015).

Other types of support for hospitals

In addition to direct supplemental payments, some hospitals also receive other types of support, such as special payment rates or tax breaks. In 2013, eligible entities that qualified for the 340b drug discount program (entities which include but are not limited to non-profit and government hospitals that serve a high proportion of Medicaid and low-income Medicare patients) received an estimated $3.8 billion in discounts from drug manufacturers (MedPAC 2015). In 2011, non-profit hospitals received indirect tax benefits estimated at $24.6 billion (Rosenbaum et al. 2015). Non-profit hospitals are required to report community benefit spending to the Internal Revenue Service in order to maintain their non-profit status, but there is no required level of community benefit spending. Government-owned public hospitals are also exempt from many federal, state, and local taxes, but we do not have data on the amount of indirect tax benefits that they receive.

Deemed DSH Hospital Characteristics

In 2011, about 29 percent of DSH hospitals were deemed DSH hospitals, meaning that they were statutorily required to receive DSH payments. The amount of DSH funding that deemed DSH hospitals receive is not specified in statute, but deemed DSH hospitals received the majority of DSH payments in 2011 (Table 1-3). Based on our analysis, deemed DSH hospitals accounted for nearly one-third of DSH hospitals, and most of the psychiatric, long-term, and children's hospitals that received DSH payments in 2011 qualified as deemed DSH hospitals. Although non-deemed DSH hospitals meet the minimum statutory requirements to qualify for receiving DSH payments, they are not statutorily required to receive them. In 2011, 36 percent of DSH payments were made to non-deemed DSH hospitals.

Deemed DSH hospitals are particularly reliant on DSH payments (Table 1-4). Although non-deemed DSH hospitals report positive operating margins after DSH payments, deemed DSH hospitals report aggregate negative operating margins of 5.3 percent after DSH payments. According to our analysis, DSH payments accounted for about 2 percent of total revenue for all DSH hospitals and 6 percent of total revenue for deemed DSH hospitals in 2011.

In addition to serving high volumes of low-income patients, deemed DSH hospitals are also more likely than other categories of hospitals to provide a wide array of services to patients of all income levels (Table 1-5). We examined a subset of community services identifiable through Medicare cost reports and the American Hospital Association annual survey. This list of services is part of a working definition that we developed to identify hospitals with high levels of uncompensated care that also provide essential community services, as required by statute. (For more information about the Commission's analyses of these hospitals, see Chapter 2).

TABLE 1-4. Aggregate Operating Margins Before and After DSH Payments, 2011

	Before DSH payments	After DSH payments
Deemed DSH hospitals	-11.7%	-5.3%
DSH hospitals, not deemed	-0.4	1.4
Non-DSH hospitals	2.5	2.5
Total (aggregate)	**-1.1%**	**0.7%**

Notes: DSH is disproportionate share hospital. Operating margins do not include non-DSH state or local subsidies to hospitals, which accounted for 0.7 percent of total revenue to all hospitals in 2011. Analysis excludes outlier values and hospitals with missing data. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. For more information about the methodology, see Appendix 3A.

Source: MACPAC 2015 analysis of 2011 Medicare cost reports and 2011 as-filed Medicaid DSH audits.

TABLE 1-5. Share of Hospitals Providing Selected Services, 2013

Service type	Deemed DSH hospitals	All hospitals
Burn services	2.9%	0.8%
Dental services	32.7	19.9
Graduate medical education	30.1	17.3
HIV/AIDS care	35.2	22.6
Inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital)	15.9	12.4
Neonatal intensive care units	35.0	21.3
Obstetrics and gynecology services	61.4	54.0
Substance use disorder services	18.5	13.7
Trauma services	49.0	37.1

Notes: DSH is disproportionate share hospital. Analysis excludes hospitals with missing data. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. For more information about the methodology, see Appendix 3A.

Source: MACPAC 2015 analysis of 2013 and 2011 Medicare cost reports, 2011 as-filed Medicaid DSH audits, and the 2013 American Hospital Association annual survey.

Medicaid DSH Allotment Reductions

Under the ACA, Congress established a schedule for reducing federal DSH allotments to account for an anticipated decrease in uncompensated care expected to occur as a result of the increased number of people with insurance due to Medicaid expansions and the availability of subsidized exchanged coverage. These reductions have since been delayed five times. Originally set to take effect beginning in FY 2014, the reductions are now scheduled to begin in FY 2018 in the following annual amounts:

- $2.0 billion in FY 2018;
- $3.0 billion in FY 2019;
- $4.0 billion in FY 2020;
- $5.0 billion in FY 2021;
- $6.0 billion in FY 2022;
- $7.0 billion in FY 2023;
- $8.0 billion in FY 2024; and
- $8.0 billion in FY 2025.

Congress directed CMS to develop a reduction methodology in such a way as to encourage better targeting of DSH payments across states. Specifically, CMS is required to apply greater DSH reductions to states that have historically high DSH payments and lower percentages of uninsured individuals. In addition, the reduction methodology is intended to reward states that target DSH payments towards hospitals with high levels of uncompensated care and hospitals that serve high volumes of Medicaid patients.

Before the implementation of DSH allotment reductions was delayed, CMS developed a reduction methodology for FYs 2014 and 2015, which we describe and model in Chapter 2. CMS has not yet proposed a reduction methodology for FY 2018, but CMS has noted that it will be evaluating the implications of state decisions to expand Medicaid coverage and will consider options to account for state coverage decisions in its methodology (CMS 2013).

Endnotes

[1] Fixed allotments were intended to continue through FY 2002, but the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) ended them after FY 2000.

[2] The methodology described here applies to most states, although there are some exceptions. Hawaii and Tennessee each have specific methodologies outlined in the Medicaid statute. In addition, each state's federal DSH allotment can be no more than 12 percent of its total Medicaid medical assistance expenditures (state and federal funds combined) during the fiscal year (§ 1923(f)(3)(B) of the Act).

[3] Total annual uncompensated care costs are defined in federal regulation as "the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS [fee-for-service] rate payments, Medicaid managed care organization payments, supplemental or enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services" (42 CFR 447.299).

[4] For California public hospitals, the limit is 175 percent of uncompensated costs.

[5] In a 1994 letter to state Medicaid directors, the Centers for Medicare & Medicaid Services (then the Health Care Financing Administration) instructed states that the cost of "hospital services" includes both inpatient and outpatient hospital costs (HCFA 1994). However, physician services provided by a hospital and hospital-based clinic services are not included in the calculation of the hospital-specific limit (CMS 2008).

[6] Medicaid state plan rate year means the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding DSH payments as well as all other Medicaid payment rates. The period usually corresponds to the state's fiscal year or the federal fiscal year but it does not have to; it can correspond to any 12-month period defined by the state (42 CFR 455.301).

[7] Deemed DSH hospitals must meet the minimum requirements for DSH hospitals: a Medicaid inpatient utilization rate of at least 1 percent and (with limited exceptions) at least two obstetricians with staff privileges that treat Medicaid enrollees (§ 1923(d) of the Act).

[8] Two of the four states with the largest unspent DSH allotments use their DSH allotments for coverage expansions through a Section 1115 demonstration. In the other two states, DSH allotments appear to exceed the total amount of uncompensated care for low-income patients in the state, which may explain why amounts are not spent.

[9] For example, aggregate Medicaid fee-for-service payments to hospitals cannot exceed what Medicare would have paid for these services; this is referred to as the upper payment limit (UPL).

[10] Non-DSH supplemental payments also include graduate medical education (GME) payments and supplemental payments authorized through Section 1115 waiver expenditure authority. In FY 2014, 49 percent of non-DSH supplemental payments were made through UPL payments, 44 percent were made through Section 1115 expenditure authority, and 7 percent were made through GME (MACPAC 2015). More background information on Medicaid supplemental payments can be found in Chapter 6 of MACPAC's March 2014 report to Congress.

[11] Specifically, Medicare pays critical access hospitals 101 percent of reasonable costs for most inpatient and outpatient services.

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APPENDIX 1A: History of Key Legislation

TABLE 1A-1. Timeline of Key Legislation Affecting Medicaid Disproportionate Share Hospital (DSH) Payment Policy

Year	Key legislation and highlights
1980	The Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499): • removes the requirement to pay nursing facilities according to Medicare cost principles; and • requires payments to be reasonable and adequate to meet the costs of efficiently and economically operated facilities. The Medicaid payment provisions of this law are commonly referred to as the Boren amendment.
1981	The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35): • expands the Boren Amendment to hospitals, removing the requirement to pay them according to Medicare cost principles; • removes the reasonable charges limitation from Section 1902(A)(30)(A) of the Social Security Act (the Act); • requires states to take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs when setting Medicaid provider payment rates for inpatient services; and • adds Section 1923 to the Act.
1985	The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272): • requires the Secretary of the U.S. Department of Health and Human Services (the Secretary) to submit a report to Congress that describes the methodology states use for making DSH payments, identifies the hospitals that receive DSH payments, and specifies the number of inpatient days attributable to low-income and Medicaid-enrolled patients at those hospitals.
1986	The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509): • clarifies that the upper payment limit on Medicaid inpatient hospital payments cannot be applied to DSH payments; and • provides explicit permission for unlimited Medicaid DSH payments.
1987	The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203): • requires states to submit state plan amendments authorizing Medicaid DSH payments; • permits two methods for distributing DSH payments: the Medicare DSH methodology or a proportional adjustment based on a hospital's Medicaid inpatient utilization rate; • establishes minimum obstetrics requirements for hospitals that receive DSH patients; and • requires states to make DSH payments to hospitals that have a low-income utilization rate of at least 25 percent or a Medicaid inpatient utilization rate of at least one standard deviation above the mean (so called deemed DSH hospitals).
1990	The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508): • provides two additional methods for states to use to target DSH payments: proportionational adjustments based on a hospital's low-income utilization rate or separate, state-defined payment methodologies for different types of hospitals; and • prohibits the Centers for Medicare & Medicaid Services (CMS) from imposing additional limits on Medicaid payments financed by voluntary contributions and provider-specific taxes.

Year	Key legislation and highlights
1991	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234): • places restrictions on providers' voluntary contributions and health care-related taxes; and • enacts a national and state-specific Medicaid DSH payment ceiling at 12 percent of each state's Medicaid expenditures, and freezes the dollar amounts for states whose Medicaid DSH spending is greater than 12 percent.
1993	The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66): • imposes hospital-specific limits on Medicaid DSH payments equal to the actual cost of uncompensated care for hospital services provided to Medicaid enrollees and uninsured individuals; and • requires hospitals to have at least a 1 percent Medicaid inpatient utilization rate in order to receive DSH payments.
1997	The Balanced Budget Act of 1997 (P.L. 105-33): • requires states to report the names of all hospitals receiving Medicaid DSH payments and the amount they receive; • decreases Medicaid DSH allotments for fiscal year (FY) 1998 to FY 2002 and limits increases in future allotments to the percent change in the Consumer Price Index for All Urban Consumers (CPI-U); • limits Medicaid DSH payments made to institutions for mental diseases and other mental health facilities; • requires that Medicaid DSH payments be made directly to hospitals, meaning that they cannot be included in managed care capitation rates; and • permits California to make Medicaid DSH payments up to 175 percent of its public hospitals' uncompensated care costs.
1999	The Consolidated Appropriations Act of 1999 (P.L. 106-113): • increases Medicaid DSH allotments for FYs 2000–2002 for Washington, DC, Minnesota, New Mexico, and Wyoming; and • clarifies that the enhanced federal matching rate for the State Children's Health Insurance Program (CHIP) does not apply to Medicaid DSH payments.
2000	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554): • eliminates Medicaid DSH reductions in the BBA for FY 2001 and FY 2002 for all states, continuing allotments at the FY 2000 level; • increases Medicaid DSH allotments for FY 2001, FY 2002, and future years by the percent change in the CPI-U, provided that these allotments do not exceed the 12 percent threshold; • brings the allotments of so-called extremely-low-DSH states up to 1 percent of their Medicaid medical assistance expenditures for FY 2001, and increases allotments by the percent change in the CPI-U for FY 2002, with subsequent increases on the same basis for future years; • permits all states to make Medicaid DSH payments of up to 175 percent of their public hospitals' uncompensated care for FYs 2002–2003; and • includes Medicaid managed care days in the Medicaid inpatient utilization rate and Medicaid managed care payments in the low-income utilization rate.
2003	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173): • exempts FY 2002 DSH allotments from the 12 percent rule; • provides a 16 percent increase in Medicaid DSH allotments for high-DSH states for FY 2004 and limits subsequent allotments to the greater of the 2004 allotment or the prior year allotment plus the percentage growth in CPI-U; • provides a 16 percent annual increase in Medicaid DSH allotments for low-DSH states for FYs 2004–2008; and • requires states to annually report each facility that received a Medicaid DSH payment and obtain an independent certified audit of their DSH programs to verify that they satisfy the hospital-specific limits.

Year	Key legislation and highlights
2005	The Deficit Reduction Act of 2005 (P.L. 109-171): • increases fixed DSH allotments for the District of Columbia for FYs 2000–2002 from $32 million to $49 million for the purposes of raising its allotment for FY 2006; and • has the practical impact of raising the District of Columbia's FY 2006 allotment to $57.5 million (a $20 million increase over what the allotment would have been without the law).
2006	The Tax Relief and Health Care Act of 2006 (P.L. 109-432): • establishes Medicaid DSH allotments for Tennessee and Hawaii.
2009	The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3): • extends the Tennessee and Hawaii Medicaid DSH allotments through December 2012.
2009	The American Recovery and Reinvestment Act of 2009 (P.L. 111-5): • increases Medicaid DSH allotments for FY 2009 to 102.5 percent of what they would have been without the law; and • increases allotments for FY 2010 to 102.5 percent of the FY 2009 allotments.
2010	The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended): • requires the Secretary to make aggregate reductions in Medicaid DSH allotments from FY 2014 to FY 2020.
2012	The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96): • extends reductions to FY 2021.
2013	The American Taxpayer Relief Act of 2012 (P.L. 112-240): • extends reductions to FY 2022.
2014	The Bipartisan Budget Act of 2013 (P.L. 113-67): • delays the onset of reductions until 2016 by eliminating the 2014 reduction and adding the 2015 reduction to the 2016 reduction; and • extends reductions to FY 2023.
2014	The Protecting Access to Medicare Act of 2014 (P.L. 113-93): • eliminates the FY 2016 reduction, delaying the reductions until FY 2017; • adjusts the amount of the reductions and extends them to FY 2024; and • requires MACPAC to submit an annual report to Congress on Medicaid DSH allotments.
2015	The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10): • eliminates the FY 2017 reduction, delaying the reductions until FY 2018; and • adjusts the amount of the reductions and extends them to FY 2025.

Sources: Mitchell 2012, Frizerra 2009, ProPAC 1994.

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