Chapter 3:

Improving the Targeting of Disproportionate Share Hospital Payments to Providers

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Key Points

- Although under current law, states can make disproportionate share hospital (DSH) payments to virtually any hospital in their state, it is the Commission's view that Medicaid DSH payments should be targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and have higher levels of uncompensated care, consistent with the original statutory intent.
- We analyzed the hospital and state effects of raising the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to the following higher standards:
  - an absolute standard that would apply equally across states;
  - a relative standard that would vary by state based on the average Medicaid or low-income utilization rate for hospitals in the state; and
  - the deemed DSH standard, which identifies hospitals that are statutorily required to receive DSH payments.
- Our analysis of 2012 DSH audits and 2014 Medicare cost reports found the following:
  - Most DSH payments went to deemed DSH hospitals, which have the most restrictive eligibility threshold that we analyzed.
  - More than half of states made DSH payments to hospitals with a Medicaid utilization rate of less than 5 percent, which is the most inclusive eligibility threshold we analyzed.
  - Many of the DSH hospitals with low Medicaid utilization rates were critical access hospitals, which are small, rural hospitals that receive a special payment designation from Medicare because they are often the sole provider in their community.
- Because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single, utilization-based standard applicable to all hospitals that represents a clear improvement over current law.
- Besides changing which hospitals are eligible for DSH payments, another approach to improving the targeting of DSH payments is to change the way DSH funding is distributed among eligible hospitals.
  - Some policymakers have proposed revising the DSH definition of uncompensated care, which would change the maximum amount of funding DSH hospitals could receive.
  - California recently received approval to test distributing DSH funding as a global payment, which provides incentives to hospitals for providing care to uninsured individuals in the most appropriate and cost-effective settings.

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Although the total amount of federal funds available for disproportionate share hospital (DSH) payments is limited by federal allotments, states are permitted under current law to make DSH payments to virtually any hospital in their state. This flexibility allows states to target DSH payments based on local circumstances but it leads to a wide variation in the share of hospitals that receive DSH payments in each state. This flexibility also reduces the share of DSH funding that goes to the hospitals that serve the highest share of Medicaid and low-income patients.

In MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, the Commission concluded that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and that have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH payments (MACPAC 2016). Over the past year, MACPAC has reviewed a range of policy approaches to improve the targeting of DSH payments to providers.

In this chapter, we review current DSH targeting rules and present our findings from the analyses we performed to estimate the effects of raising the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to a higher standard. We examined seven different utilization-based thresholds, including absolute standards that would apply equally across states and relative standards that would vary by state based on the average Medicaid or low-income utilization rate for hospitals in the state. However, because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single utilization-based standard applicable to all hospitals that represents a clear improvement over current law.

The chapter concludes with a discussion of other approaches that might be used to better target funding, such as changing the types of uncompensated care that DSH funding can pay for. However, because of a lack of hospital-specific data on Medicaid payments, analyses of these approaches are preliminary and it is not possible to model the full implications of these policies at this time. The Commission has previously called for more complete and reliable data on Medicaid payments to hospitals in order to help inform approaches to better target DSH funding and to improve the transparency and accountability of Medicaid payments more generally (MACPAC 2016).

As discussed in Chapter 2, DSH allotments are scheduled to be reduced by $2 billion (16 percent) in fiscal year (FY) 2018, and Congress is currently debating changes to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that could affect hospitals' levels of uncompensated care and need for DSH payments. Such uncertainty makes it difficult to make recommendations about DSH policy at this time. The Commission will be monitoring the debate and will publish additional analyses as warranted. Certainly, if less DSH funding is available in the future, it will be particularly important to target remaining DSH funds to the states and hospitals that need them most.

Current Targeting of DSH Payments

The Social Security Act (the Act) requires Medicaid hospital payments 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). The statute does not, however, explicitly

define which hospitals meet this standard. States are permitted to make DSH payments to any hospital that has a Medicaid inpatient utilization rate of 1 percent, which includes virtually all U.S. hospitals.[1] However, they are required to make DSH payments to deemed DSH hospitals, which must meet one of two criteria:

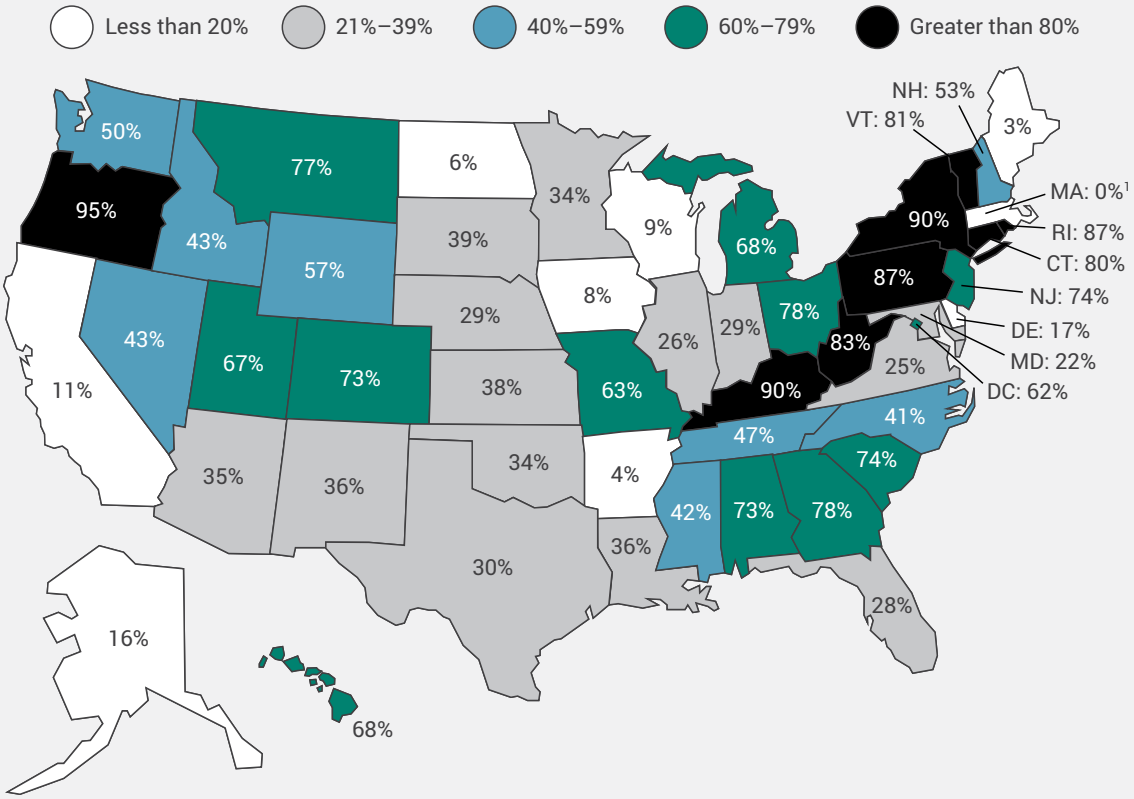
- the hospital has a Medicaid inpatient utilization rate of at least one standard deviation above the average for hospitals in the state that receive Medicaid payments; or
- the hospital has a low-income utilization rate in excess of 25 percent.

In 2012, about 12 percent of U.S. hospitals met the deemed DSH standards and these hospitals received $10.6 billion in DSH payments (65 percent of all DSH payments). However, about half of all U.S. hospitals received DSH payments in 2012, and about one-third of DSH payments were made to hospitals that did not meet the deemed DSH standard.

Share of hospitals receiving DSH payments

The share of hospitals in each state receiving DSH payments varies widely from state to state (Figure 3-1). For example, in 2012, nine states provided DSH payments to fewer than 20 percent of hospitals in their state while eight states provided DSH payments to more than 80 percent of hospitals in their state.

FIGURE 3-1. Share of Hospitals Receiving DSH Payments by State, SPRY 2012



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, 2016, analysis of 2012 Medicare cost reports and 2012 as-filed Medicaid DSH audits.

In general, states with larger DSH allotments make DSH payments to a greater proportion of hospitals, but there are exceptions. In 2012, the 17 states with the smallest DSH allotments as a share of Medicaid benefit spending (referred to as low-DSH states) made DSH payments to an average of 42 percent of the hospitals in their respective states, but four of these—Hawaii, Montana, Oregon, and Utah—made DSH payments to over 60 percent of their hospitals.[2] Those states not classified as low-DSH states (33 states and the District of Columbia) made DSH payments to an average of 51 percent of the hospitals in their respective states, but California and Maine (both not classified as low-DSH states) made DSH payments to fewer than 20 percent of their hospitals.

The approaches that states use to finance the non-federal share of DSH payments may also affect the share of hospitals that receive DSH payments. In 2012, states that financed DSH payments with above average levels of health care related taxes distributed DSH payments to about twice as many hospitals (as a share of all hospitals in the state) as states that financed DSH payments with lower levels of health care related taxes. States that financed DSH with above average levels of intergovernmental transfers or certified public expenditures distributed about twice as much DSH funding to public hospitals (as a share of all DSH spending in the state) as states that financed DSH payments with lower levels of local government funding.

State DSH targeting policies

In addition to complying with minimum federal eligibility standards in making DSH payments, states use their own criteria. Such criteria can be used to determine not only which hospitals are eligible to receive DSH payments but also how much DSH funding eligible hospitals can receive. States' criteria for identifying eligible DSH hospitals vary, but are often related to hospital ownership, hospital type, and geographic factors (Table 3-1). Some states have also established Medicaid and low-income utilization thresholds that are higher than the federal minimum standard but lower than the deemed DSH hospital standard. Information on each state's DSH eligibility criteria can be found in Appendix 3A.

TABLE 3-1. Number of States Targeting DSH Payments to Selected Hospital Types, 2016

Hospital type	Number of states
State-owned or public hospitals	36
Psychiatric hospitals or institutions for mental diseases	30
Teaching hospitals	19
Rural or critical access hospitals	15
Children's hospitals	11

Notes: DSH is disproportionate share hospital. This analysis shows the number of states that explicitly make certain types of hospitals eligible for DSH payments in their Medicaid state plan. States can also target DSH funding to particular types of providers by establishing different payment methods for different categories of eligible DSH providers.

Source: MACPAC, 2017, analysis of Medicaid state plans.

States can also establish different payment methods for different categories of hospitals. For example, many states give priority to a subset of DSH hospitals when distributing DSH payments.

State DSH targeting policies are dynamic and subject to change based on a variety of state and local circumstances, such as the opening or closing of hospitals in certain areas of the state. According to MACPAC's analysis of Medicaid state plan information provided on Medicaid.gov, 34 states submitted 173 Medicaid state plan amendments between 2012 and 2016 to change their DSH policies. These amendments ranged from incremental changes to the amount of DSH funding for particular types of hospitals to changes to the types of hospitals eligible to receive DSH payments. Changes to state DSH payment policies can change DSH payments to particular hospitals even if states' federal DSH allotments are unchanged (Box 3-1).

BOX 3-1. Examples of Recent Changes in State Disproportionate Share Hospital Payment Policies

To complement our quantitative analyses, MACPAC profiled seven disproportionate share hospitals (DSH) during the summer and fall of 2016:

- Parkland Hospital in Dallas, Texas;
- MetroHealth Hospital in Cleveland, Ohio;
- Santa Clara Valley Regional Medical Center in San Jose, California;
- Vidant Medical Center in Greenville, North Carolina;
- Henry Ford Hospital in Detroit, Michigan;
- Northeastern Vermont Regional Hospital in St. Johnsbury, Vermont; and
- Connecticut Children's Hospital in Hartford, Connecticut.

Hospital executives from three of the seven DSH hospitals that we profiled reported recent changes in their states' DSH policies that lowered their DSH payments:

- Parkland Hospital executives reported that Texas's 2014 changes to its DSH targeting policy to make more privately owned hospitals eligible for DSH payments resulted in a 14 percent drop in net DSH payments to Parkland, which is publicly owned.
- MetroHealth Hospital executives reported that Ohio's 2015 change in its methodology for determining the size of DSH payments resulted in a decline of payments for MetroHealth because the new formula de-emphasized hospital unpaid costs of care for uninsured individuals.
- Connecticut Children's Hospital executives reported that their DSH payments were specified as a line item in the state budget and fluctuated from year to year based on budget constraints—from a low of $10 million in 2012 to a high of $20 million in 2015, and most recently $12.5 million in 2016.

More information about the hospitals we profiled can be found in Chapter 2, and the complete hospital profiles are available on MACPAC's website (MACPAC 2017).

Effects of Raising the Minimum Federal DSH Eligibility Standard to a Higher Threshold

One approach to improve the targeting of DSH payments to providers is raising the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to a higher threshold. As noted above, virtually all hospitals meet the current standard.

To inform the discussion of whether to raise the minimum federal eligibility criteria for DSH payments, we analyzed the effects of implementing several different utilization-based thresholds, including both thresholds based on the Medicaid inpatient utilization rate and the low-income utilization rate (Box 3-2). DSH hospitals were identified using 2012 DSH audits and utilization rates were measured using 2014 Medicare cost reports, the most recent data available.[3] To minimize the effects of missing data and to provide consistent comparisons between the various thresholds, we limited this analysis to short-term and critical access DSH hospitals with complete Medicaid and low-income utilization data for 2014.

We were not able to include institutions for mental diseases (IMDs) in this analysis due to incomplete utilization data, but they may merit special consideration in DSH targeting policy. As discussed above, more than half of states (30) explicitly target DSH payments to IMDs, and in 2012, 26 percent of DSH payments were made to psychiatric hospitals. Federal statute limits the amount of DSH payments that each state can make to IMDs.[4] In addition, IMDs cannot receive Medicaid payment for services provided to individuals age 21–64 (§ 1905(a)(B) of the Act), so the Medicaid utilization rates of IMDs may be lower than the utilization rates of other types of hospitals.

BOX 3-2. Measures of Medicaid and Low-Income Utilization

The **Medicaid inpatient utilization rate** is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid.

- For Medicaid disproportionate share hospital (DSH) purposes, individuals who are dually eligible for Medicare and Medicaid are included even if their inpatient hospital services are paid for through Medicare. However, because of data limitations, dually eligible individuals are not included in the Medicaid utilization rate thresholds that we analyze in this chapter.
- The Medicaid inpatient utilization rate does not include outpatient days or primary care services provided by the hospital.

The **low-income utilization rate** is a measure of Medicaid and charity care utilization. It is composed of a Medicaid fraction, which is Medicaid revenue divided by total revenue, and a charity care fraction, which is charity care charges divided by total charges.

- The Medicaid fraction includes inpatient and outpatient Medicaid revenue. Medicare revenue for dually eligible beneficiaries is not included.
- The charity care fraction includes only inpatient charges and does not include outpatient charges. Also, bad debt for uninsured patients is not included (although it is an eligible type of uncompensated care for Medicaid DSH purposes).

First, we analyzed the effects of increasing the minimum Medicaid utilization rate standard to a higher absolute standard that would apply equally across states, similar to the current 1 percent Medicaid utilization rate threshold. We examined a 15 percent Medicaid utilization rate threshold (which is similar to the current Medicare DSH standard),[5] and two lower thresholds (5 percent and 10 percent Medicaid utilization). Nationally, the average Medicaid utilization rate was 19 percent in 2014.

Second, we analyzed the effects of using a relative utilization threshold based on the average Medicaid utilization rate within a state. Compared to an absolute standard that applies equally in all states, a relative utilization threshold would vary by state based on the average Medicaid utilization rate for hospitals in that state. Because Medicaid eligibility levels, family incomes, and other factors vary by state, the average Medicaid utilization rate also varies widely— in 2014, it varied from 10 percent in Nebraska and New Hampshire to 32 percent in New Mexico.[6]

Third, we analyzed the effects of applying relative utilization thresholds that are based on the low-income utilization rate, a measure of Medicaid and uninsured utilization that is used to identify hospitals that are statutorily required to receive DSH payments (deemed DSH hospitals). The Medicaid utilization rate accounts for care to Medicaid-enrolled patients only, and the low-income utilization rate accounts for care to Medicaid-enrolled patients as well as care to uninsured patients (as measured by a hospital's charity care charges). We examined two thresholds: (1) above average low-income utilization in the state and (2) above average Medicaid or low-income utilization in the state. In 2014, the average low-income utilization rate was 11 percent, but it varied widely by state, from 5 percent in New Hampshire to 21 percent in the District of Columbia.

Finally, we analyzed the effects of requiring all DSH hospitals to meet the deemed DSH standard, which is a combination of a relative utilization threshold (a Medicaid inpatient utilization rate that is one standard deviation above the average in the state) and an absolute standard (a low-income utilization rate above 25 percent). Deemed DSH hospitals qualify if they meet either the Medicaid or low-income utilization standard.

Below we describe the number and share of DSH hospitals meeting various targeting standards as well as the characteristics of hospitals at various utilization thresholds. We discuss the implications of these findings, including considerations for developing eligibility thresholds based on other measures, which the Commission may explore in future reports.

Number of hospitals meeting various utilization standards

Of the 2,278 DSH hospitals included in our analysis, we find that the majority would meet most of the higher eligibility thresholds that we analyzed (Table 3-2). Fewer than one-third of the DSH hospitals in our analysis met the deemed DSH standard, but these deemed DSH hospitals received the majority of DSH payments in 2012 (65 percent).

In general, fewer hospitals that currently receive DSH payments would qualify if the minimum eligibility threshold were raised to a higher standard. For example, in 2014, 95 percent of DSH hospitals met the 5 percent Medicaid utilization standard, but only 69 percent of DSH hospitals met the 15 percent Medicaid utilization standard. However, the share of DSH payments affected is lower than the share of DSH hospitals affected. For example, although 69 percent of DSH hospitals had Medicaid inpatient utilization rates above 15 percent, these hospitals received 92 percent of DSH payments in 2012.

TABLE 3-2. Summary Statistics of DSH Hospitals by Various Targeting Thresholds, 2014

Summary statistics	Current standard: 1% Medicaid utilization rate	Absolute utilization standards			Relative utilization standards			Deemed DSH standard
		5% Medicaid utilization rate	10% Medicaid utilization rate	15% Medicaid utilization rate	Average Medicaid utilization rate	Average low-income utilization rate	Average Medicaid or low-income utilization rate	
Number of DSH hospitals above threshold (2014)	2,278	2,157	1,922	1,574	1,293	1,326	1,675	634
Share of DSH hospitals	100%	95%	84%	69%	57%	58%	74%	28%
DSH payments to hospitals above threshold, billions (2012)	$12.6	$12.5	$12.3	$11.6	$10.8	$9.4	$11.4	$8.2
Share of DSH payments	100%	99%	97%	92%	85%	75%	90%	65%

Notes: DSH is disproportionate share hospital. Analysis was limited to short-term and critical access hospitals that received DSH payments in 2012 and reported complete Medicaid and low-income utilization data in 2014 (N = 2,278).

Source: MACPAC, 2017, analysis of 2012 DSH audits and 2014 Medicare cost reports.

Comparison of absolute and relative standards. In our analyses, more DSH hospitals were affected by the average Medicaid utilization rate standard, a relative threshold, than by the absolute utilization standards. However, the average Medicaid utilization rate nationally was 19 percent in 2014 and was higher than 15 percent in 40 states.

Because average Medicaid utilization rates are typically lower in states that have not expanded Medicaid, fewer hospitals in these states are affected by using a relative threshold than they are by using an absolute threshold. However, low-income utilization rates are less affected by state expansion decisions because they account for both Medicaid and uninsured patient utilization.

Comparison of Medicaid and low-income utilization rate measures. Fewer DSH hospitals are affected by the above average low-income standard than by the average Medicaid utilization standard. However, fewer hospitals would be affected if hospitals could qualify by meeting either the average Medicaid utilization standard or the low-income utilization standard. This is due, in part, to the fact that Medicaid and low-income utilization rates are not well correlated.

For example, about 300 DSH hospitals in our analysis had below average low-income utilization rates but above average Medicaid utilization rates. Hospitals in this category included those that primarily treat pregnant women and children, patients who are more likely to be enrolled in Medicaid and less likely to be uninsured.

In addition, about 400 DSH hospitals in our analysis had below average Medicaid utilization rates but above average low-income utilization rates. Hospitals in this category included those that primarily serve adults under age 65 and other demographic categories that are more likely to be uninsured.

Characteristics of hospitals that meet various utilization standards

We compared the characteristics of DSH hospitals above and below various utilization thresholds (Table 3-3). We identified critical access and teaching hospitals separately, because many states currently apply different DSH targeting standards for these hospital types. We also identified hospitals that provide burn or trauma services, because these quaternary care services are often provided at a loss for the hospital and they are identified in the statute calling for MACPAC to identify hospitals that provide essential community services.

We found that most of the DSH hospitals in our analysis that had Medicaid utilization rates of less than 10 percent were critical access hospitals. Critical access hospitals are small rural hospitals that receive a special payment designation from Medicare because they are often the sole provider in their community. We note that critical access hospitals comprised only about 22 percent of all DSH hospitals in our analysis. Although Medicaid utilization rates are typically higher in rural areas than in urban areas, critical access hospitals report lower Medicaid utilization rates on average than other types of hospitals. Our inability to include patients who are dually enrolled in Medicaid and Medicare in our calculations of Medicaid utilization may contribute to this discrepancy, because dually enrolled patients account for a large share of patients at rural hospitals (Bennett et al. 2014).

In contrast, DSH hospitals providing burn or trauma services and DSH teaching hospitals were more likely to have had above average Medicaid or low-income utilization rates, which means that a smaller percentage of them are likely to be affected by policies that raise the minimum DSH eligibility threshold.

We found that DSH hospitals with above average Medicaid or low-income utilization rates had higher levels of uncompensated care as a

share of operating expenses (3.7 percent) than hospitals with below average Medicaid or low-income utilization rates (2.6 percent) or Medicaid utilization rates below 10 percent (3.1 percent). This finding suggests that raising the minimum eligibility threshold for DSH would target more DSH funds to hospitals that provide higher levels of uncompensated care.

For DSH hospitals above and below the various utilization thresholds we analyzed, hospital margins were not clearly related to Medicaid or low-income utilization rates. Other researchers have also found that hospital margins are affected by many factors other than patient mix. For example, an analysis of Medicare cost report data for 2013 found that hospital prestige, regional market concentration, managed care penetration, hospital costs, and ownership type were also significantly correlated with hospital margins (Bai and Anderson 2016). In addition, there is substantial regional variation: in 2013, the median hospital in northeastern states reported a net loss of $236 per adjusted discharge in 2013, while the median hospital in western states reported a net profit of $45 per adjusted discharge (Bai and Anderson 2016).

TABLE 3-3. Characteristics of DSH Hospitals at Various Utilization Thresholds, 2014

Hospital characteristics	Less than 10% Medicaid utilization (n = 356)	Below average Medicaid or low-income utilization (n = 603)	Above average Medicaid or low-income utilization, not deemed (n = 1,067)	Deemed DSH hospitals (n = 608)	All DSH hospitals (N = 2,278)
Hospital type (share of all DSH hospitals at each utilization threshold)					
Critical access hospitals	57.9%	31.2%	20.3%	16.0%	22.0%
Hospitals providing burn or trauma services	25.6	28.4	41.4	51.5	40.6
Teaching hospitals	8.7	20.9	28.1	39.6	29.3
Uncompensated care (aggregate)					
Bad debt and charity care as a share of operating expenses	3.1%	2.6%	3.7%	5.9%	4.3%
Operating margins (median)					
Operating margins before DSH payments	-7.5%	-3.1%	-2.1%	-6.7%	-3.4%
Operating margins after DSH payments	-5.4	-1.5	-0.9	-3.7	-1.5
Total margins (after DSH and revenue not directly related to patient care)	2.5	3.5	4.3	3.2	3.8

Notes: DSH is disproportionate share hospital. Deemed DSH hospitals have a Medicaid utilization rate one standard deviation above average or a low-income utilization rate above 25 percent. Total margins include revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state or local subsidies to hospitals. Analysis is limited to short-term and critical access hospitals that received DSH payments in 2012 and reported complete Medicaid and low-income utilization data in 2014 (N = 2,278). Hospital and utilization categories are not mutually exclusive.

Source: MACPAC, 2017, analysis of 2012 DSH audits and 2014 Medicare cost reports.

Characteristics of states with affected DSH providers

Most states have at least one hospital that would be affected by even small changes to the minimum DSH eligibility threshold (Table 3-4). In general, states that distribute DSH payments more broadly are more likely to be affected by higher utilization thresholds. However, in the states that would be most affected, only a relatively small amount of DSH funds goes to hospitals that do not meet the various thresholds. For example, although most states (45) have at least one DSH hospital that does not meet the average Medicaid or low-income utilization rate threshold, only 10 percent of DSH payments are made to these hospitals (Table 3-2, above). Moreover, only two states (Alaska and Rhode Island) make more than one-third of their DSH payments to these hospitals.

TABLE 3-4. Number of States with at Least One DSH Hospital That Does Not Meet Various Thresholds, 2014

State distribution of DSH payments	Absolute utilization standards			Relative utilization standards			Deemed DSH standard
	5% Medicaid utilization rate	10% Medicaid utilization rate	15% Medicaid utilization rate	Average Medicaid utilization rate	Average low-income utilization rate	Average Medicaid or low-income utilization rate	
Wide DSH distribution states (states that make DSH payments to more than 67% of hospitals) (n = 20)	14	18	19	20	20	20	20
Medium DSH distribution states (states that make DSH payments to 33%–66% of hospitals) (n = 16)	9	14	15	16	16	16	16
Narrow DSH distribution states (states that make DSH payments to less than 33% of hospitals) (n = 13)	5	7	9	10	11	9	11
All states in analysis (N = 49)[1]	28	39	43	46	47	45	47

Notes: DSH is disproportionate share hospital. Analysis limited to short-term and critical access hospitals that received DSH payments in 2012 and reported complete Medicaid and low-income utilization data in 2014 (N = 2,278).

[1] Analysis excludes Maine, which makes DSH payments to institutions for mental diseases only, and Massachusetts, which does not make DSH payments.

Source: MACPAC, 2017, analysis of 2012 DSH audits and 2014 Medicare cost reports.

One reason so many states have at least one DSH hospital that would be affected by small changes in the DSH eligibility threshold is that many states provide exceptions or have special criteria for certain types of hospitals. For example, in 2016, 15 states targeted DSH payments specifically to critical access hospitals, which, according to our analysis, are more likely to have lower Medicaid utilization rates.

Implications and topics for future analysis

Although our analyses describe the potential effects of raising the minimum eligibility threshold for DSH payments, they do not point to a clearly superior alternative or answer the normative question of which threshold should be used. DSH hospitals that serve a lower share of Medicaid and low-income patients have less uncompensated care than other DSH hospitals, but they still report low operating margins. In addition, applying a utilization-based standard uniformly to all hospital types may negatively affect critical access hospitals and other hospital types that often are singled out in state policy to ensure access in rural communities or for other, similar reasons.

In future reports, the Commission may explore the effects of using other eligibility criteria, such as implementing different standards for different types of hospital types. In the analysis above, we were not able to include children's hospitals because of missing data, but most of these hospitals have high Medicaid utilization rates and are less likely to be affected by higher utilization thresholds. We were also not able to include rehabilitation and long-term care hospitals. Few rehabilitation and long-term care hospitals receive Medicaid DSH payments, but these hospitals are different from most general acute care hospitals because they provide care only to patients with particular diagnoses.

Other Approaches for Improving the Targeting of DSH Payments

Changing which hospitals are eligible for DSH payments is not the only way DSH funding can be better targeted; targeting of DSH payments can also be improved by changing the amount of funding that eligible DSH hospitals receive. Below we review two potential approaches that MACPAC has begun to examine:

- changing the DSH definition of uncompensated care, which would change the maximum amount of funding that DSH hospitals can receive; and
- converting DSH payments to a global payment that is based on the quality of care provided instead of being based on the cost.

Because of a lack of timely and reliable hospital-specific data on Medicaid payments, we are not able to fully model the effects of these potential policies at this time. The Congress also is considering policies that would combine Medicaid and Medicare DSH payments (Box 3-3). As data become available, the Commission will continue to explore these and other policy approaches.

BOX 3-3. Recent Congressional Disproportionate Share Hospital Policy Proposals

As part of larger proposals that make substantial changes to Medicaid and Medicare, members of Congress have proposed combining Medicaid and Medicare disproportionate share hospital (DSH) funding, specifically:

- The House fiscal year (FY) 2017 budget resolution recommends combining Medicaid and Medicare DSH funding into a single uncompensated care fund that would support all providers serving low-income populations, including uncompensated care provided outside the hospital setting. The proposal describes the new pool of funding as a "flexibility fund" but it does not specify whether the funding would be managed by states or the federal government (Committee on the Budget 2016).
- House Speaker Paul Ryan's white paper, *A Better Way*, included a proposal to combine Medicaid and Medicare DSH payments into a single pool of funding that would be distributed by CMS based on hospital charity care costs reported on Medicare cost reports. Medicaid DSH funds would not be allowed to be used to offset Medicaid shortfall or hospital bad debt expenses, which are included in the current Medicaid DSH definition of uncompensated care (Office of the Speaker of the U.S. House of Representatives 2016).

In 2012, about 49 percent of Medicaid DSH hospitals received Medicare DSH payments. Medicare DSH payments are made to short-term acute hospitals only and are not made to other types of hospitals that receive Medicaid DSH payments, such as critical access hospitals, institutions for mental diseases, and children's hospitals.

Many important details of these proposals are not known. For example, these proposals do not specify whether states would be required to contribute toward the non-federal share of Medicaid DSH payments or whether Medicaid DSH payments would be federalized, like Medicare. States are more likely to rely on providers and local governments for contributions toward the non-federal share of DSH payments than they are for the non-federal share of other types of Medicaid payments. In 2012, for example, state funds accounted for 62.9 percent of the non-federal share of all Medicaid expenditures but only 36.1 percent of the non-federal share of DSH payments (GAO 2014). Assuming that provider taxes and local government contributions for DSH are returned to providers and public hospitals, then approximately 78.2 percent of net DSH payments were paid for by the federal government in 2012. In comparison, the average federal share for all Medicaid expenditures was 58 percent in 2012 (OACT 2016).

Changing the DSH definition of uncompensated care

Currently, Medicaid DSH payments to a hospital are limited to the hospital's unpaid costs for hospital services provided to Medicaid-enrolled and uninsured patients. Some policymakers have proposed expanding this definition to include the costs of services provided outside the hospital setting, and others have proposed narrowing this definition to exclude payments for Medicaid shortfall and bad debt (Committee on the Budget 2016, Office of the Speaker of the U.S. House of Representatives 2016).

Expanding the DSH definition of uncompensated care to include hospital-provided physician and clinic services could help promote access to outpatient primary and specialty care. Using 2012 Medicaid claims data, we estimate that about 23 percent of hospital patient care costs are not included in the current DSH definition of uncompensated care.[7] Adding these other services to the existing DSH definition would, on average, increase the maximum amount of funding that DSH hospitals could receive by about 30 percent.

Narrowing the DSH definition of uncompensated care to exclude Medicaid shortfall would reduce the potential for duplication between Medicaid DSH payments and base payment rates for Medicaid services and provide more transparency about how much hospitals are paid for Medicaid services. However, the resulting payment cuts could exacerbate financial challenges for hospitals that serve a high share of Medicaid-enrolled patients. In 2012, Medicaid shortfall—the difference between Medicaid payments and hospitals' cost of care for Medicaid-enrolled patients—accounted for about one-fifth of the total hospital uncompensated care reported on DSH audits. Medicaid shortfall reported on DSH audits includes shortfall for Medicaid-enrolled patients for which Medicaid is not the primary payer, such as patients dually eligible for Medicare and Medicaid.[8]

Further narrowing the DSH definition of uncompensated care to exclude bad debt would target DSH funding based on charity care to uninsured patients. However, it would reduce the maximum amount of DSH funding hospitals could receive by almost half. In 2014, charity care accounted for about half (54 percent) of the uncompensated care reported by DSH hospitals on Medicare cost reports, which is slightly higher than the share reported by non-DSH hospitals (52 percent).

Changes to the DSH definition of uncompensated care would primarily affect hospitals that are already receiving the maximum amount of DSH funding allowable. In 2012, about 10 percent of DSH hospitals received DSH payments that met or exceeded the total amount of uncompensated care reported on their DSH audits, which is referred to as the hospital-specific limit.[9] About twice as many hospitals would have had DSH payments at or above their hospital-specific limit if Medicaid shortfall were excluded from the DSH definition of uncompensated care (18 percent), and about five times as many hospitals would have had DSH payments at or above their hospital-specific limit if both Medicaid shortfall and bad debt were excluded from the DSH definition of uncompensated care (53 percent). We estimate that expanding the definition of uncompensated care to include care provided outside the hospital setting would reduce the share of DSH hospitals affected by narrowing the DSH definition of uncompensated care (from 18 to 11 percent in the scenario that excludes Medicaid shortfall and from 53 to 46 percent in the scenario that excluded both Medicaid shortfall and bad debt). Because of data lag, this analysis is based on hospital uncompensated care reported on 2012 DSH audits, and we do not know how the coverage expansions implemented as part of the ACA might affect these estimates.

Converting DSH payments to a global payment

Instead of making DSH payments based on the cost of services provided, DSH payments could be made using other value-based payment methods. In December 2015, California received approval from the Centers for Medicare & Medicaid Services (CMS) for a Section 1115 demonstration to establish a new Global Payment Program (GPP), which combines DSH and other Medicaid funding for uncompensated care into a global payment for certain deemed DSH hospitals in California.

Payments to hospitals participating in the GPP are delinked from hospital uncompensated care and are instead based on a point system that rewards

public health systems when value-based care is provided to uninsured patients. For example, hospitals can earn points for providing traditional inpatient and outpatient services, such as dental care and mental health treatment, and they can also earn points for providing additional patient support services, such as health coaching and technology-based consultations. During the initial years of the demonstration, the point system is based on the relative costs of each service, but in later years of the demonstration, potentially avoidable services, such as emergency room visits, will earn fewer points to encourage hospitals to provide care in the most appropriate and cost-effective setting.

To get a sense of early experience with the GPP, we interviewed hospital executives at one of the hospitals participating in the program, Santa Clara Valley Medical Center in San Jose, California, as part of our work profiling selected DSH hospitals. Hospital executives noted that the GPP helped support clinic services for uninsured patients that were previously not paid for by DSH, but they also expressed concern about whether the hospital would meet its targets and earn its full GPP payments, because payments under GPP are not guaranteed and must be earned (MACPAC 2017). At the time of our interview, in the summer of 2016, California and CMS had recently approved the baselines and targets for the GPP program. These decisions, like those in any value-based payment program, are complex and would need to be re-evaluated if other states adopted a similar approach. The task of measuring the quality of care provided at safety-net hospitals and setting improvement targets is particularly challenging because of the social risk factors that low-income patients face (ASPE 2016).

Next Steps

This is the Commission's second annual report on Medicaid DSH policy. Future reports will present results of the Commission's continued monitoring of the distribution of DSH payments across states and hospitals to understand how any changes in health insurance coverage for low-income families will affect safety-net institutions. We plan to further explore alternative eligibility criteria and the implications of applying different standards to different types of hospitals. We will also continue to monitor the potential effects of changes to the ACA and Medicaid's financing structure on DSH policy. In addition, notwithstanding the limitations of currently available Medicaid payment data, we plan to further explore policies to improve the targeting of DSH funding to states and providers and may also examine proposals to change the amount of funding that DSH hospitals are eligible to receive and the way DSH funding is distributed.

Endnotes

[1] DSH hospitals are also required to have at least two obstetricians with staff privileges who will treat Medicaid enrollees (with certain exceptions).

[2] Low-DSH states are those with 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).

[3] Centers for Medicare & Medicaid Services (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 the state plan rate year ends.

[4] Each state's IMD limit is the lesser amount of (1) the DSH allotment the state paid to IMDs and other mental health facilities in FY 1995 or (2) 33 percent of the state's FY 1995 DSH allotment.

[5] Hospitals are eligible for Medicare DSH payments if their Medicaid and Supplemental Security Income patient utilization rate exceeds 15 percent.

[6] New Hampshire expanded Medicaid to childless adults on August 15, 2014. As a result, most of the effects of this expansion are not included in the 2014 Medicare cost report data.

[7] To estimate the share of hospital costs that are not covered by the current DSH definition of uncompensated care, we compared total 2012 fee-for-service claims for inpatient and outpatient hospital services to claims for other types of services that were provided in an inpatient or outpatient setting. This analysis does not include the costs of non-covered services or services for which hospitals do not submit claims.

[8] For Medicaid DSH purposes, Medicaid shortfall includes the costs of care for all Medicaid-eligible patients, regardless of whether Medicaid is the primary payer. Costs for patients who are dually eligible for Medicaid and Medicare are included, minus any Medicare payments received for those patients (including Medicare DSH payments). In August 2016, CMS proposed a rule to clarify that payment from third-party payers, such as Medicare, should be included in calculations of Medicaid shortfall, but this rule has not yet been finalized (CMS 2016).

[9] Through the DSH audit process, CMS is currently working with states to recoup DSH payments to hospitals that exceed their hospital uncompensated care costs.

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APPENDIX 3A. State DSH Targeting Methods

TABLE 3A-1. Common Hospital Types Defined and Targeted for DSH Payments by State

State	State-owned or public hospitals	Psychiatric hospitals or institutions for mental diseases	Teaching hospitals	Children's hospitals	Rural or critical access hospitals
Alabama	✓		✓		
Alaska		✓		✓	✓
Arizona	✓				
Arkansas	✓	✓	✓		
California	✓				
Colorado	✓				
Connecticut	✓	✓		✓	
Delaware		✓			
District of Columbia	✓	✓			
Florida	✓	✓	✓	✓	✓
Georgia	✓				✓
Hawaii	✓				
Iowa				✓	✓
Idaho	✓				✓
Illinois	✓	✓			
Indiana	✓	✓			
Kansas	✓	✓	✓		
Kentucky	✓	✓	✓		
Louisiana	✓	✓	✓		✓
Maine		✓			
Maryland		✓			
Massachusetts[1]					
Michigan	✓	✓	✓		✓
Minnesota		✓		✓	
Mississippi	✓		✓		
Missouri					
Montana					
Nebraska	✓	✓	✓	✓	
Nevada	✓				✓
New Hampshire	✓	✓			✓

TABLE 3A-1. (continued)

State	State-owned or public hospitals	Psychiatric hospitals or institutions for mental diseases	Teaching hospitals	Children's hospitals	Rural or critical access hospitals
New Jersey	✓	✓	✓		
New Mexico			✓		
New York	✓	✓			
North Carolina	✓	✓	✓		
North Dakota	✓	✓			✓
Ohio				✓	✓
Oklahoma	✓		✓		
Oregon	✓	✓	✓		
Pennsylvania	✓	✓	✓		✓
Rhode Island	✓				
South Carolina	✓	✓			
South Dakota	✓	✓			
Tennessee		✓		✓	
Texas	✓		✓	✓	✓
Utah	✓	✓	✓	✓	✓
Vermont			✓		
Virginia	✓	✓	✓		
Washington	✓			✓	✓
West Virginia	✓	✓			✓
Wisconsin	✓				
Wyoming					

Notes: DSH is disproportionate share hospital. This analysis shows the number of states that explicitly make certain types of hospitals eligible for DSH payments in their Medicaid state plan. States can also target DSH funding to particular types of providers by establishing different payment methods for different categories of eligible DSH providers. Categories are not mutually exclusive (e.g., a state targeting state-owned teaching hospitals would be counted as targeting both state-owned hospitals and teaching hospitals).

[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, 2017, analysis of Medicaid state plans.

TABLE 3A-2. DSH Targeting Policies by State, 2016

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Alabama	73 percent	• Teaching hospitals owned by University of Alabama • Acute care public hospitals • Private acute care hospitals that are members of a prepaid health plan, located in counties with between 75,000 and 100,000 people or above 200,000 people without a publicly owned hospital and meet certain Medicaid utilization criteria	• Private acute care hospitals located in counties with 75,000–100,000 people must have an MIUR that exceeds the average MIUR in the state • Private acute care hospitals located in counties with over 200,000 people must have an MIUR that exceeds one-half of the average MIUR in the state
Alaska	16 percent	• Acute care, psychiatric, and specialty rehabilitation hospitals that have entered into agreements with the state agency to participate in one or more of nine state-specific DSH classifications, which primarily target: – hospitals providing certain psychiatric and substance abuse disorder services – children's hospitals – rural hospital clinics	N/A
Arizona	35 percent	• Government-operated hospitals • Privately owned acute care general hospitals meeting certain low-income utilization criteria	• Privately owned acute care general hospitals must have low-income utilization rate (LIUR) exceeding the mean LIUR for private hospitals receiving Medicaid payments in the state, or provide at least 1 percent of total Medicaid days across the state
Arkansas	4 percent	• State-owned teaching hospitals • State-owned psychiatric hospitals	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
California	11 percent	• Government-operated hospitals	N/A
Colorado	73 percent	• Hospitals participating in the Colorado Indigent Care Program (CICP), with prioritization for hospitals that have CICP write-off costs exceeding certain thresholds	• Hospitals with CICP write-off costs greater than 750 percent of the statewide average prioritized first • Hospitals with CICP write-off costs greater than 200 percent but less than 750 percent of the statewide average prioritized second
Connecticut	80 percent	• Hospitals serving low-income persons • Psychiatric hospitals • Private and public acute care general short-term hospitals, including those located in distressed economic zones • Public chronic disease hospitals • Private freestanding children's hospitals	N/A
Delaware	17 percent	• Delaware-owned psychiatric hospitals that meet requirements for serving low-income patients, as well as other hospitals meeting all of the following criteria: – are non-profit – have a facility located in a Delaware city of over 50,000 people that provides obstetric services to Medicaid enrollees – are enrolled as a provider in fee-for-service Medicaid and CHIP and all participating managed care organizations – meet LIUR criteria	• For Delaware-owned psychiatric hospitals, at least 60 percent of revenue must be from a combination of public funds, charity care, and bad debts • For other hospitals, LIUR must exceed 15 percent
District of Columbia	62 percent	• Public psychiatric hospitals	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Florida	28 percent	• State mental health hospitals • Teaching hospitals • Rural hospitals • Specialty hospitals that receive all of their inpatient clients through referrals or admissions from county public health departments • Children's hospitals • Provider Service Network hospitals • Hospitals qualifying for primary care DSH payments under Florida law	• Private hospitals are targeted differently based on whether or not they have 3,100 or more Medicaid days in the state plan rate year
Georgia	78 percent	• Rural hospitals targeted using separate funding pools	N/A
Hawaii	68 percent	• Governmental providers have a slightly larger pool than non-governmental providers	N/A
Iowa	8 percent	• Children's hospitals • Rural hospitals participating in the rural disproportionate share fund	N/A
Idaho	43 percent	• Idaho has two categories of DSH eligibility: mandatory and deemed, which are defined differently than the federal definition of deemed DSH hospitals. The deemed group receives DSH payments only if the mandatory group has been fully funded. The state targets non-state, government owned hospitals and private hospitals, including rural and critical access hospitals.	• To qualify as a mandatory DSH hospital, a hospital must meet the federal criteria for deemed DSH hospitals • To qualify as a deemed DSH hospital based on Idaho's methodology, a hospital must have an MIUR of at least one percent
Illinois	26 percent	• Public hospitals with an intergovernmental agreement between the state agency and the authorized governmental body for the qualifying hospital • State-owned mental health facilities	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Indiana	29 percent	• Municipal hospitals • Hospitals located in Lake County, IN • Private psychiatric hospitals	N/A
Kansas	38 percent	• Targets only deemed DSH hospitals, and pays IMDs and state-owned teaching hospitals out of a separate payment pool	N/A
Kentucky	90 percent	• Acute care hospitals • State university teaching hospital owned and operated by either University of Kentucky or Louisville Medical School • State-owned psychiatric hospitals	N/A
Louisiana	36 percent	• State-operated hospitals • Small rural hospitals • Public or private non-rural community hospitals • Low-income academic hospitals • Hospitals participating in the Low-Income and Needy Care Collaboration program • Private acute general hospitals located outside of Baton Rouge and New Orleans Metropolitan Statistical Area (MSA) meeting criteria related to the ratio of interns and residents to inpatient beds, and Medicaid and low-income utilization	• Hospitals qualifying as private acute care general hospitals outside of Baton Rouge and New Orleans MSA must have an MIUR greater than 18.9%
Maine	3 percent	• IMDs	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Maryland	22 percent	• Hospitals governed by the Maryland Medicaid waiver do not receive additional payments under DSH because their rates already include a disproportionate share adjustment. Among hospitals not governed by the waiver, hospitals receive the minimum amount of DSH required under federal law, except for: – freestanding psychiatric hospitals meeting charity care thresholds – freestanding rehabilitation hospitals meeting charity care thresholds	• Psychiatric hospitals must have charity care inpatient costs exceeding 40 percent of total inpatient hospital costs • Rehabilitation hospitals must have charity care inpatient costs exceeding 20 percent of total inpatient hospital costs
Massachusetts[1]	0 percent	• Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for its safety-net care pool instead	N/A
Michigan	68 percent	• Government-owned or government-operated hospitals receive DSH payments first, and other hospitals can receive payments if there are remaining funds in the allotment period. Other hospitals targeted through payment pools include: – IMDs – small private rural hospitals – large private urban hospitals – hospitals with an indigent care pool agreement – government hospitals – DRG inpatient and per diem inpatient hospitals – university hospitals with both a college of allopathic medicine and a college of osteopathic medicine	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Minnesota	34 percent	• Hospitals with a contract with the state to provide extended inpatient psychiatric services • Hospitals that received Medicaid fee-for-service payments for 20 transplants in the base year • Hospitals meeting various MIUR thresholds can receive greater adjustments • Children's hospitals	• Hospitals with an MIUR greater than the statewide mean can receive additional payment adjustments, which become greater for hospitals that exceed one or three standard deviations.
Mississippi	42 percent	• State-owned teaching hospital located in Hinds County	N/A
Missouri	63 percent	• No particular groups targeted, but children's hospitals may only qualify if they are federally deemed	N/A
Montana	77 percent	• Hospitals must meet MIUR or LIUR thresholds	• Hospitals must have an MIUR equal to or above the mean for all hospitals receiving Medicaid payments in the state or have an LIUR above 20 percent
Nebraska	29 percent	• Children's hospitals • State-owned IMDs • Non-profit acute care teaching hospitals affiliated with state-owned medical college • Hospitals providing services to low-income persons covered by a county administered general assistance program • Other hospitals that meet MIUR criteria	• Hospitals can also qualify for DSH payments if they have an MIUR equal to or above the mean for all hospitals receiving Medicaid payments in the state

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Nevada	43 percent	• Public hospitals targeted separately through different payment methods based on population of the county in which they are located • Private hospitals targeted separately through different payment methods based on population of the county in which they are located	N/A
New Hampshire	53 percent	• Government-owned psychiatric hospitals in which 50 percent or more of revenue is attributable to public funds excluding Medicare, Medicaid, bad debts, and charity care • Critical access hospitals that participate in New Hampshire Medicaid managed care, with an extra payment for critical access hospitals providing essential access to maternity care • Private hospitals that participate in New Hampshire Medicaid managed care	N/A
New Jersey	74 percent	• Hospitals with a contract with the Division of Mental Health and Hospitals to provide services to low-income mentally ill or developmentally disabled beneficiaries • Governmental acute and psychiatric hospitals • Non-state-owned major teaching hospitals • Other hospitals that meet Medicaid, uninsured, and low-income utilization criteria	• Hospitals can also qualify for DSH if they have Medicaid, uninsured or low-income utilization greater than 25 percent
New Mexico	36 percent	• Teaching hospitals • PPS hospitals • Hospitals that have had a disproportionate shift in the delivery of services between low-income and Medicaid-covered inpatient days	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
New York	90 percent	• State- and county-operated hospitals • Hospitals operated by municipalities with populations greater than 1 million • Private hospitals • State-and private-operated freestanding psychiatric hospitals	• Non-major public hospitals with Medicaid discharges of 40 percent or greater have a separate pool for DSH
North Carolina	41 percent	• To receive DSH, hospitals must meet deemed DSH requirements or state-defined Medicaid revenue or utilization criteria unless they are a psychiatric hospital owned by the government or the University of North Carolina (UNC). Within these parameters, North Carolina targets: – State-owned IMDs – Hospitals providing services to clients of the Division of Vocational Rehabilitation Services – Hospitals owned or controlled by the UNC health care system	• Hospitals in which the sum of Medicaid gross revenues, bad debt, and charity care exceeds 20 percent of total gross patient revenue • Hospital among the top group that accounts for 50 percent of total Medicaid patient days
North Dakota	6 percent	• Hospitals paid using PPS • State-owned psychiatric hospitals • Critical access hospitals	N/A
Ohio	78 percent	• Hospitals with high uncompensated care • Rural and critical access hospitals • Children's hospitals	N/A
Oklahoma	34 percent	• Private major teaching hospitals • Public hospitals	N/A
Oregon	95 percent	• Inpatient psychiatric hospitals • Public academic medical centers with more than 200 residents or interns	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Pennsylvania	87 percent	• Hospitals must be deemed or meet Medicaid utilization criteria. Within that criteria, targets: – state-operated psychiatric hospitals and non-state operated hospitals targeted separately – acute care general hospitals with higher Medicaid days – rehabilitation hospitals – hospitals that qualify as level I, II, or III trauma centers – hospitals with qualifying burn centers – hospitals providing neonatal intensive care service, a high volume of obstetrical services to Medicaid recipients (rural and nonrural hospitals in this category are targeted separately) – teaching hospitals that provide psychiatric services for Medicaid beneficiaries – critical access hospitals – hospitals meeting criteria for or are designated as sole community hospitals – hospitals providing surgical services to patients with cleft palate and craniofacial abnormalities – hospitals in cities with a per capita income significantly below the statewide average – hospitals that provide a high volume of emergency department visits	• All non-deemed hospitals must meet specific utilization criteria for their category in order to qualify or receive payment under that category. However, in general, most categories must meet at least one of the following criteria: – rural or sole community hospital with 75 percent MIUR – Medicaid inpatient days two standard deviations above the statewide mean – located in a county ranked above the 96th percentile for Medicaid utilization for all counties
Rhode Island	87 percent	• State-operated hospitals that meet deemed DSH standards receive additional payments • Non-government hospitals • Women and infant specialty hospitals	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
South Carolina	74 percent	• Psychiatric hospitals operated by the South Carolina Department of Mental Health	N/A
South Dakota	39 percent	• Hospitals must be deemed or meet MIUR criteria. Within that, South Dakota targets: – qualifying acute care hospitals – state-owned psychiatric hospitals	• Hospitals that are not federally deemed must have an MIUR exceeding the statewide mean
Tennessee	47 percent	• Targets hospitals based on a point system, with points based on Medicaid utilization criteria; hospitals are classified within four groups: – hospitals providing essential services such as regional trauma or perinatal centers – children's safety-net hospitals – freestanding psychiatric hospitals – other essential acute care hospitals	• To receive DSH payments, hospitals must have at least one point; points are earned by meeting at least one of the following criteria: – an MIUR of at least 9.5 percent, and the number of Medicaid days must be greater than average for hospitals in the other essential acute care hospitals group – an MIUR of at least 13.5 percent – 4.5 percent of operating expenses attributable to bad debt, charity care, or medically indigent costs
Texas	30 percent	• All hospitals must have or be in active pursuit of obtaining a trauma facility designation. In addition, hospitals must be federally deemed or meet one of the following criteria: – rural hospitals that meet MIUR criteria – hospital in an urban county with a population under 290,000 people – children's state-owned teaching hospital, or state chest hospitals	• Rural hospitals can qualify if they if they have an MIUR greater than the statewide mean

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Utah	67 percent	• To qualify, hospitals must be federally deemed or be located in a rural county, participate in the Utah Primary Care Network, or meet Medicaid utilization criteria. Within these criteria, Utah targets: – private, general acute care urban hospitals – general acute care rural hospitals – the state psychiatric hospital – the state teaching hospital – children's hospitals – frontier county hospitals in economically depressed areas	• Except for rural hospitals and hospitals participating in the Utah primary care network, hospitals must be deemed or have an MIUR greater than 14 percent
Vermont	81 percent	• In-state, postgraduate teaching facilities • Hospitals with a large proportion of all statewide inpatient days	N/A
Virginia	25 percent	• Hospitals must be federally deemed or meet MIUR criteria. Within these criteria, Virginia targets: – state-owned teaching hospitals – freestanding psychiatric hospitals	• Hospitals that are not federally deemed must have an MIUR of greater than 10.5 percent
Washington	50 percent	• Rural hospitals with fewer than 75 acute beds • Non-rural hospitals providing charity care • Public hospitals • Children's hospitals • Rural hospitals certified by CMS as a sole community hospital	N/A
West Virginia	83 percent	• Acute care, psychiatric, rehabilitation, or critical access hospitals owned by the state	N/A

TABLE 3A-2. (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Wisconsin	9 percent	• Hospitals owned by the state or county • Private acute care hospitals	N/A
Wyoming	57 percent	• All hospitals meeting MIUR requirements	• 5 percent MIUR

Notes: DSH is disproportionate share hospital. MIUR is Medicaid inpatient utilization rate. N/A is not applicable. LIUR is low-income utilization rate. IMD is institution for mental diseases. DRG is diagnosis-related group. PPS is prospective payment system. CMS is Centers for Medicare & Medicaid Services. Although the hospital targeting methods and criteria reflect the latest state DSH polices as of December 2016, the share of hospitals receiving DSH is based on 2012 data, meaning that the share of hospitals receiving DSH payments as of December 2016 may be different from what is shown.

[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, 2017, analysis of Medicaid state plans, as-filed 2012 Medicaid DSH audits, and 2014 Medicare cost reports.