

Chapter 3:

# Annual Analysis of Disproportionate Share Hospital Allotments to States

# Annual Analysis of Disproportionate Share Hospital Allotments to States

## Key Points

- MACPAC continues to find no meaningful relationship between states' disproportionate share hospital (DSH) allotments and the three factors that Congress has asked the Commission to study:
  - the number of uninsured individuals;
  - the amount and sources of hospitals' uncompensated care costs; and
  - the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.
- In 2017, 28.5 million people were uninsured, a 32 percent decline from 2013.
- The coverage expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) are resulting in different effects on the two types of uncompensated care that DSH payments help offset: (1) unpaid costs of care for uninsured individuals, and (2) Medicaid shortfall, the difference between a hospital's Medicaid payments and its costs of providing services to Medicaid-enrolled patients.
  - Charity care and bad debt are declining. Nationally, hospitals reported a \$5.7 billion decline in charity care and bad debt from 2013 to 2014.
  - Medicaid shortfall is increasing. Hospitals reported a \$0.9 billion increase in Medicaid shortfall on the American Hospital Association Annual Survey in the same period.
  - For hospitals that received DSH payments in state plan rate years 2013 and 2014 (41 percent of all U.S. hospitals), the increase in Medicaid shortfall reported on DSH audits (\$4.0 billion) outpaced the decline in unpaid costs of care for uninsured patients (\$1.6 billion) for these years.
  - In 2016, hospitals reported a total of \$35.0 billion in charity care and bad debt and \$20.0 billion in Medicaid shortfall.
- In fiscal year (FY) 2019, \$12.6 billion in federal DSH funds were allotted to states (\$22.3 billion in state and federal funds combined). These allotments are scheduled to be reduced in fiscal FY 2020, with cuts continuing through FY 2025.
- State DSH allotments, which are based on state DSH spending in FY 1992, vary widely today, and the DSH allotment reduction methodology prescribed by statute is projected to preserve much of that variation.
- In the coming year, the Commission will continue to examine other DSH policy issues as part of its broader examination of all types of Medicaid payments to hospitals.

## CHAPTER 3:

# Annual Analysis of Disproportionate Share Hospital Allotments to States

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. The total amount of such payments is limited by annual federal DSH allotments, which vary widely by state. States can distribute DSH payments to virtually any hospital in their state, but total DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides. DSH payments help to offset two types of uncompensated care: Medicaid shortfall (the difference between a hospital's Medicaid payments and its costs of providing services to Medicaid-enrolled patients) and unpaid costs of care for uninsured individuals. More generally, DSH payments also help to support the financial viability of safety-net hospitals.

MACPAC is statutorily required to report annually on the relationship between state allotments and several potential indicators of the need for DSH funds:

- changes in the number of uninsured individuals;
- the amounts and sources of hospitals' uncompensated care costs; and
- the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.

As in our previous DSH reports, we find little meaningful relationship between DSH allotments and the factors that Congress asked the Commission to study. This is because DSH allotments are largely based on states' historical DSH spending before federal limits were established. Moreover, the variation is projected to continue after federal DSH allotment reductions take effect.

In this report, we update our previous findings to reflect new information on changes in the number of uninsured individuals and levels of hospital uncompensated care. We also provide updated information on deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Specifically, we find the following:

- According to the Current Population Survey, 28.5 million people, or 8.8 percent of the U.S. population, were uninsured in 2017, about the same percentage as in 2016. Since 2013, the number of uninsured individuals has declined 32 percent, with the largest declines in states that expanded Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).<sup>1</sup>
- Hospitals reported \$35.0 billion in hospital charity care and bad debt on Medicare cost reports in 2016, an 8 percent decline from 2015. Because of recent changes in Medicare cost report definitions that affected uncompensated care reported for 2015 and subsequent years, we can no longer compare these data with the amount of uncompensated care reported in 2013.<sup>2</sup>
- Hospitals reported \$20.0 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey in 2016, a 24 percent increase from the amount reported in 2015. Since 2013, the amount of Medicaid shortfall for all hospitals has increased by \$6.8 billion (AHA 2017, 2015).

- In 2016, deemed DSH hospitals continued to report lower aggregate operating margins than other hospitals (negative 6.0 percent for deemed DSH hospitals versus negative 0.9 percent for all hospitals). Total margins (which include government appropriations and revenue not directly related to patient care) were similar between deemed DSH hospitals (6.2 percent) and all hospitals (6.7 percent). Aggregate operating and total margins for deemed DSH hospitals would have been about 4 percentage points lower without DSH payments.

In this report, we also present new data on the early effects of the ACA coverage expansions using DSH audit data. While other data suggest that total hospital uncompensated declined in 2014, state plan rate year (SPRY) 2014 DSH audit data show a net increase in total uncompensated care costs for DSH hospitals because of an increase in Medicaid shortfall.<sup>3</sup> For hospitals included in SPRY 2013 and 2014 DSH audits, the increase in Medicaid shortfall (\$4.0 billion) was more than twice as large as the decline in unpaid costs of care for uninsured patients (\$1.6 billion).

We also project fiscal year (FY) 2020 DSH allotments before and after implementation of federal DSH allotment reductions.<sup>4</sup> DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid and the exchanges would lead to reductions in hospital uncompensated care and thereby lessen the need for DSH payments. DSH allotment reductions have been delayed several times, most recently in February 2018 by the Bipartisan Budget Act (P.L. 115-123). Under current law, the first round of reductions (amounting to \$4 billion or 31 percent of unreduced amounts) is now scheduled to take effect in FY 2020. Reductions are currently scheduled to increase to \$8 billion in FYs 2021–2025, which is more than half of states' unreduced allotment amounts.

Chapter 1 of this report provides the Commission's recommendations for restructuring DSH allotment reductions. Specifically, the Commission is calling

for phasing in reductions more gradually and changing the methodology for distributing reductions among states to help improve the relationship between DSH allotments and measures related to hospital uncompensated care costs. Although the Commission is concerned that the magnitude of DSH cuts assumed under current law may affect the financial viability of some safety-net hospitals, the Commission's analyses have focused on budget-neutral ways to restructure available funding.

This chapter focuses on DSH allotments to states, but the Commission is also interested in exploring changes to other policies that would affect the distribution of DSH payments to hospitals within states. The Commission has long held that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income uninsured patients and have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH payments. However, development of policy to achieve this goal must be considered in terms of all Medicaid payments that hospitals receive.

## Background

Current DSH allotments vary widely among states, reflecting the evolution of federal policy over time. States began making Medicaid DSH payments in 1981, when Medicaid hospital payments were delinked from Medicare payment levels. Initially, states were slow to make these payments, and in 1987, Congress required states to make payments to hospitals that serve a high share of Medicaid-enrolled and low-income patients, referred to as deemed DSH hospitals. DSH spending grew rapidly in the early 1990s—from \$1.3 billion in 1990 to \$17.7 billion in 1992—after Congress clarified that DSH payments were not subject to Medicaid's hospital payment limitations and CMS issued guidance permitting the use of provider taxes to finance the non-federal share of Medicaid payments (Holahan et al. 1998).<sup>5</sup>

In 1991, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments, referred to as allotments (Box 3-1). Allotments were initially established for FY 1993 and were generally based on each state's FY 1992 DSH spending. Although Congress has made several incremental adjustments to these allotments, the states that spent the most in FY 1992 still have the largest allotments, and the states that spent the least in FY 1992 still have the smallest allotments.<sup>6</sup>

In FY 2017, federal funds allotted to states for DSH payments totaled \$12.0 billion, of which states spent \$10.4 billion.<sup>7</sup> (States spent \$18.1 billion in state and federal funds combined.) DSH allotments that year ranged from less than \$15 million in six states (Delaware, Hawaii, Montana, North Dakota, South Dakota, and Wyoming) to more than \$1 billion in three states (California, New York, and Texas).

DSH spending accounted for 3.2 percent of total Medicaid benefit spending in FY 2017, an amount

that has been relatively consistent since FY 2011.<sup>8</sup> DSH spending as a share of total state Medicaid benefit spending varied widely by state, from less than 1 percent in 9 states to 12.3 percent in New Hampshire (Figure 3-1).

States have up to two years to spend their DSH allotment, and \$1.2 billion in federal DSH allotments for FY 2016 went unspent.<sup>9</sup> There are two primary reasons states do not spend their full DSH allotment: (1) they lack state funds to provide the non-federal share; and (2) the DSH allotment exceeds the total amount of hospital uncompensated care in the state. As noted above, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care. In FY 2016, half of unspent DSH allotments were attributable to five states (Connecticut, New Hampshire, New Jersey, Pennsylvania, and Washington) and the District of Columbia, all of which had FY 2016 DSH allotments (including both state and federal funds) that were larger than the

### **BOX 3-1. Glossary of Key Medicaid Disproportionate Share Hospital Terminology**

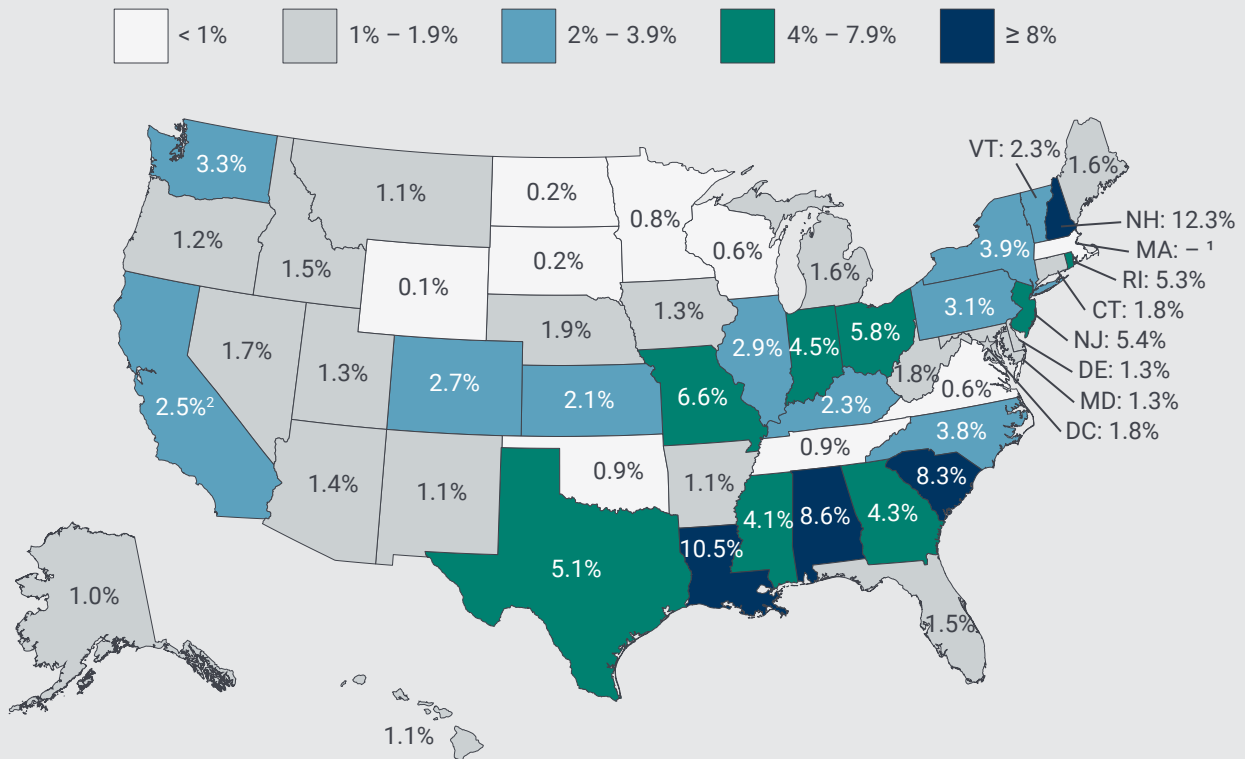
**DSH hospital.** A hospital that receives disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments; that is, a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions for rural and children's hospitals).

**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 Social Security Act (the Act)).

**State DSH allotment.** The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other Medicaid service expenditures. If a state does not spend the full amount of its allotment for 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 prior year's allotment, adjusted for inflation (§ 1923(f) of the Act).

**Hospital-specific DSH limit.** The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

**FIGURE 3-1. DSH Spending as a Share of Total Medicaid Benefit Spending, by State, FY 2017**



**Notes:** DSH is disproportionate share hospital. FY is fiscal year.

— Dash indicates zero.

<sup>1</sup> Massachusetts does not make DSH payments to hospitals because its Section 1115 demonstration allows the state to use all of its DSH funding for the state’s safety-net care pool instead.

<sup>2</sup> DSH spending for California includes DSH-financed spending under the state’s Global Payment Program, which is authorized under the state’s Section 1115 demonstration.

**Source:** MACPAC, 2019, analysis of CMS-64 Financial Management Report net expenditure data as of October 19, 2018.

total amount of hospital uncompensated care in the state as reported on 2016 Medicare cost reports.<sup>10</sup>

In SPRY 2014, 45 percent of U.S. hospitals received DSH payments (Table 3-1).<sup>11</sup> States are allowed to make DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent, which is true of almost all U.S. hospitals.<sup>12</sup> Public teaching hospitals in urban settings received the largest share of total DSH funding. Half of all rural hospitals also received DSH payments, including many critical access hospitals, which

receive a special payment designation from Medicare because they are small and often the only provider in their geographic area. Many states also make DSH payments to institutions for mental diseases (IMDs), which historically have not been eligible for Medicaid payment for services provided to individuals age 21–64, but are eligible for DSH funding.<sup>13</sup> In SPRY 2014, Maine made DSH payments exclusively to IMDs, and four states (Alaska, Connecticut, Maryland, and North Dakota) spent more than half of their DSH allotments on DSH payments to IMDs.<sup>14</sup>

**TABLE 3-1.** Distribution of DSH Spending by Hospital Characteristics, SPRY 2014 **T 3-1**

Hospital characteristics	Number and share of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as percentage of all hospitals in category	
<b>Total</b>	<b>2,714</b>	<b>5,969</b>	<b>45%</b>	<b>\$17,745</b>
<b>Hospital type</b>				
Short-term acute care hospital	1,887	3,307	57	<b>14,618</b>
Critical access hospital	591	1,339	44	<b>378</b>
Psychiatric hospital	134	547	24	<b>2,401</b>
Long-term care hospital	24	416	6	<b>45</b>
Rehabilitation hospital	31	271	11	<b>7</b>
Children's hospital	47	89	53	<b>296</b>
<b>Urban or rural</b>				
Urban	1,457	3,503	42	<b>15,940</b>
Rural	1,257	2,466	51	<b>1,805</b>
<b>Hospital ownership</b>				
For-profit	436	1,791	24	<b>1,235</b>
Non-profit	1,562	2,931	53	<b>5,466</b>
Public	716	1,247	57	<b>11,044</b>
<b>Teaching status</b>				
Non-teaching hospital	1,901	4,779	40	<b>4,747</b>
Low-teaching hospital	462	737	63	<b>2,737</b>
High-teaching hospital	351	453	77	<b>10,262</b>
<b>Deemed DSH status</b>				
Deemed	832	832	100	<b>12,350</b>
Not deemed	1,882	5,137	37	<b>5,396</b>

**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. Excludes 111 DSH hospitals that did not submit a 2016 Medicare cost report. Low-teaching hospitals have an intern-and-resident-to-bed ratio (IRB) of less than 0.25 and high-teaching hospitals have an IRB equal to or greater than 0.25. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Total DSH spending includes state and federal funds.

**Source:** MACPAC, 2019, analysis of 2016 Medicare cost reports and SPRY 2014 as-filed Medicaid DSH audits.

As noted above, states are statutorily required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid-enrolled and low-income patients. In SPRY 2014, about 14 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just under one-third (31 percent) of DSH hospitals but accounted for more than two-thirds (70 percent) of all DSH payments, receiving \$12.4 billion in DSH payments.

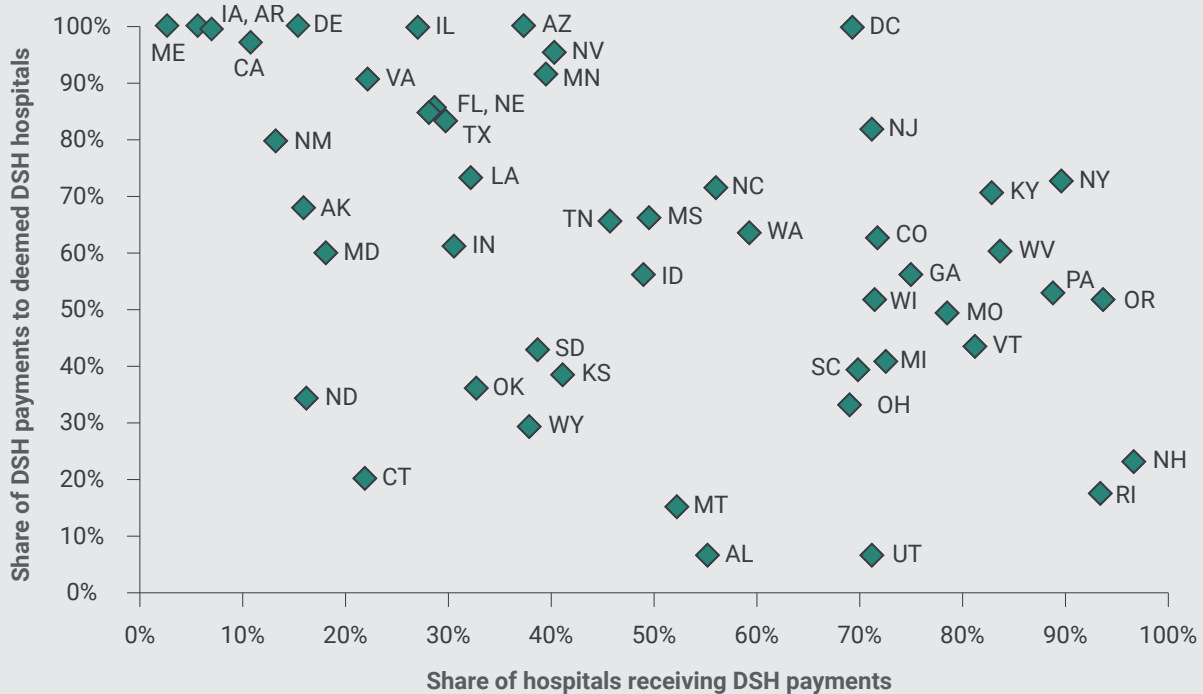
Deemed DSH hospitals accounted for about half (52 percent) of all uncompensated care reported for DSH hospitals in SPRY 2014. States vary in how they distribute DSH payments to deemed DSH hospitals, from less than 10 percent of payments in two states (Alabama and Utah) to 100 percent in six states (Arkansas, Arizona, Delaware, Illinois, Iowa, and Maine) and the District of Columbia.

State DSH targeting policies are difficult to categorize. States that concentrate DSH payments among a small number of hospitals do not necessarily make the largest share of payments to deemed DSH hospitals (e.g., North Dakota); conversely, some states that distribute DSH payments across most hospitals still target the largest share of DSH payments to those that are deemed DSH hospitals (e.g., New York) (Figure 3-2). States' criteria for identifying eligible DSH hospitals and how much funding they receive vary, but are often related to hospital ownership, hospital type, and geographic factors. The methods states use to finance the non-federal share of DSH payments may also affect their DSH targeting policies.<sup>15</sup> More

information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017a).

State DSH policies change frequently, often as a function of state budgets; the amounts paid to hospitals are more likely to change than the types of hospitals receiving payments. About 9 in 10 of the hospitals that received DSH payments in SPRY 2014 also received DSH payments in SPRY 2013. But about one-quarter of hospitals receiving DSH payments in both SPRY 2013 and SPRY 2014 reported that the amount they received in SPRY 2014 differed (either increased or decreased) from the amount they received in SPRY 2013 by more than 50 percent.

**FIGURE 3-2.** Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2014



**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. The share of DSH payments to deemed DSH hospitals shown does not account for provider contributions to the non-federal share; these contributions may reduce net payments. Analysis excludes Massachusetts, which does not make DSH payments to hospitals because its Section 1115 demonstration allows the state to use all of its DSH funding for the state's safety-net care pool instead, and Hawaii, which did not make DSH payments in SPRY 2014.

**Source:** MACPAC, 2019, analysis of 2016 Medicare cost reports and SPRY 2014 as-filed Medicaid DSH audits.



## Changes in the Number of Uninsured Individuals

According to the Current Population Survey, 28.5 million people, or 8.8 percent of the U.S. population, were uninsured in 2017, which is not statistically different from 2016 (28.1 million, 8.8 percent) (Berchick et al. 2018).<sup>16</sup> This number does not include individuals who were uninsured for part of the year.<sup>17</sup>

The number of uninsured individuals in the United States in 2017 (28.5 million) represented a decline of 13.3 million from the number reported in 2013 (41.8 million), a 32 percent decrease. The decline in the number of uninsured individuals reflects increases in both private and publicly funded health insurance coverage. From 2013 to 2017, the share of the U.S. population with private coverage at some point in the year (including individual insurance purchased through a health insurance exchange) increased 3.0 percentage points to 67.2 percent, and the share of the population covered at some point in the year by publicly funded coverage (including Medicaid) increased 3.2 percentage points to 37.7 percent (Berchick et al. 2018).<sup>18</sup>

In 2017, most uninsured individuals were low-income adults. About one-quarter (24 percent) of uninsured individuals had family incomes below 100 percent of the federal poverty level (FPL) and almost half (49 percent) had family incomes below 200 percent FPL. Compared to states that did not expand Medicaid, states that expanded Medicaid had lower uninsured rates not only for individuals with family incomes at or below 138 percent FPL, but also for individuals at higher family income levels (Berchick et al. 2018).

The uninsured rate declined in all states between 2013 and 2017, and states that expanded Medicaid had larger declines (5.8 percentage points) than those that did not (4.2 percentage points), according to the American Community Survey. Louisiana, which expanded its Medicaid program in July 2016, had a 1.9 percentage point decrease in its uninsured rate between 2016 and 2017, the largest state decline in that period (Berchick et al. 2018).

Looking ahead, the number of uninsured individuals is expected to increase as the population grows, policies change, and the year-over-year effects of the ACA coverage expansions diminish. For example, in September 2018, the Congressional Budget Office (CBO) estimated that between 2018 and 2019, the number of uninsured individuals will increase by 3 million (CBO 2018a).

CBO's projections incorporate estimates of the effects of new regulations to promote the use of association health plans and short-term, limited duration insurance plans (EBSA 2018, IRS et al. 2018). These regulations are expected to decrease the number of uninsured individuals. However, some individuals purchasing short-term, limited duration insurance plans are expected to have coverage that does not meet CBO's minimum definition of health insurance.<sup>19</sup>

CBO's estimates do not include the potential effects of a proposed rule issued by the U.S. Department of Homeland Security that would change the definition of public charge for purposes of immigration status. The Kaiser Family Foundation estimates that if this rule is implemented, 2.1 million to 4.9 million enrollees in Medicaid and the State Children's Health Insurance Program who have at least one non-citizen in their families will disenroll from the programs (Artiga et al. 2018).<sup>20</sup>

## Changes in the Amount of Hospital Uncompensated Care

In considering changes in the amount of uncompensated care, it is important to note that DSH payments cover both unpaid costs of care for uninsured individuals and Medicaid shortfall. Since the implementation of the ACA coverage expansions in 2014, unpaid costs of care for uninsured individuals have declined substantially, particularly in states that have expanded Medicaid. However, as the number of Medicaid enrollees has increased, Medicaid shortfall has also increased.

Definitions of uncompensated care vary among data sources, complicating comparisons and our ability to fully understand effects at the hospital level (Box 3-2). The most recently available data on hospital uncompensated care for all hospitals comes from Medicare cost reports, which define uncompensated care as charity care and bad debt. However, Medicare cost reports do not include reliable information on Medicaid shortfall, the difference between a hospital's costs of care for Medicaid-enrolled patients and the total payments it receives for those services. Medicaid DSH audits include data on both Medicaid shortfall and unpaid costs of care for uninsured individuals for DSH hospitals, but these data are not published until about five years after DSH payments are made.<sup>21</sup>

Below, we review the most recent uncompensated care data available for all hospitals in 2016 and new data from Medicaid DSH audits that shed light on changes in uncompensated care costs incurred by DSH hospitals between SPRY 2013 and SPRY 2014. Because DSH audit data are used for making Medicaid DSH payments, they are more accurate and better aligned with Medicaid DSH definitions than other data sources.

## Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of \$35.0 billion in charity care and bad debt in 2016, which was 3.6 percent of hospital operating expenses. These total costs of hospital uncompensated care for 2016 represented a decline from 2015 of \$3.1 billion, or 8 percent. The states that expanded Medicaid in 2016 (Montana and Louisiana) reported a 38 percent decline from 2015.

Due to recent changes in Medicare cost report instructions, uncompensated care reported on 2016 Medicare cost reports cannot be compared with 2013 data.<sup>22</sup> Previously, MACPAC found that charity care and bad debt reported on Medicare costs reports had declined \$8.6 billion (23 percent) between 2013 and 2015 (MACPAC 2018a).

Hospitals have retroactively adjusted their 2015 cost reports to comply with new definitions, but they are not required to update uncompensated care data from 2013.<sup>23</sup>

As a share of hospital operating expenses, charity care and bad debt varied widely by state in 2016 (Figure 3-3). In the aggregate, hospitals in states that expanded Medicaid under the ACA before December 31, 2016 reported uncompensated care that was less than half of what was reported in non-expansion states (2.3 percent of hospital operating expenses in Medicaid expansion states versus 6.0 percent in states that did not expand Medicaid).

Uncompensated care reported on Medicare cost reports includes the costs of care provided to both uninsured individuals and patients with insurance who cannot pay deductibles, co-payments, or coinsurance. In 2016, about 43 percent of uncompensated care reported was for charity care for uninsured individuals (\$15.1 billion), 16 percent was charity care for insured individuals (\$5.7 billion), and 40 percent was for bad debt expenses for both insured and uninsured individuals (\$14.2 billion).<sup>24</sup> Uncompensated care for uninsured individuals is largely affected by the uninsured rate while uncompensated care for patients with insurance is affected by specific features of their health insurance, such as deductibles and other forms of cost sharing. When patients cannot pay cost sharing, these costs often become bad debt expenses for hospitals. In 2016, the share of private-sector enrollees in high-deductible health plans was 46.5 percent, up from 11.4 percent in 2006 (Miller et al. 2018).

## Medicaid shortfall

According to the AHA annual survey, Medicaid shortfall in 2016 for all U.S. hospitals totaled \$20.0 billion, an increase of \$3.8 billion from 2015. The aggregate Medicaid payment-to-cost ratio reported on the AHA survey was 88 percent in 2016, a decline from the 90 percent payment-to-cost ratio reported in 2015 (AHA 2017, 2016).

## BOX 3-2. Data Sources and Definitions of Uncompensated Care Costs

### Data Sources

**American Hospital Association (AHA) annual survey.** An annual survey of hospital finances that provides aggregated national estimates of uncompensated care for community hospitals.

**Medicare cost report.** An annual report on hospital finances that must be submitted by all hospitals that receive Medicare payments (that is, most U.S. hospitals with the exception of some freestanding children's hospitals). Medicare cost reports define hospital uncompensated care as bad debt and charity care.

**Medicaid disproportionate share hospital (DSH) audit.** A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-five percent of U.S. hospitals were included on DSH audits in 2014, the latest year for which data are available.

### Definitions

#### Medicare cost report components of uncompensated care

**Charity care.** Health care services for which a hospital determines the patient does not have the capacity to pay and, based on its charity care policy, either does not charge the patient at all for the services or charges the patient a discounted rate below the hospital's cost of delivering the care. Charity care costs cannot exceed a hospital's cost of delivering the care.

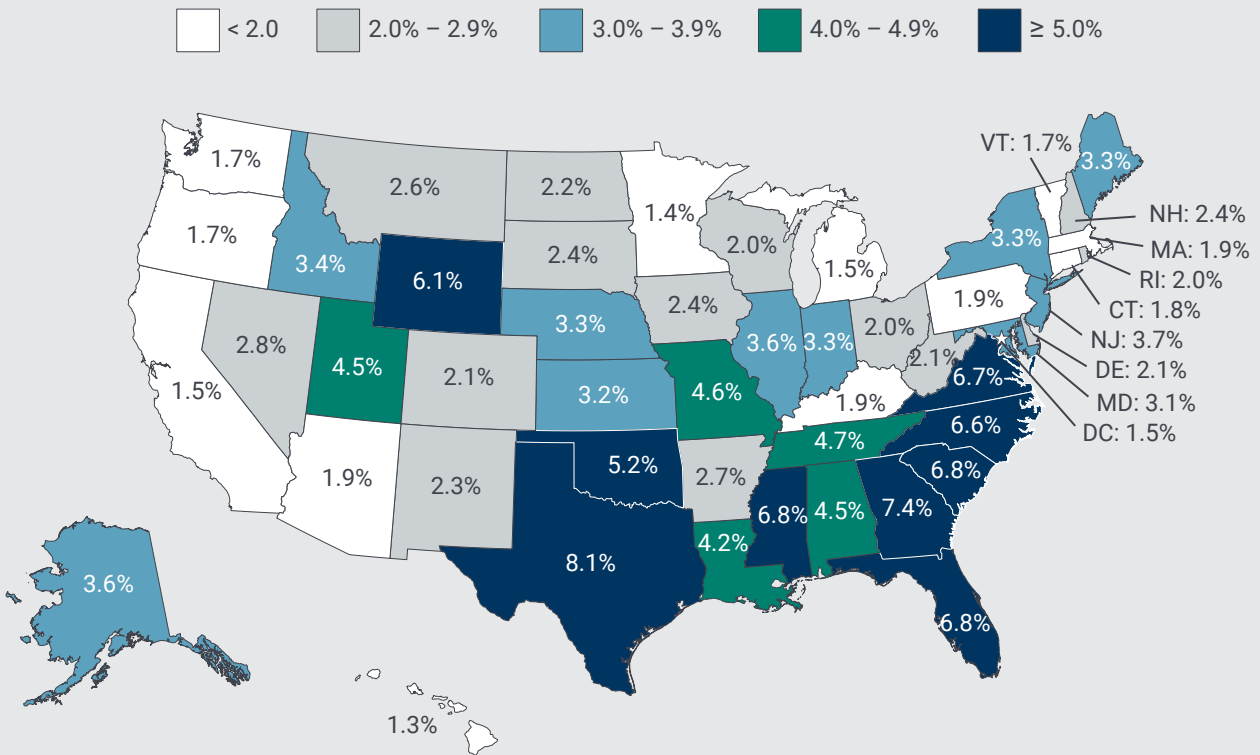
**Bad debt.** Expected payment amounts that a hospital is not able to collect from patients who are determined to have the financial capacity to pay according to the hospital's charity care policy.

#### Medicaid DSH audit components of uncompensated care

**Unpaid costs of care for uninsured individuals.** The difference between a hospital's costs of providing services to individuals without health coverage and the total amount of payment received for those services. This includes charity care and bad debt for individuals without health coverage and generally excludes charity care and bad debt for individuals with health coverage.

**Medicaid shortfall.** The difference between a hospital's costs of providing services to Medicaid-enrolled patients and the total amount of Medicaid payment received for those services (under both fee-for-service and managed care, excluding DSH payments but including other types of supplemental payments). Costs for patients dually eligible for Medicaid and other coverage (such as Medicare) are included, and costs for physician services and other care that does not meet the definition of inpatient and outpatient hospital services are excluded.

**FIGURE 3-3.** Charity Care and Bad Debt as a Share of Hospital Operating Expenses, 2016



Source: MACPAC, 2019, analysis of 2016 Medicare cost reports.

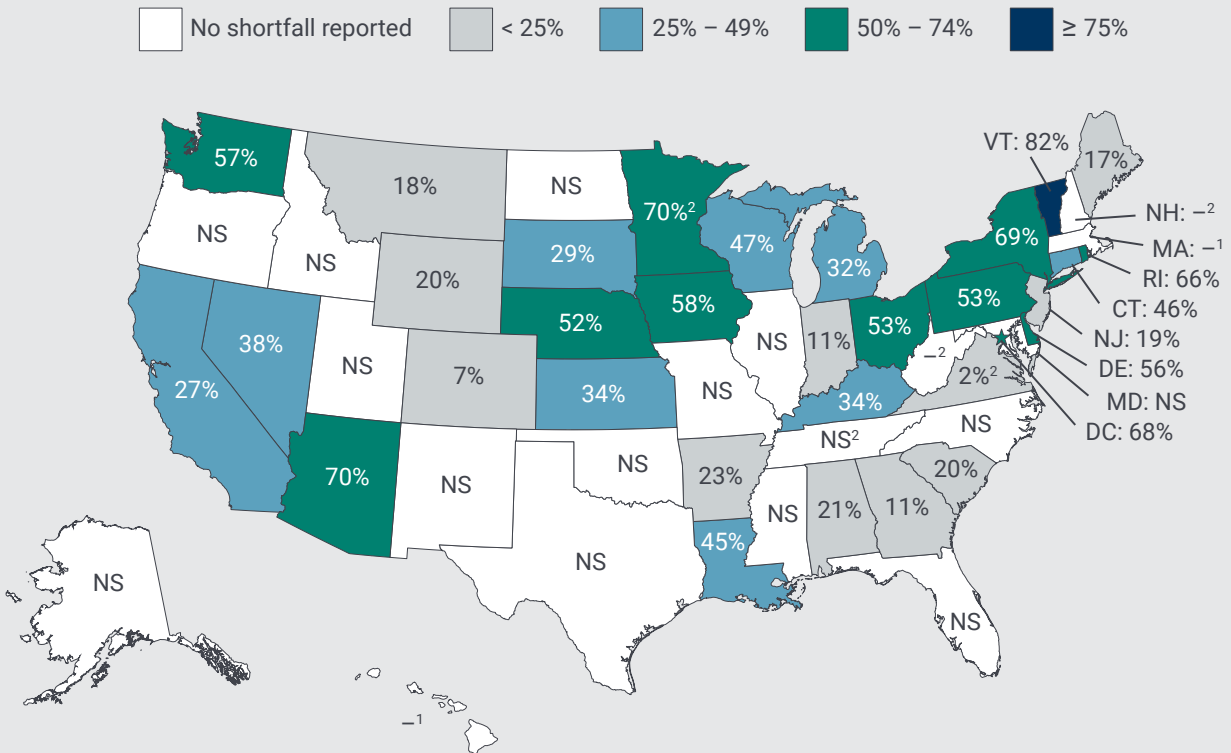
In contrast to the AHA survey, which provides data for all U.S. hospitals, Medicaid DSH audits provide data on Medicaid shortfall for the subset of hospitals that receive Medicaid DSH payments (45 percent of U.S. hospitals in SPRY 2014).<sup>25</sup> In SPRY 2014, DSH hospitals reported a total of \$11.8 billion in Medicaid shortfall and an aggregate Medicaid payment-to-cost ratio of 91 percent before DSH payments.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 3-4). In SPRY 2014, 15 states reported no Medicaid shortfall for DSH hospitals and 11 states and the District of Columbia reported shortfall that exceeded 50 percent of total DSH hospital uncompensated care. There is also wide variation in Medicaid payment-to-cost ratios

for DSH hospitals. Before DSH payments, Medicaid payments to DSH hospitals ranged from 70 percent of costs in Arizona to 119 percent of costs in Utah in SPRY 2014.<sup>26</sup> Complete state-by-state data on Medicaid payments to DSH hospitals as a share of costs for Medicaid-enrolled and uninsured patients is provided in Appendix 3A.

Aggregate data on Medicaid shortfall for DSH hospitals may not reflect the experience of all hospitals in a state because Medicaid payment rates vary by hospital and because the net payment that a hospital receives may be lower than the total payment reported on DSH audits. For example, in the aggregate, DSH hospitals in Mississippi did not report a Medicaid shortfall in SPRY 2014, but 38 of the 58 hospitals that received DSH payments reported

**FIGURE 3-4. Medicaid Shortfall as a Share of Total Uncompensated Care Costs for DSH Hospitals, SPRY 2014**



**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. NS is no shortfall reported.

– Dash indicates no data available.

<sup>1</sup> Hawaii and Massachusetts did not submit SPRY 2014 DSH audits because they did not make any DSH payments in SPRY 2014.

<sup>2</sup> Analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall (2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia).

**Source:** MACPAC, 2019, analysis of as-filed SPRY 2014 DSH audit data.

Medicaid shortfall in that year.<sup>27</sup> Moreover, Mississippi finances DSH payments with provider taxes, and stakeholders report that net Medicaid payments to hospitals in the state are below costs after adding the costs of these taxes (Marks et al. 2018).

As a result of recent litigation, some states are changing how they report Medicaid shortfall on DSH audits, which will affect the amount of Medicaid shortfall reported in future years. Specifically, hospitals have challenged CMS’s policy of requiring

states to subtract payments from third-party payers (e.g., Medicare and private insurance) when calculating Medicaid shortfall for Medicaid-eligible patients with third-party coverage.<sup>28</sup> In March 2018, the U.S. District Court of the District of Columbia ruled against CMS on this issue.<sup>29</sup> CMS has appealed the decision, but in December 2018, CMS withdrew its prior subregulatory guidance on this issue and noted that it would not be enforcing its prior policy while the March 2018 decision is operative in its current form (CMS 2018b).

## Changes in uncompensated care for DSH hospitals between SPRY 2013 and SPRY 2014

To examine the effects of the ACA coverage expansions, we reviewed uncompensated care costs reported for the subset of 2,441 hospitals that were included in DSH audits for both SPRY 2013 and SPRY 2014; this subset accounts for 86 percent of the 2,825 hospitals that were included in DSH audits for SPRY 2014 alone.<sup>30</sup> These data do not reflect the full effects of coverage expansions, because SPRY 2014 ended on June 30, 2014 for most states.<sup>31</sup>

For hospitals in this subset, the increase in Medicaid shortfall (\$4.0 billion) from SPRY 2013 to SPRY 2014 was larger than the decline in unpaid costs of care for uninsured individuals (\$1.6 billion) in the same period (Table 3-2). Increases in total DSH hospital uncompensated care were reported in both expansion and non-expansion states. The total amount of Medicaid shortfall increased more in expansion states than in non-expansion states from SPRY 2013 to SPRY 2014, but the percentage change was larger in non-expansion states because DSH hospitals in these states reported less shortfall in SPRY 2013.

In contrast, other national data for all hospitals suggest that uncompensated care has declined as a result of the ACA coverage expansions, even after accounting for the increase in Medicaid shortfall. Specifically, on Medicare cost reports, hospitals reported a \$5.7 billion decrease in charity care and bad debt between 2013 and 2014, which was larger than the \$0.9 billion increase in Medicaid shortfall reported on the AHA annual survey for those years.

Below, we examine potential reasons for the observed differences in the effects of the ACA coverage expansions on unpaid costs of care for uninsured individuals and Medicaid shortfall, compare the SPRY 2013–2014 data to prior years, and examine state variation in the amount of reported Medicaid shortfall for DSH hospitals.

### Unpaid costs of care for uninsured individuals.

The smaller decline in unpaid costs of care reported on DSH audits compared to Medicare cost reports can largely be explained by the fact that SPRY 2014 DSH audits include only half a year of ACA coverage expansions and about half of all U.S. hospitals. For example, the matching DSH hospitals included in our analysis reported a \$3.8 billion decline in charity care and bad debt from calendar year 2013 to calendar year 2014, but they reported a \$1.6 billion decline in

**TABLE 3-2. Uncompensated Care for DSH Hospitals, SPRYs 2013–2014 (billions)** T 3-2

Medicaid expansion status as of June 30, 2014	Unpaid costs of care for uninsured individuals				Medicaid shortfall			
	SPRY 2013	SPRY 2014	Difference (2014 less 2013)	Percent change	SPRY 2013	SPRY 2014	Difference (2014 less 2013)	Percent change
<b>All states</b>	<b>\$24.7</b>	<b>\$23.0</b>	<b>-\$1.6</b>	<b>-7%</b>	<b>\$6.4</b>	<b>\$10.4</b>	<b>\$4.0</b>	<b>62%</b>
Expansion states	11.5	9.3	-2.2	-19	6.1	8.2	2.2	36
Non-expansion states	13.1	13.7	0.6	5	0.3	2.1	1.8	546

**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. Analysis limited to 2,441 hospitals that received DSH payments in both SPRY 2013 and SPRY 2014 that provided complete information necessary to calculate Medicaid shortfall. Analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall (2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia). All Medicaid expansion states in this analysis expanded Medicaid on January 1, 2014, except for Michigan, which expanded Medicaid on March 1, 2014. Numbers do not sum due to rounding.

**Source:** MACPAC, 2019, analysis of 2016 Medicare cost reports and SPRY 2013 and SPRY 2014 as-filed Medicaid DSH audits.

those unpaid costs of care for uninsured individuals on DSH audits from SPRY 2013 to SPRY 2014.<sup>32</sup>

**Medicaid shortfall.** Overall, Medicaid shortfall appears to be increasing because Medicaid payments are not increasing at the same rate as Medicaid costs (Table 3-3). Total base payments increased in expansion states, presumably because of increased Medicaid enrollment; and in both expansion and non-expansion states, the amount of non-DSH supplemental payments was largely unchanged.<sup>33</sup> However, total Medicaid payments increased at a slower rate than Medicaid costs in both expansion and non-expansion states, thus increasing the amount of shortfall reported. Medicaid costs are affected by several different factors, such as Medicaid enrollment, changes in the intensity and mix of services, and inflation, but these components are not separately identified on DSH audits (Box 3-3).

**Comparison to prior years.** To better understand whether the variation that we observed between SPRY 2013 and SPRY 2014 is a result of ACA coverage expansions, we also compared uncompensated care reported on DSH audits

between SPRY 2012 and SPRY 2013 for hospitals that received DSH payments in all three years (Table 3-4).<sup>34</sup> Between SPRY 2012 and SPRY 2013, Medicaid payments for these hospitals increased at a faster rate than Medicaid costs, resulting in a decrease in Medicaid shortfall. However, between SPRY 2013 and SPRY 2014, Medicaid costs increased at a faster rate than Medicaid payments, thus increasing Medicaid shortfall for these hospitals.

## Hospitals with High Levels of Uncompensated Care That Also Provide Essential Community Services

MACPAC is required to provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services. Given that the concept of essential community services is not defined elsewhere in Medicaid statute or regulation, MACPAC has developed a working definition based on the types of services suggested in the statutory provision

**TABLE 3-3.** Components of Medicaid Shortfall Reported on DSH Audits by State Expansion Status, SPRYs 2013–2014 (billions) **T 3-3**

Category	Expansion states			Non-expansion states			All states		
	SPRY 2013	SPRY 2014	Percent change	SPRY 2013	SPRY 2014	Percent change	SPRY 2013	SPRY 2014	Percent change
Base payments	\$47.8	\$53.1	11%	\$38.8	\$39.5	2%	\$86.6	\$92.6	7%
Non-DSH supplemental payments	6.0	6.0	0	7.2	7.2	-1	13.3	13.2	0
<b>Total Medicaid payments</b>	<b>\$53.9</b>	<b>\$59.1</b>	<b>10%</b>	<b>\$46.0</b>	<b>\$46.7</b>	<b>2%</b>	<b>\$99.9</b>	<b>\$105.8</b>	<b>6%</b>
Medicaid costs	59.9	67.4	12	46.4	48.9	5	106.3	116.2	9
<b>Medicaid shortfall</b>	<b>\$6.1</b>	<b>\$8.2</b>	<b>36%</b>	<b>\$0.3</b>	<b>\$2.1</b>	<b>546%</b>	<b>\$6.4</b>	<b>\$10.4</b>	<b>62%</b>

**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. Analysis limited to 2,441 hospitals that received DSH payments in both SPRY 2013 and SPRY 2014 that provided complete information necessary to calculate Medicaid shortfall. Analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall (2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia). All Medicaid expansion states in this analysis expanded Medicaid on January 1, 2014, except for Michigan, which expanded Medicaid on March 1, 2014

**Source:** MACPAC, 2019, analysis of SPRY 2013 and SPRY 2014 as-filed Medicaid DSH audits.

### BOX 3-3. Factors Affecting Medicaid Hospital Costs

The cost of hospital care for Medicaid enrollees is affected by the number of Medicaid enrollees using hospital care, the volume and intensity of services used, and unit costs. Below we examine each of these factors in more detail, including information about how these factors changed between 2013 and 2014.

**Number of enrollees.** Between 2013 and 2014, the number of Medicaid enrollees increased 9 percent (from 59.8 million to 65.1 million), and the number of Medicaid inpatient hospital admissions increased 8 percent (from 7.4 million admissions to 8.0 million) (MACPAC 2018b, AHRQ 2018a). Medicaid enrollment and Medicaid hospital admissions increased more in states that expanded Medicaid than those that did not (Nikpay et al. 2016).

**Volume and intensity of services used.** Uninsured individuals who gained Medicaid coverage as a result of ACA coverage expansions may have had pent-up demand that resulted in increased use of services immediately after being enrolled. For example, an Avalere Health study examining claims data for Medicaid expansion enrollees across nine state and plan combinations found that the enrollees' use of hospital care declined during the first year of coverage, resulting in lower average costs for expansion enrollees in the second half of 2014 than in the first half of 2014 (Avalere Health 2018).

**Unit costs.** The cost of care for a particular unit of service varies by hospital due to a range of market characteristics (e.g., costs of labor and technology) and hospital characteristics (e.g., productivity and efficiency). According to MACPAC's analysis of data from the Healthcare Cost and Utilization Project, between 2013 and 2014, the average cost per hospital stay nationally increased 1.5 percent, which was the same as the change in the Consumer Price Index for All Urban Consumers during that period (AHRQ 2018b).

**TABLE 3-4.** Percent Change in Components of Uncompensated Care for DSH Hospitals, SPRYs 2012–2014 T 3-4

Components of uncompensated care	SPRYs 2012–2013	SPRYs 2013–2014
Unpaid costs of care for uninsured individuals	2.1%	-6.3%
Medicaid costs	6.2	10.2
Medicaid payments (base and non-DSH supplemental payments)	7.0	7.0
Medicaid shortfall (Medicaid costs minus Medicaid payments)	-5.6	61.4

**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. Analysis limited to 2,295 hospitals that received DSH payments in SPRYs 2012, 2013, and 2014. Analysis excludes 87 DSH hospitals in that did not include payments from third-party payers when calculating Medicaid shortfall (2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia).

**Source:** MACPAC, 2019, analysis of SPRY 2012, SPRY 2013, and SPRY 2014 as-filed Medicaid DSH audits.



calling for MACPAC's study and the limits of available data (Box 3-4). In Chapter 3 of MACPAC's March 2017 report, the Commission analyzed other criteria that could be used to identify hospitals that should receive DSH payments (MACPAC 2017a).

Using data from 2016 Medicare cost reports and the 2016 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2014, 91 percent provided at least one of the services included in MACPAC's working definition of essential community services, 73 percent provided two of these services, and 59 percent provided

three or more of these services. By contrast, among non-deemed hospitals, 44 percent provided three or more of these services.

### Hospital systems

To examine the continuum of services that hospitals provide, it is necessary to consider services provided by the larger health systems in which hospitals operate. For example, of the 2,472 hospitals that reported providing primary care services in the 2016 AHA annual survey (41 percent

#### **BOX 3-4. Identifying Hospitals with High Levels of Uncompensated Care That Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations**

The statute requires that MACPAC provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services. Based on the types of services suggested in the statute and the limits of available data, we included the following services in our working definition of essential community services in this report:

- burn services;
- dental services;
- graduate medical education;
- HIV/AIDS care;
- inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital);
- neonatal intensive care units;
- obstetrics and gynecology services;
- primary care services;
- substance use disorder services; and
- trauma services.

We also included deemed DSH hospitals that were designated as critical access hospitals because they are often the only hospital in their geographic area. See Appendix 3B for further discussion of our methodology and its limitations.

of all hospitals), one-quarter provided access to primary care outside of the hospital setting, either through clinics owned by the larger system or those that contracted directly with the hospital.

In 2016, 69.7 percent of U.S. hospitals were part of health systems, and hospitals within these health systems accounted for 91.6 percent of all U.S. hospital discharges. One-third of all U.S. hospitals (33.8 percent) were part of health systems that included hospitals in multiple states. Of the 626 health systems identified by the Agency for Healthcare Research and Quality, 255 (41 percent) included at least one deemed DSH hospital (AHRQ 2019).

Consistent with industry trends, many health systems provide primary and specialty care through arrangements with physician groups and other hospitals. Between 2007 and 2017, consolidation of physician practices by hospitals increased for all physician types, but was highest among medical and surgical specialty practices (Nikpay et al. 2018).

Compared to hospitals that do not have arrangements with physician groups, health systems may have more capacity to participate in value-based payment arrangements that aim to manage care provided outside of the hospital setting. Of the 68 hospitals that reported participating in a Medicaid accountable care organization in the 2016 AHA annual survey, 65 hospitals (96 percent) were part of health systems.

In December 2015, California received CMS approval for a Section 1115 demonstration to distribute DSH funding as a global payment to health systems that serve a high share of Medicaid and uninsured patients. The demonstration's interim evaluation found that health systems participating in this program expanded the availability of primary care services and other care outside the hospital setting during the first two years of the program (Timbie et al. 2018). A final evaluation for California's Global Payment Program is expected in the summer of 2019, and the Commission will continue to monitor these findings.

## Hospital margins

Hospitals that are part of multihospital health systems may be able to offset financial losses at one hospital with profits from other hospitals in the health system. For example, deemed DSH hospitals that were part of multihospital health systems reported negative aggregate operating margins of -0.6 percent in 2016, but all hospitals in these health systems reported positive aggregate operating margins of 2.1 percent in this period.

In 2016, aggregate hospital operating margins were 1.0 percent lower and aggregate total margins were 0.7 percent higher for all hospitals than in 2015. Many factors affect a hospital's margins, such as changes in the prices that a hospital can negotiate because of its competitive position in its market and changes in the hospital's costs (Bai and Anderson 2016). Additionally, margins are an imperfect measure of a hospital's financial health and may not be reported reliably on Medicare cost reports. Moreover, hospitals that are struggling financially might decide to cut unprofitable services, which would increase their margins in the short term, and hospitals that are doing well financially might make additional investments, which could decrease their margins in the short term.

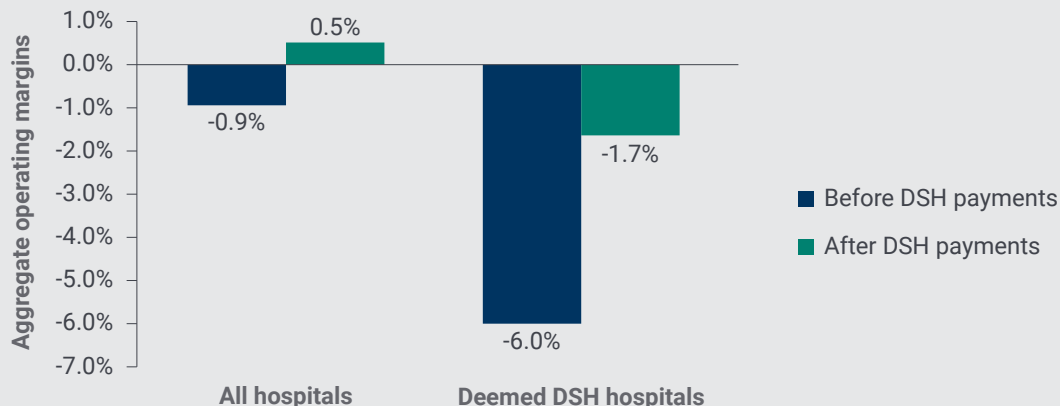
## DSH Allotment Reductions

Under current law, DSH allotments are scheduled to be reduced by the following annual amounts:

- \$4.0 billion in FY 2020;
- \$8.0 billion in FY 2021;
- \$8.0 billion in FY 2022;
- \$8.0 billion in FY 2023;
- \$8.0 billion in FY 2024; and
- \$8.0 billion in FY 2025.

DSH allotment reductions are applied against unreduced DSH allotments; that is, the amount that

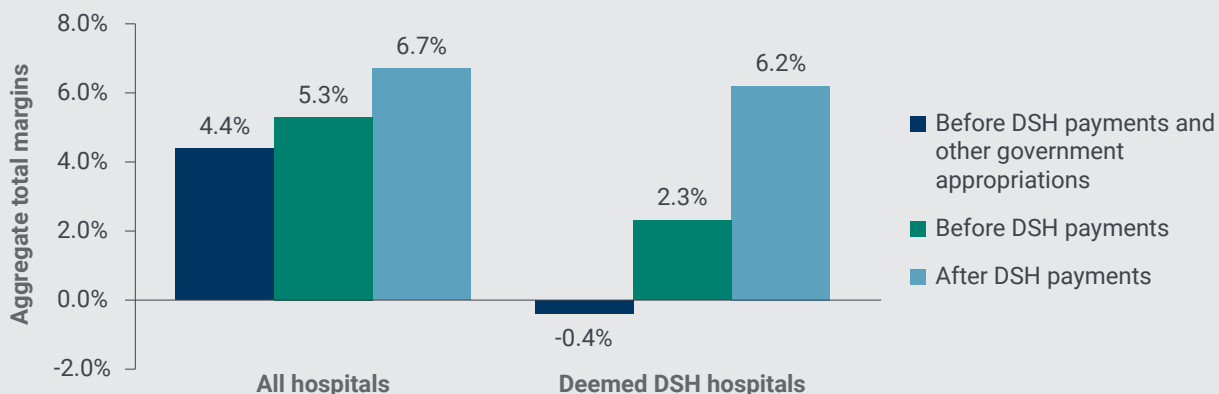
**FIGURE 3-5.** Aggregate Hospital Operating Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, 2016



**Notes:** DSH is disproportionate share hospital. Operating margins measure income from patient care divided by net patient revenue. Operating margins before DSH payments in 2016 were estimated using state plan rate year (SPRY) 2014 DSH audit data. Analysis excluded outlier hospitals reporting operating margins greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of this methodology and limitations, see Appendix 3B.

**Source:** MACPAC, 2019, analysis of 2016 Medicare cost reports and SPRY 2014 DSH audit data.

**FIGURE 3-6.** Aggregate Hospital Total Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, 2016



**Notes:** DSH is disproportionate share hospital. Total margins include revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state and local subsidies to hospitals. Total margins before DSH payments in 2016 were estimated using state plan rate year (SPRY) 2014 DSH audit data. Other government appropriations include state or local subsidies to hospitals that are not Medicaid payments. Analysis excluded outlier hospitals reporting total margins greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of this methodology and limitations, see Appendix 3B.

**Source:** MACPAC, 2019, analysis of 2016 Medicare cost reports and SPRY 2014 DSH audit data.

states would have received without DSH allotment reductions. In FY 2020, DSH allotment reductions amount to 31 percent of states' unreduced DSH allotment amounts; by FY 2025, DSH allotment reductions will be equal to 55 percent of states' unreduced DSH allotments. In FY 2026 and beyond, there are no DSH allotments reductions scheduled. Thus, under current law, state DSH allotments would return to their higher, unreduced DSH allotment amounts in those years. Unreduced allotments increase each year based on inflation, and these inflation-based increases continue to apply even when DSH allotment reductions take effect.

Chapter 1 of this report provides the Commission's analyses and recommendations for restructuring DSH allotment reductions by phasing in reductions more gradually and changing the methodology for distributing reductions among states. Here, we examine DSH allotment reductions under current law, which MACPAC is statutorily required to report.

Current law requires CMS to develop a methodology for distributing DSH allotment reductions among states, referred to as the DSH Health Reform Reduction Methodology (DHRM), and directs CMS to use specific criteria, such as applying greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals (Box 3-5). In July 2017, CMS proposed changes to the DHRM for FY 2018 and subsequent years (CMS 2017b).

MACPAC provided comments on CMS's proposed DSH allotment reduction formula in August 2017 (MACPAC 2017b). Specifically, the Commission encouraged CMS to apply DSH allotment reductions to unspent DSH funding first, to minimize the effects of DSH allotment reductions on hospitals that are currently receiving DSH payments. MACPAC also analyzed the state-by-state effects of CMS's proposal to increase the relative weight of the uninsured percentage factor and provided technical comments on ways to improve the calculation of various factors in CMS's proposed methodology.

Although CMS may revise its methodology before making allotment reductions in FY 2020, we used the proposed methodology to estimate FY 2020 DSH allotment reductions below. In FY 2021 through FY 2025, the size of DSH allotment reductions will double from \$4 billion to \$8 billion, but the distribution of DSH allotment reductions among states is expected to be largely the same if states do not change their DSH targeting policies and if there are no changes in the rate of uninsurance across states.

We also compare FY 2018 DSH allotments to other factors, such as hospital uncompensated care costs. Complete state-by-state information on current DSH allotments and their relationship to the state-by-state data that Congress requested are provided in Appendix 3A.

## Reduced DSH allotments compared to unreduced DSH allotments

The \$4 billion in DSH allotment reductions scheduled to take effect in FY 2020 are projected to affect states differently, with estimated reductions ranging from 3.8 percent to 46.6 percent of unreduced allotment amounts (Figure 3-7). Because of the low-DSH factor, the projected percentage reduction in DSH allotments for the 17 states that meet the low-DSH criteria (8.9 percent in the aggregate) is less than one-third that of the other states (31.4 percent in the aggregate). Among states that do not meet the low-DSH criteria, the projected percentage reduction in DSH allotments is larger for states that expanded Medicaid (33.7 percent in the aggregate) than for states that did not expand Medicaid (27.1 percent in the aggregate).

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 15 states are projected to have FY 2020 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2016, which means that these states could continue to make the same amount of DSH payments in FY 2020 that they made in FY 2016.<sup>35</sup>

### **BOX 3-5. Factors Used in Disproportionate Share Hospital Health Reform Reduction Methodology**

The Disproportionate Share Hospital (DSH) Health Reform Reduction Methodology (DHRM) provides a model for calculating how DSH allotment reductions will be distributed across states. In July 2017, the Centers for Medicare & Medicaid Services (CMS) proposed changes to the DHRM, but as of this writing, the DHRM has not yet been finalized by CMS. As required by statute, the proposed DHRM applies five factors when calculating state DSH allotment reductions:

**Low-DSH factor.** Allocates a smaller proportion of the total DSH allotment reductions to low-DSH states based on the size of these states' DSH allotments relative to their total Medicaid expenditures. Low-DSH states are defined in statute as states with FY 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000. There are 17 low-DSH states, a number that includes Hawaii, whose eligibility as a low-DSH state is based on a special statutory exception (§§ 1923(f)(5) and 1923(f)(6) of the Social Security Act).

**Uninsured percentage factor.** Imposes larger DSH allotment reductions on states with lower uninsured rates relative to other states. One-half of DSH reductions are based on this factor.

**High volume of Medicaid inpatients factor.** Imposes larger DSH allotment reductions on states that do not target DSH payments to hospitals with high Medicaid volume. The proportion of a state's DSH payments made to hospitals with Medicaid inpatient utilization that is one standard deviation above the mean (the same criteria used to determine deemed DSH hospitals) is compared among states. One-quarter of DSH reductions are based on this factor.

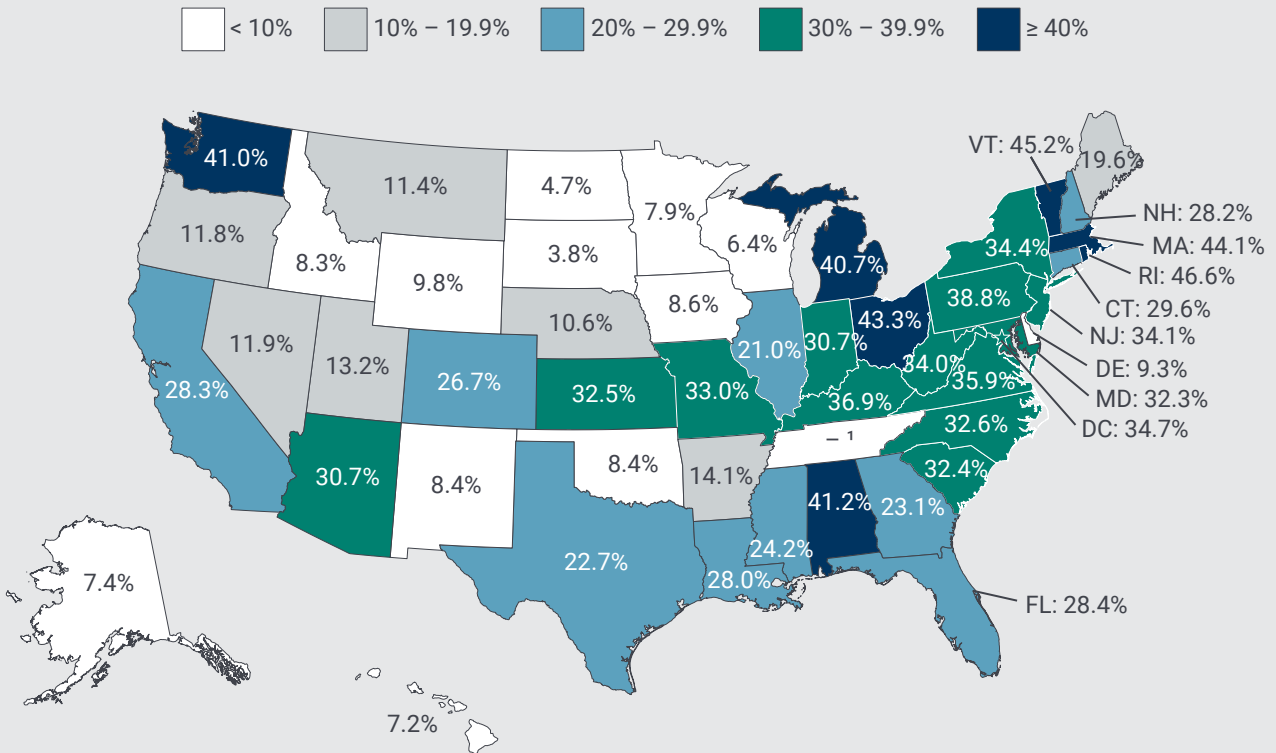
**High level of uncompensated care factor.** Imposes larger reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care. The proportion of a state's DSH payments made to hospitals with above-average uncompensated care as a proportion of total hospital costs is compared among states. This factor is calculated using DSH audit data, which defines uncompensated care costs as the sum of Medicaid shortfall and unpaid costs of care for uninsured individuals. One-quarter of DSH reductions are based on this factor.

**Budget neutrality factor.** An adjustment to the high Medicaid and high uncompensated care factors that accounts for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under Section 1115 waivers. (Four states—Indiana, Maine, Massachusetts, and Wisconsin—and the District of Columbia meet the statutory criteria for the budget neutrality factor.) Specifically, DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments were targeted to high Medicaid or high uncompensated care hospitals.

We do not know how states will respond to these reductions. As noted above, some states distribute DSH funding proportionally among eligible hospitals, while other states target DSH payments to particular hospitals. Thus, some states may apply reductions to all DSH hospitals in their states while

others may reduce DSH payments only to specific hospitals. Because the DHRM proposed by CMS applies larger reductions to states that do not target DSH funds to hospitals with high Medicaid volume or high levels of uncompensated care, states might change their DSH targeting policies to minimize

**FIGURE 3-7.** Decrease in State DSH Allotments as a Percentage of Unreduced Allotments, by State, FY 2020



**Notes:** DSH is disproportionate share hospital. FY is fiscal year.

<sup>1</sup> Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

**Source:** MACPAC, 2019, analysis of Census 2019, CBO 2018b, 2016 Medicare cost reports, and the CMS Medicaid Budget and Expenditure System.

their DSH allotment reductions in future years.<sup>36</sup> However, the DSH audit data used to calculate the DSH targeting factors in the DHRM have a substantial data lag of about four to five years.

### Relationship of DSH allotments to the statutorily required factors

As in our past reports, we find little meaningful relationship between current DSH allotments and the factors that Congress asked MACPAC to consider.

**Changes in number of uninsured individuals.** FY 2019 DSH allotments range from less than \$100 per uninsured individual in five states to more than

\$1,000 per uninsured individual in nine states. Nationally, the average FY 2019 DSH allotment per uninsured individual is \$451.

### Amount and sources of hospital uncompensated care costs.

As a share of hospital charity care and bad debt costs reported on 2016 Medicare cost reports, FY 2019 federal DSH allotments range from less than 10 percent in six states to more than 80 percent in six states. Nationally, FY 2019 federal DSH allotments are equal to 36 percent of hospital charity care and bad debt costs. At the state level, total FY 2018 DSH funding (including state and federal funds combined) exceeds reported hospital charity care and bad debt costs in 12

states. Because DSH payments to hospitals may not exceed total uncompensated care costs, states with DSH allotments larger than the amount of uncompensated care in their state may not be able to spend their full DSH allotment.<sup>37</sup>

**Number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.** Finally, there continues to be no meaningful relationship between state DSH allotments and the number of deemed DSH hospitals in the state that provided at least one of the services included in MACPAC’s working definition of essential community services.

## Next Steps

The analyses in this chapter underscore MACPAC’s prior findings that DSH allotments have little meaningful relationship to measures meant to identify those hospitals most in need. Although much of the variation in state DSH allotment amounts reflects the basis of these allotments in historic patterns of spending, we also find that CMS’s methodology for implementing DSH allotment reductions is projected to preserve most of this historical variation.

Chapter 1 of this report provides the Commission’s analyses and recommendations for restructuring the distribution of reductions among states to improve the relationship between DSH allotments and measures related to hospital uncompensated care costs. The chapter also provides recommendations for ways to phase in reductions more gradually to help mitigate disruption for states and providers.

In the coming year, the Commission will continue to examine other DSH policy issues as part of its broader examination of all types of Medicaid payments to hospitals. The Commission has long held that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-

enrolled and low-income uninsured patients and that have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH payments. However, development of policy to achieve this goal must be considered in terms of all Medicaid payments that hospitals receive.

## Endnotes

<sup>1</sup> The ACA gives states the option of expanding Medicaid to adults under age 65 with incomes at or below 138 percent of the federal poverty level (FPL).

<sup>2</sup> Specifically, CMS modified the definition of charity care to include uninsured discounts and changed the way that cost-to-charge ratios were applied on Medicare cost reports (CMS 2017a).

<sup>3</sup> On Medicare cost reports, hospitals reported a \$5.7 billion decrease in charity care and bad debt between 2013 and 2014, which was larger than the \$0.9 billion increase in Medicare shortfall reported on the AHA annual survey for those years. Unlike Medicaid DSH audits, these other data sources include both DSH and non-DSH hospitals. Also, definitions of uncompensated care differ among data sources, as discussed further in Box 3-2.

<sup>4</sup> At this writing, CMS has not yet finalized its methodology for distributing DSH allotment reductions so our analyses in this chapter reflect the methodology that CMS proposed in July 2017 (CMS 2017b).

<sup>5</sup> Medicaid fee-for-service payments for hospitals cannot exceed a reasonable estimate of what Medicare would have paid in the aggregate. DSH payments are not subject to this upper payment limit, but DSH payments to an individual hospital are limited to that hospital’s uncompensated care costs for Medicaid-enrolled and uninsured patients.

<sup>6</sup> Additional background information about the history of DSH payment policy is included in Chapter 1 and Appendix A of MACPAC’s first DSH report (MACPAC 2016).

<sup>7</sup> Total DSH spending includes an estimate of the portion of California’s Section 1115 waiver spending that is based on the state’s DSH allotment but excludes Massachusetts.

<sup>8</sup> The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) increased FY 2009 and FY 2010 DSH allotments to 102.5 percent of what they would have been without the law. Since FY 2011, DSH allotments have accounted for 3 percent to 4 percent of total Medicaid benefit spending. Medicaid benefit spending excludes Medicaid spending on state program administration.

<sup>9</sup> Analysis excludes unspent DSH funding that is reported for California and Massachusetts (\$1.2 billion total) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

<sup>10</sup> Medicare cost reports define uncompensated care as charity care and bad debt, including uncompensated care for individuals with insurance, which is not part of the Medicaid DSH definition of uncompensated care. Medicare cost reports do not include reliable information on Medicaid shortfall, which is part of the Medicaid DSH definition.

<sup>11</sup> States report hospital-specific DSH data on a SPRY basis, which often corresponds to the state fiscal year and may not align with the federal fiscal year.

<sup>12</sup> DSH hospitals are also required to have at least two obstetricians with staff privileges who will treat Medicaid enrollees (with certain exceptions for rural and children's hospitals).

<sup>13</sup> The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 (P.L. 115-271) provides a state option to cover services provided by an IMD for patients with substance use disorders in FYs 2020–2023. Under Medicaid managed care and Section 1115 waivers, states can also make payments for some services provided by an IMD to Medicaid enrollees age 21–64 (42 CFR 438.6(e)).

<sup>14</sup> 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 FY 1995 or 33 percent of the state's FY 1995 DSH allotment.

<sup>15</sup> In 2012, states that financed DSH payments with above-average levels of health care-related taxes distributed DSH payments to a proportion of hospitals in the state that was

about double the proportion of hospitals receiving DSH funding in states that financed DSH payments with lower levels of health care-related taxes. States that financed DSH payments with above-average levels of intergovernmental transfers or certified public expenditures distributed a higher share of total DSH spending to public hospitals—about double the share to public hospitals in states that financed DSH payments with lower levels of local government funding (MACPAC 2017a).

<sup>16</sup> The national estimates of the number of uninsured individuals cited in this chapter do not match the state-level estimates of the number of uninsured cited in Appendix 3A because of different data sources used. National estimates of the number of uninsured individuals come from the Current Population Survey, a monthly survey of households by the U.S. Census Bureau for the U.S. Bureau of Labor Statistics, which is the preferred source for national analyses. State-level data come from the American Community Survey, which has a larger sample size and is the preferred source for subnational analyses (Census 2017).

<sup>17</sup> There are a variety of ways to count the number of uninsured individuals. Estimates in this chapter reflect the number of people without health insurance for the entire calendar year.

<sup>18</sup> In the Current Population Survey, estimates of health insurance coverage are not mutually exclusive. People can be covered by more than one type of health insurance during the year.

<sup>19</sup> CBO broadly defines health insurance coverage as a policy that, at a minimum, covers high-cost medical events and various services, including physician and hospital services (CBO 2018a).

<sup>20</sup> Federal law states that the applications of individuals seeking admission to the United States or seeking to change their status to lawful permanent residents must be denied if, at any time, these individuals are likely to become public charges. Public charge has historically been defined as when an individual is primarily dependent on the government for subsistence. On October 10, 2018, the U.S. Department of Homeland Security proposed changing the definition of public charge to include individuals who receive one or more public benefits, including Medicaid (USCIS 2018).



<sup>21</sup> DSH audit data are not due until three years after DSH payments are made and they are not published until after CMS reviews the data for completeness (42 CFR 455.304).

<sup>22</sup> Specifically, CMS modified the definition of charity care to include uninsured discounts and changed the way that cost-to-charge ratios were applied on Medicare cost reports (CMS 2017a).

<sup>23</sup> As a result of retroactive changes to Medicare cost reports, the adjusted amount of uncompensated care reported by hospitals for 2015 under the new definitions was \$9 billion higher than had been reported under the prior definitions.

<sup>24</sup> Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2016 Medicare cost report data that we report in this chapter have not been audited, so bad debt and charity care costs may not be reported consistently for all hospitals. Beginning in the fall of 2018, CMS began to audit charity care and bad debt costs reported on Medicare cost reports (CMS 2018a).

<sup>25</sup> The AHA annual survey also differs from DSH audit data in its definition of Medicaid shortfall. Most notably, the AHA survey includes the costs of provider taxes, which are not included on DSH audits (Nelb et al. 2016).

<sup>26</sup> Analysis excludes New Hampshire and West Virginia, which used a different definition of Medicaid costs than other states in their SPRY 2014 DSH audits.

<sup>27</sup> An additional 55 hospitals in Mississippi are not included on the state's SPRY 2014 DSH audit because these hospitals did not receive DSH payments.

<sup>28</sup> Medicaid shortfall is the difference between a hospital's costs of providing care to Medicaid-eligible patients minus the payments that the hospital receives for those services. Because some Medicaid-eligible patients have third-party coverage (e.g., Medicare or private coverage), hospitals receive payments from both Medicaid and other payers for these patients. In 2010, CMS issued subregulatory guidance indicating that the costs of patients with third-party coverage should be included in DSH audits and the amount of third-party payments received for these patients should be subtracted when calculating Medicaid shortfall (CMS 2018b). For example, under CMS's policy, Medicaid shortfall for

patients dually eligible for Medicare and Medicaid would be the total hospital cost of treating the patient, less the amount that Medicare and Medicaid paid for the service provided.

<sup>29</sup> *Children's Hosp. of the King's Daughters, Inc. v. Azar*, 896 F.3d 615 (4th Cir. 2018).

<sup>30</sup> We excluded 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

<sup>31</sup> SPRYs are based on state fiscal years. Most state fiscal years end on June 30th, but in New York, the state fiscal year ends on March 31st; in Texas, the state fiscal year ends on August 31st; and in Michigan and Mississippi, the state fiscal year ends on September 30th.

<sup>32</sup> Change in charity care and bad debt for matching hospitals is based on data from cost reports available as of March 31, 2017, prior to CMS's change in instructions for how uncompensated care is reported.

<sup>33</sup> In general, Medicaid enrollment between 2013 and 2014 increased more in states that expanded Medicaid than in those that did not, but some states that did not expand Medicaid nevertheless saw increases in Medicaid enrollment in 2014 among individuals who were previously eligible for Medicaid. Although total base payments for DSH hospitals increased in Medicaid expansion states, we do not have data about how base payment rates changed.

<sup>34</sup> The subset of hospitals used to examine three-year trends in DSH hospital uncompensated care costs in Table 3-4 is smaller than the subset used in Tables 3-2 and 3-3 to examine the change in costs between SPRY 2013 and 2014, so the numbers in these tables do not match.

<sup>35</sup> For states to spend the same amount of DSH funding in FY 2020 as they spent in FY 2016, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs. Unspent DSH funds for a given year cannot be used for DSH expenditures for future years.

<sup>36</sup> Additional analyses of potential strategic state responses to the DSH allotment reduction methodology proposed by CMS are provided in Chapter 2 of MACPAC's 2016 DSH report (MACPAC 2016).

<sup>37</sup> For Medicaid DSH purposes, uncompensated care includes Medicaid shortfall, which is not included in the Medicare cost report definition of uncompensated care. As a result, the total amount of uncompensated care reported on Medicare cost reports may differ from the amount of uncompensated care costs states may be able to pay for with Medicaid DSH funds.

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## APPENDIX 3A: State-Level Data

**TABLE 3A-1.** State DSH Allotments, FYs 2019 and 2020 (millions) **T 3A-1**

State	FY 2019		FY 2020	
	Total (state and federal)	Federal	Total (state and federal)	Federal
<b>Total</b>	<b>\$22,281.1</b>	<b>\$12,627.6</b>	<b>\$15,738.0</b>	<b>\$8,935.3</b>
Alabama	492.4	353.9	296.6	213.2
Alaska	46.9	23.4	44.5	22.2
Arizona	166.9	116.5	118.6	82.8
Arkansas	70.4	49.7	62.0	43.7
California	2,523.5	1,261.7	1,854.7	927.4
Colorado	212.9	106.5	160.0	80.0
Connecticut	460.4	230.2	332.0	166.0
Delaware	18.1	10.4	16.8	9.7
District of Columbia	100.7	70.5	67.4	47.2
Florida	378.2	230.2	277.3	168.8
Georgia	457.4	309.3	360.4	243.7
Hawaii	20.8	11.2	19.8	10.7
Idaho	26.6	18.9	25.0	17.8
Illinois	491.9	247.5	398.2	200.4
Indiana	373.0	246.0	264.9	174.7
Iowa	75.6	45.3	70.8	42.5
Kansas	83.1	47.5	57.5	32.8
Kentucky	232.9	166.9	150.5	107.8
Louisiana	1,214.1	789.2	895.2	581.9
Maine	187.3	120.9	154.3	99.6
Maryland	175.5	87.8	121.7	60.8
Massachusetts	702.1	351.0	402.2	201.1
Michigan	473.2	305.0	287.4	185.2
Minnesota	171.9	86.0	162.3	81.2
Mississippi	229.8	175.5	178.5	136.3
Missouri	833.7	545.3	572.0	374.1
Montana	19.9	13.1	18.1	11.9
Nebraska	61.9	32.6	56.7	29.8
Nevada	82.1	53.2	74.1	48.0
New Hampshire	368.5	184.3	271.1	135.6
New Jersey	1,481.9	740.9	1,001.0	500.5
New Mexico	32.4	23.4	30.4	22.0
New York	3,697.5	1,848.7	2,484.4	1,242.2
North Carolina	505.6	339.5	349.2	234.5

**TABLE 3A-1.** (continued)

State	FY 2019		FY 2020	
	Total (state and federal)	Federal	Total (state and federal)	Federal
North Dakota	\$22.0	\$11.0	\$21.5	\$10.7
Ohio	741.1	467.6	430.4	271.5
Oklahoma	66.8	41.7	62.7	39.1
Oregon	83.3	52.1	75.3	47.1
Pennsylvania	1,236.3	646.0	775.4	405.2
Rhode Island	142.3	74.8	77.8	40.9
South Carolina	529.3	376.9	366.4	261.0
South Dakota	22.4	12.7	22.1	12.5
Tennessee	80.6	53.1	80.6	53.1
Texas	1,891.4	1,100.6	1,497.7	871.5
Utah	32.4	22.6	28.8	20.1
Vermont	48.1	25.9	27.0	14.5
Virginia	201.7	100.8	132.5	66.2
Washington	425.9	212.9	257.5	128.8
West Virginia	104.5	77.7	70.7	52.6
Wisconsin	183.3	108.8	175.8	104.4
Wyoming	0.5	0.3	0.5	0.2

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. Under current law, federal DSH allotments will be reduced by \$4 billion in FY 2020. DSH allotment estimates for FY 2020 are based on the DSH allotment reduction methodology that CMS proposed in July 2017; these estimates may change if CMS changes this methodology when it finalizes this DSH allotment reduction rule.

**Source:** MACPAC, 2019, analysis of Census 2019, CBO 2018b, 2016 Medicare cost reports, and the CMS Medicaid Budget and Expenditure System.

**TABLE 3A-2.** FY 2020 DSH Allotment Reductions, by State (millions) **T 3A-2**

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reduction in federal DSH allotments
<b>Total</b>	<b>\$22,824.3</b>	<b>\$12,935.3</b>	<b>\$7,086.3</b>	<b>\$4,000.0</b>	<b>30.9%</b>
Alabama	504.4	362.6	207.8	149.4	41.2
Alaska	48.0	24.0	3.6	1.8	7.4
Arizona	171.0	119.4	52.4	36.6	30.7
Arkansas	72.1	50.9	10.2	7.2	14.1
California	2,585.2	1,292.6	730.5	365.3	28.3
Colorado	218.1	109.1	58.2	29.1	26.7
Connecticut	471.7	235.8	139.6	69.8	29.6
Delaware	18.5	10.7	1.7	1.0	9.3
District of Columbia	103.2	72.2	35.8	25.0	34.7
Florida	387.4	235.8	110.1	67.0	28.4
Georgia	468.6	316.9	108.3	73.2	23.1
Hawaii	21.3	11.5	1.5	0.8	7.2
Idaho	27.2	19.4	2.3	1.6	8.3
Illinois	503.9	253.5	105.7	53.2	21.0
Indiana	382.1	252.0	117.2	77.3	30.7
Iowa	77.5	46.4	6.6	4.0	8.6
Kansas	85.2	48.6	27.7	15.8	32.5
Kentucky	238.6	171.0	88.1	63.1	36.9
Louisiana	1,243.8	808.5	348.7	226.6	28.0
Maine	191.9	123.8	37.6	24.3	19.6
Maryland	179.8	89.9	58.1	29.1	32.3
Massachusetts	719.3	359.6	317.1	158.6	44.1
Michigan	484.8	312.5	197.4	127.2	40.7
Minnesota	176.1	88.1	13.8	6.9	7.9
Mississippi	235.4	179.8	56.9	43.5	24.2
Missouri	854.1	558.6	282.2	184.5	33.0
Montana	20.4	13.4	2.3	1.5	11.4
Nebraska	63.5	33.4	6.7	3.5	10.6
Nevada	84.1	54.5	10.0	6.5	11.9
New Hampshire	377.6	188.8	106.4	53.2	28.2
New Jersey	1,518.1	759.1	517.2	258.6	34.1
New Mexico	33.2	24.0	2.8	2.0	8.4
New York	3,788.0	1,894.0	1,303.5	651.8	34.4
North Carolina	517.9	347.8	168.8	113.3	32.6

**TABLE 3A-2.** (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reduction in federal DSH allotments
North Dakota	<b>\$22.5</b>	\$11.3	<b>\$1.1</b>	\$0.5	4.7%
Ohio	<b>759.3</b>	479.0	<b>328.9</b>	207.5	43.3
Oklahoma	<b>68.5</b>	42.7	<b>5.8</b>	3.6	8.4
Oregon	<b>85.3</b>	53.4	<b>10.0</b>	6.3	11.8
Pennsylvania	<b>1,266.6</b>	661.8	<b>491.2</b>	256.6	38.8
Rhode Island	<b>145.8</b>	76.6	<b>68.0</b>	35.7	46.6
South Carolina	<b>542.2</b>	386.2	<b>175.8</b>	125.2	32.4
South Dakota	<b>23.0</b>	13.0	<b>0.9</b>	0.5	3.8
Tennessee <sup>1</sup>	<b>80.6</b>	53.1	–	–	–
Texas	<b>1,937.7</b>	1,127.5	<b>440.0</b>	256.0	22.7
Utah	<b>33.2</b>	23.1	<b>4.4</b>	3.1	13.2
Vermont	<b>49.2</b>	26.5	<b>22.2</b>	12.0	45.2
Virginia	<b>206.6</b>	103.3	<b>74.1</b>	37.1	35.9
Washington	<b>436.3</b>	218.1	<b>178.7</b>	89.4	41.0
West Virginia	<b>107.1</b>	79.6	<b>36.4</b>	27.0	34.0
Wisconsin	<b>187.7</b>	111.5	<b>12.0</b>	7.1	6.4
Wyoming	<b>0.5</b>	0.3	<b>0.1</b>	0.0	9.8

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. DSH allotment estimates for FY 2020 are based on the DSH allotment reduction methodology that CMS proposed in July 2017; these estimates may change if CMS changes this methodology when it finalizes this DSH allotment reduction rule.

– Dash indicates zero; 0.0 indicates a non-zero amount less than \$0.5 million.

<sup>1</sup> Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act).

**Source:** MACPAC, 2019, analysis of Census 2019, CBO 2018b, 2016 Medicare cost reports, and the CMS Medicaid Budget and Expenditure System.



**TABLE 3A-3.** Number of Uninsured Individuals and Uninsured Rate, by State, 2013–2017 **T 3A-3**

State	2013		2017		Difference in uninsured (2017-2013)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
<b>Total</b>	<b>45,181</b>	<b>14.5%</b>	<b>28,019</b>	<b>8.7%</b>	<b>-17,162</b>	<b>-5.8%</b>
Alabama	645	13.6	449	9.4	-196	-4.2
Alaska	132	18.5	98	13.7	-34	-4.8
Arizona	1,118	17.1	695	10.1	-423	-7.1
Arkansas	465	16.0	232	7.9	-233	-8.1
California	6,500	17.2	2,797	7.2	-3,703	-10.0
Colorado	729	14.1	414	7.5	-315	-6.6
Connecticut	333	9.4	194	5.5	-139	-3.9
Delaware	83	9.1	51	5.4	-32	-3.7
District of Columbia	42	6.7	26	3.8	-16	-2.8
Florida	3,853	20.0	2,676	12.9	-1,177	-7.1
Georgia	1,846	18.8	1,375	13.4	-471	-5.4
Hawaii	91	6.7	53	3.8	-38	-2.9
Idaho	257	16.2	172	10.1	-85	-6.0
Illinois	1,618	12.7	859	6.8	-759	-5.9
Indiana	903	14.0	536	8.2	-367	-5.8
Iowa	248	8.1	146	4.7	-102	-3.4
Kansas	348	12.3	249	8.7	-99	-3.5
Kentucky	616	14.3	235	5.4	-381	-8.9
Louisiana	751	16.6	383	8.4	-368	-8.3
Maine	147	11.2	107	8.1	-40	-3.1
Maryland	593	10.2	366	6.1	-227	-4.0
Massachusetts	247	3.7	190	2.8	-57	-0.9
Michigan	1,072	11.0	510	5.2	-562	-5.8
Minnesota	440	8.2	243	4.4	-197	-3.8
Mississippi	500	17.1	352	12.0	-148	-5.0
Missouri	773	13.0	548	9.1	-225	-3.9
Montana	165	16.5	88	8.5	-77	-8.0
Nebraska	209	11.3	157	8.3	-52	-3.0
Nevada	570	20.7	333	11.2	-237	-9.4
New Hampshire	140	10.7	77	5.8	-63	-4.9
New Jersey	1,160	13.2	688	7.7	-472	-5.5
New Mexico	382	18.6	187	9.1	-195	-9.5

**TABLE 3A-3.** (continued)

State	2013		2017		Difference in uninsured (2017-2013)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
New York	2,070	10.7%	1,113	5.7%	-957	-5.0%
North Carolina	1,509	15.6	1,076	10.7	-433	-5.0
North Dakota	73	10.4	56	7.5	-17	-2.8
Ohio	1,258	11.0	686	6.0	-572	-5.1
Oklahoma	666	17.7	545	14.2	-121	-3.5
Oregon	571	14.7	281	6.8	-290	-7.8
Pennsylvania	1,222	9.7	692	5.5	-530	-4.2
Rhode Island	120	11.6	48	4.6	-72	-7.0
South Carolina	739	15.8	542	11.0	-197	-4.8
South Dakota	93	11.3	77	9.1	-16	-2.2
Tennessee	887	13.9	629	9.5	-258	-4.4
Texas	5,748	22.1	4,817	17.3	-931	-4.8
Utah	402	14.0	282	9.2	-120	-4.8
Vermont	45	7.2	28	4.6	-17	-2.7
Virginia	991	12.3	729	8.8	-262	-3.5
Washington	960	14.0	446	6.1	-514	-7.9
West Virginia	255	14.0	109	6.1	-146	-7.9
Wisconsin	518	9.1	309	5.4	-209	-3.7
Wyoming	77	13.4	70	12.3	-7	-1.2

Source: Berchick et al. 2018.

**TABLE 3A-4. State Levels of Uncompensated Care, 2015–2016** **T 3A-4**

State	Total hospital uncompensated care costs, 2015		Total hospital uncompensated care costs, 2016		Difference in total hospital uncompensated care costs (2016 less 2015)	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
<b>Total</b>	<b>\$38,058</b>	<b>4.1%</b>	<b>\$35,002</b>	<b>3.6%</b>	<b>-\$3,056</b>	<b>-0.5%</b>
Alabama	610	5.5	514	4.5	-96	-1.0
Alaska	101	3.8	105	3.6	4	-0.2
Arizona	458	2.8	307	1.9	-151	-0.9
Arkansas	250	3.6	193	2.7	-57	-0.9
California	2,141	1.9	1,810	1.5	-331	-0.4
Colorado	387	2.7	317	2.1	-69	-0.6
Connecticut	412	3.6	213	1.8	-199	-1.8
Delaware	73	2.2	71	2.1	-2	-0.2
District of Columbia	87	1.9	73	1.5	-14	-0.4
Florida	3,682	7.7	3,336	6.8	-346	-0.9
Georgia	1,788	7.4	1,865	7.4	77	0.0
Hawaii	47	1.3	51	1.3	4	0.0
Idaho	189	4.3	149	3.4	-40	-0.8
Illinois	1,444	3.8	1,458	3.6	14	-0.2
Indiana	1,073	5.1	751	3.3	-322	-1.7
Iowa	227	2.7	221	2.4	-6	-0.2
Kansas	343	4.1	283	3.2	-60	-0.9
Kentucky	310	2.3	273	1.9	-37	-0.4
Louisiana	966	7.2	587	4.2	-380	-3.0
Maine	198	3.7	189	3.3	-10	-0.4
Maryland	516	3.2	507	3.1	-9	-0.2
Massachusetts	519	1.9	552	1.9	33	0.0
Michigan	551	1.8	493	1.5	-58	-0.3
Minnesota	246	1.4	261	1.4	15	0.0
Mississippi	559	7.0	521	6.8	-38	-0.1
Missouri	1,133	5.4	1,016	4.6	-117	-0.8

TABLE 3A-4. (continued)

State	Total hospital uncompensated care costs, 2015		Total hospital uncompensated care costs, 2016		Difference in total hospital uncompensated care costs (2016 less 2015)	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Montana	\$155	3.9%	\$108	2.6%	-\$47	-1.3%
Nebraska	280	4.3	229	3.3	-51	-1.0
Nevada	218	3.7	174	2.8	-45	-0.9
New Hampshire	132	2.9	114	2.4	-18	-0.5
New Jersey	813	3.4	896	3.7	83	0.2
New Mexico	183	3.3	132	2.3	-51	-1.1
New York	2,554	3.6	2,448	3.3	-106	-0.3
North Carolina	1,594	6.3	1,782	6.6	187	0.4
North Dakota	85	2.2	89	2.2	4	0.0
Ohio	1,157	2.7	920	2.0	-237	-0.7
Oklahoma	645	6.1	565	5.2	-80	-1.0
Oregon	227	2.0	210	1.7	-17	-0.3
Pennsylvania	1,044	2.4	870	1.9	-175	-0.5
Rhode Island	75	2.1	73	2.0	-3	-0.2
South Carolina	1,008	8.2	878	6.8	-130	-1.4
South Dakota	97	2.4	103	2.4	6	0.0
Tennessee	864	5.1	825	4.7	-38	-0.4
Texas	6,188	9.2	5,713	8.1	-475	-1.1
Utah	301	4.5	323	4.5	22	0.0
Vermont	41	1.8	41	1.7	-0	-0.1
Virginia	1,116	5.8	1,375	6.7	258	1.0
Washington	349	1.7	365	1.7	16	0.0
West Virginia	165	2.7	134	2.1	-31	-0.6
Wisconsin	339	1.6	416	2.0	77	0.3
Wyoming	114	6.8	103	6.1	-11	-0.7

**TABLE 3A-4. (continued)**

**Notes:** Uncompensated care is calculated using Medicare cost reports, which define uncompensated care as charity care and bad debt. Because of recent changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years.

0 or -0 indicates a non-zero amount between \$500,000 and -\$500,000 that rounds to zero.

**Source:** MACPAC, 2019, analysis of 2015 and 2016 Medicare cost reports.

**TABLE 3A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria, by State, 2014** T 3A-5

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
<b>Total</b>	<b>5,969</b>	<b>2,714</b>	<b>45%</b>	<b>832</b>	<b>14%</b>	<b>761</b>	<b>13%</b>
Alabama	114	63	55	4	4	4	4
Alaska	25	4	16	1	4	1	4
Arizona	104	39	38	39	38	31	30
Arkansas	98	7	7	4	4	4	4
California	401	44	11	41	10	36	9
Colorado	99	71	72	16	16	16	16
Connecticut	41	9	22	3	7	2	5
Delaware	13	2	15	2	15	2	15
District of Columbia	13	9	69	6	46	6	46
Florida	251	72	29	40	16	37	15
Georgia	168	126	75	33	20	22	13
Hawaii <sup>1</sup>	25	–	–	–	–	–	–
Idaho	47	23	49	7	15	6	13
Illinois	206	56	27	47	23	42	20
Indiana	167	51	31	11	7	11	7
Iowa	121	7	6	7	6	7	6
Kansas	150	62	41	12	8	12	8
Kentucky	117	97	83	34	29	31	26
Louisiana	208	67	32	34	16	30	14
Maine	37	1	3	1	3	1	3
Maryland	60	11	18	8	13	7	12
Massachusetts <sup>2</sup>	97	–	–	–	–	–	–
Michigan	164	119	73	20	12	18	11
Minnesota	144	57	40	13	9	13	9
Mississippi	109	54	50	15	14	14	13
Missouri	144	113	78	27	19	25	17
Montana	65	34	52	3	5	3	5
Nebraska	96	27	28	14	15	12	13
Nevada	52	21	40	6	12	5	10
New Hampshire	30	29	97	6	20	6	20
New Jersey	97	69	71	23	24	23	24
New Mexico	53	7	13	3	6	3	6
New York	192	172	90	36	19	35	18

**TABLE 3A-5.** (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
North Carolina	132	74	56%	20	15%	20	15%
North Dakota	49	8	16	3	6	3	6
Ohio	230	159	69	17	7	16	7
Oklahoma	152	50	33	13	9	11	7
Oregon	63	59	94	15	24	15	24
Pennsylvania	226	201	89	41	18	39	17
Rhode Island	15	14	93	3	20	2	13
South Carolina	83	58	70	14	17	14	17
South Dakota	62	24	39	13	21	12	19
Tennessee	142	65	46	18	13	12	8
Texas	589	175	30	102	17	100	17
Utah	59	42	71	5	8	4	7
Vermont	16	13	81	1	6	1	6
Virginia	108	24	22	6	6	6	6
Washington	101	60	59	14	14	13	13
West Virginia	61	51	84	10	16	8	13
Wisconsin	144	103	72	20	14	19	13
Wyoming	29	11	38	1	3	1	3

**Notes:** DSH is disproportionate share hospital. Excludes 111 DSH hospitals that did not submit a 2016 Medicare cost report. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our working definition of essential community services includes the following services: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services. For further discussion of the methodology and limitations, see Appendix 3B.

— Dash indicates zero.

<sup>1</sup> Hawaii did not report DSH spending in 2014.

<sup>2</sup> Massachusetts does not make DSH payments to hospitals because its Section 1115 demonstration allows the state to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be characterized as DSH or deemed DSH hospitals.

**Source:** MACPAC, 2019, analysis of state plan rate year 2014 DSH audits, 2014 and 2016 Medicare cost reports, and the 2016 American Hospital Association annual survey.

**TABLE 3A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals, by State, 2014** **T 3A-6**

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
<b>Total</b>	<b>664,083</b>	<b>386,268</b>	<b>58%</b>	<b>140,872</b>	<b>21%</b>	<b>40,729</b>	<b>27,612</b>	<b>68%</b>	<b>14,846</b>	<b>36%</b>
Alabama	12,650	8,701	69	586	5	670	462	69	51	8
Alaska	1,217	493	41	80	7	72	42	57	2	3
Arizona	12,091	5,861	48	5,861	48	916	654	71	654	71
Arkansas	8,044	1,429	18	1,080	13	318	73	23	57	18
California	61,564	7,004	11	5,910	10	4,935	1,092	22	960	19
Colorado	8,649	6,826	79	2,152	25	578	538	93	281	49
Connecticut	7,129	2,419	34	535	8	530	220	41	86	16
Delaware	2,280	269	12	269	12	143	8	6	8	6
District of Columbia	2,480	2,056	83	936	38	252	241	95	125	50
Florida	46,642	19,302	41	11,185	24	2,742	1,699	62	1,284	47
Georgia	18,521	15,109	82	4,949	27	1,152	1,099	95	548	48
Hawaii <sup>1</sup>	2,255	–	–	–	–	162	–	–	–	–
Idaho	2,573	1,839	71	918	36	119	105	89	61	52
Illinois	26,786	10,642	40	8,200	31	1,801	1,047	58	792	44
Indiana	14,700	5,090	35	2,403	16	776	358	46	249	32
Iowa	6,629	1,261	19	1,261	19	332	129	39	129	39
Kansas	7,177	3,837	53	1,197	17	227	166	73	75	33
Kentucky	12,294	11,329	92	4,487	36	789	761	96	439	56
Louisiana	14,764	6,775	46	3,304	22	652	380	58	263	40
Maine	2,702	51	2	51	2	135	1	1	1	1
Maryland	10,944	2,237	20	1,720	16	768	113	15	69	9
Massachusetts <sup>2</sup>	16,770	–	–	–	–	1,318	–	–	–	–
Michigan	20,600	17,057	83	4,988	24	1,195	1,039	87	553	46
Minnesota	9,376	5,849	62	1,781	19	586	492	84	254	43
Mississippi	9,106	5,523	61	2,355	26	456	297	65	175	38
Missouri	15,391	12,567	82	1,839	12	906	622	69	186	21



**TABLE 3A-6. (continued)**

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Montana	2,607	1,872	72%	176	7%	72	69	96%	9	13%
Nebraska	4,749	3,145	66	1,856	39	156	147	94	113	72
Nevada	5,473	3,118	57	1,580	29	407	345	85	249	61
New Hampshire	2,356	2,356	100	749	32	83	83	100	49	59
New Jersey	18,780	16,495	88	5,329	28	1,023	955	93	438	43
New Mexico	3,777	1,141	30	415	11	316	158	50	92	29
New York	38,384	37,129	97	8,526	22	3,528	3,446	98	1,272	36
North Carolina	18,657	14,708	79	4,404	24	1,114	1,007	90	356	32
North Dakota	2,282	1,064	47	583	26	84	55	66	42	50
Ohio	27,120	23,256	86	4,606	17	1,620	1,506	93	633	39
Oklahoma	10,122	5,007	49	1,367	14	496	259	52	100	20
Oregon	5,920	5,589	94	1,555	26	390	384	99	180	46
Pennsylvania	31,590	30,153	95	5,868	19	1,641	1,617	99	593	36
Rhode Island	2,564	2,482	97	805	31	143	143	100	53	37
South Carolina	10,540	9,149	87	2,922	28	561	553	99	293	52
South Dakota	2,508	1,667	66	1,008	40	89	83	93	59	66
Tennessee	15,612	11,169	72	4,100	26	876	758	86	441	50
Texas	59,617	29,897	50	18,776	31	2,988	2,321	78	1,828	61
Utah	4,651	3,731	80	525	11	225	218	97	50	22
Vermont	980	814	83	344	35	48	47	99	27	58
Virginia	14,401	5,803	40	1,285	9	698	381	55	141	20
Washington	10,290	7,899	77	1,806	18	766	606	79	122	16
West Virginia	5,595	5,177	93	1,215	22	300	297	99	124	41
Wisconsin	10,916	9,410	86	2,999	27	551	527	96	278	51
Wyoming	1,258	511	41	26	2	24	9	39	0	2

**TABLE 3A-6. (continued)**

**Notes:** DSH is disproportionate share hospital. Excludes 111 DSH hospitals that did not submit a 2016 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of the methodology and limitations, see Appendix 3B.

— Dash indicates zero; 0 indicates non-zero amount less than 500.

<sup>1</sup> Hawaii did not report DSH spending in 2014.

<sup>2</sup> Massachusetts does not make DSH payments to hospitals because its Section 1115 demonstration allows the state to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be characterized as DSH or deemed DSH hospitals.

**Source:** MACPAC, 2019, analysis of 2014 and 2016 Medicare cost reports and state plan rate year 2014 DSH audits.

**TABLE 3A-7. FY 2019 DSH Allotment per Uninsured Individual, by State (millions) T 3A-7**

State	FY 2019 DSH allotment		FY 2019 DSH allotment per uninsured individual		FY 2019 DSH allotment per uninsured individual and Medicaid enrollee	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
<b>Total</b>	<b>\$22,281.1</b>	<b>\$12,627.6</b>	<b>\$795.2</b>	<b>\$450.7</b>	<b>\$288.6</b>	<b>\$163.6</b>
Alabama	492.4	353.9	1,096.6	788.2	431.1	309.9
Alaska	46.9	23.4	478.5	239.2	213.0	106.5
Arizona	166.9	116.5	240.2	167.7	88.0	61.4
Arkansas	70.4	49.7	303.5	214.0	85.4	60.2
California	2,523.5	1,261.7	902.2	451.1	232.2	116.1
Colorado	212.9	106.5	514.3	257.2	170.5	85.2
Connecticut	460.4	230.2	2,373.1	1,186.6	629.6	314.8
Delaware	18.1	10.4	355.0	204.3	103.0	59.3
District of Columbia	100.7	70.5	3,873.4	2,711.4	628.1	439.6
Florida	378.2	230.2	141.3	86.0	70.6	43.0
Georgia	457.4	309.3	332.7	225.0	172.3	116.5
Hawaii	20.8	11.2	392.5	211.6	89.8	48.4
Idaho	26.6	18.9	154.6	110.0	69.7	49.6
Illinois	491.9	247.5	572.6	288.1	171.6	86.3
Indiana	373.0	246.0	695.9	459.0	263.4	173.7
Iowa	75.6	45.3	518.0	310.5	140.5	84.2
Kansas	83.1	47.5	333.9	190.7	157.7	90.0
Kentucky	232.9	166.9	990.9	710.2	205.6	147.3
Louisiana	1,214.1	789.2	3,170.0	2,060.5	878.1	570.7
Maine	187.3	120.9	1,750.5	1,129.5	762.4	491.9
Maryland	175.5	87.8	479.6	239.8	149.3	74.7
Massachusetts	702.1	351.0	3,695.2	1,847.6	537.5	268.8
Michigan	473.2	305.0	927.9	598.1	220.8	142.3
Minnesota	171.9	86.0	707.5	353.8	172.9	86.5
Mississippi	229.8	175.5	652.8	498.6	270.2	206.4
Missouri	833.7	545.3	1,521.4	995.0	695.3	454.7

**TABLE 3A-7. (continued)**

State	FY 2019 DSH allotment		FY 2019 DSH allotment per uninsured individual		FY 2019 DSH allotment per uninsured individual and Medicaid enrollee	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Montana	\$19.9	\$13.1	\$226.5	\$148.5	\$80.2	\$52.6
Nebraska	61.9	32.6	394.5	207.5	189.6	99.7
Nevada	82.1	53.2	246.4	159.9	107.5	69.8
New Hampshire	368.5	184.3	4,786.2	2,393.1	1,730.7	865.4
New Jersey	1,481.9	740.9	2,153.9	1,076.9	813.6	406.8
New Mexico	32.4	23.4	173.5	125.4	45.3	32.7
New York	3,697.5	1,848.7	3,322.1	1,661.0	760.1	380.0
North Carolina	505.6	339.5	469.9	315.6	206.1	138.4
North Dakota	22.0	11.0	392.6	196.3	196.4	98.2
Ohio	741.1	467.6	1,080.4	681.6	289.0	182.3
Oklahoma	66.8	41.7	122.6	76.5	63.1	39.4
Oregon	83.3	52.1	296.4	185.4	84.4	52.8
Pennsylvania	1,236.3	646.0	1,786.6	933.5	505.7	264.2
Rhode Island	142.3	74.8	2,964.8	1,558.6	632.1	332.3
South Carolina	529.3	376.9	976.5	695.5	427.3	304.3
South Dakota	22.4	12.7	291.1	165.1	139.2	78.9
Tennessee	80.6	53.1	128.2	84.4	50.2	33.1
Texas	1,891.4	1,100.6	392.7	228.5	223.2	129.9
Utah	32.4	22.6	114.9	80.1	63.9	44.5
Vermont	48.1	25.9	1,716.2	924.9	320.6	172.8
Virginia	201.7	100.8	276.6	138.3	141.7	70.9
Washington	425.9	212.9	954.8	477.4	265.9	133.0
West Virginia	104.5	77.7	958.8	712.8	214.7	159.6
Wisconsin	183.3	108.8	593.1	352.1	188.5	111.9
Wyoming	0.5	0.3	7.4	3.7	4.5	2.3

**TABLE 3A-7. (continued)**

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. Excludes DSH hospitals that did not submit a Medicare cost report. Calculations of DSH allotments per uninsured individual and Medicaid enrollee are based on the 2017 American Community Survey (ACS) from the U.S. Census Bureau. Estimates of Medicaid enrollment in the ACS include CHIP and other state-funded, means-tested programs; ACS estimates of Medicaid enrollment are typically lower than what is reported in administrative data.

**Source:** MACPAC, 2019, analysis of state plan rate year 2014 DSH audits, 2014 and 2016 Medicare cost reports, the American Hospital Association annual survey, and Census 2019.

**TABLE 3A-8.** FY 2019 Unreduced DSH Allotments as a Percentage of Hospital Uncompensated Care, by State, 2016 **T 3A-8**

State	FY 2019 federal DSH allotment (millions)	FY 2019 federal DSH allotment as a percentage of hospital uncompensated care in the state, 2016	FY 2019 DSH allotment (state and federal, millions)	FY 2019 total DSH allotment as a percentage of hospital uncompensated care in the state, 2016
<b>Total</b>	<b>\$12,627.6</b>	<b>36%</b>	<b>\$22,281.1</b>	<b>64%</b>
Alabama	353.9	69	492.4	96
Alaska	23.4	22	46.9	44
Arizona	116.5	38	166.9	54
Arkansas	49.7	26	70.4	36
California	1,261.7	70	2,523.5	139
Colorado	106.5	34	212.9	67
Connecticut	230.2	108	460.4	216
Delaware	10.4	15	18.1	25
District of Columbia	70.5	97	100.7	138
Florida	230.2	7	378.2	11
Georgia	309.3	17	457.4	25
Hawaii	11.2	22	20.8	41
Idaho	18.9	13	26.6	18
Illinois	247.5	17	491.9	34
Indiana	246.0	33	373.0	50
Iowa	45.3	21	75.6	34
Kansas	47.5	17	83.1	29
Kentucky	166.9	61	232.9	85
Louisiana	789.2	135	1,214.1	207
Maine	120.9	64	187.3	99
Maryland	87.8	17	175.5	35
Massachusetts	351.0	64	702.1	127
Michigan	305.0	62	473.2	96
Minnesota	86.0	33	171.9	66
Mississippi	175.5	34	229.8	44
Missouri	545.3	54	833.7	82

**TABLE 3A-8.** (continued)

State	FY 2019 federal DSH allotment (millions)	FY 2019 federal DSH allotment as a percentage of hospital uncompensated care in the state, 2016	FY 2019 DSH allotment (state and federal, millions)	FY 2019 total DSH allotment as a percentage of hospital uncompensated care in the state, 2016
Montana	\$13.1	12%	\$19.9	18%
Nebraska	32.6	14	61.9	27
Nevada	53.2	31	82.1	47
New Hampshire	184.3	162	368.5	324
New Jersey	740.9	83	1,481.9	165
New Mexico	23.4	18	32.4	25
New York	1,848.7	76	3,697.5	151
North Carolina	339.5	19	505.6	28
North Dakota	11.0	12	22.0	25
Ohio	467.6	51	741.1	81
Oklahoma	41.7	7	66.8	12
Oregon	52.1	25	83.3	40
Pennsylvania	646.0	74	1,236.3	142
Rhode Island	74.8	103	142.3	195
South Carolina	376.9	43	529.3	60
South Dakota	12.7	12	22.4	22
Tennessee	53.1	6	80.6	10
Texas	1,100.6	19	1,891.4	33
Utah	22.6	7	32.4	10
Vermont	25.9	63	48.1	117
Virginia	100.8	7	201.7	15
Washington	212.9	58	425.9	117
West Virginia	77.7	58	104.5	78
Wisconsin	108.8	26	183.3	44
Wyoming	0.3	0	0.5	1

**TABLE 3A-8.** (continued)

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. Excludes DSH hospitals that did not submit a Medicare cost report. Uncompensated care is calculated using 2016 Medicare cost reports, which define uncompensated care as charity care and bad debt. Because of recent changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years.

0 indicates a non-zero amount less than 0.5 percent.

**Source:** MACPAC, 2019, analysis of state plan rate year 2014 DSH audits, 2016 Medicare cost reports, and the American Hospital Association annual survey.



**TABLE 3A-9.** FY 2019 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service, by State (millions) **T 3A-9**

State	FY 2019 DSH allotment		FY 2019 DSH allotment per deemed DSH hospital		FY 2019 DSH allotment per deemed DSH hospital providing at least one essential community service	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
<b>Total</b>	<b>\$22,281.1</b>	<b>\$12,627.6</b>	<b>\$26.8</b>	<b>\$15.2</b>	<b>\$29.3</b>	<b>\$16.6</b>
Alabama	492.4	353.9	123.1	88.5	123.1	88.5
Alaska	46.9	23.4	46.9	23.4	46.9	23.4
Arizona	166.9	116.5	4.3	3.0	5.4	3.8
Arkansas	70.4	49.7	17.6	12.4	17.6	12.4
California	2,523.5	1,261.7	61.5	30.8	70.1	35.0
Colorado	212.9	106.5	13.3	6.7	13.3	6.7
Connecticut	460.4	230.2	153.5	76.7	230.2	115.1
Delaware	18.1	10.4	9.1	5.2	9.1	5.2
District of Columbia	100.7	70.5	16.8	11.7	16.8	11.7
Florida	378.2	230.2	9.5	5.8	10.2	6.2
Georgia	457.4	309.3	13.9	9.4	20.8	14.1
Hawaii <sup>1</sup>	20.8	11.2	-	-	-	-
Idaho	26.6	18.9	3.8	2.7	4.4	3.2
Illinois	491.9	247.5	10.5	5.3	11.7	5.9
Indiana	373.0	246.0	33.9	22.4	33.9	22.4
Iowa	75.6	45.3	10.8	6.5	10.8	6.5
Kansas	83.1	47.5	6.9	4.0	6.9	4.0
Kentucky	232.9	166.9	6.8	4.9	7.5	5.4
Louisiana	1,214.1	789.2	35.7	23.2	40.5	26.3
Maine	187.3	120.9	187.3	120.9	187.3	120.9
Maryland	175.5	87.8	21.9	11.0	25.1	12.5
Massachusetts <sup>2</sup>	702.1	351.0	-	-	-	-
Michigan	473.2	305.0	23.7	15.3	26.3	16.9
Minnesota	171.9	86.0	13.2	6.6	13.2	6.6
Mississippi	229.8	175.5	15.3	11.7	16.4	12.5

**TABLE 3A-9.** (continued)

State	FY 2019 DSH allotment		FY 2019 DSH allotment per deemed DSH hospital		FY 2019 DSH allotment per deemed DSH hospital providing at least one essential community service	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Missouri	<b>\$833.7</b>	\$545.3	<b>\$30.9</b>	\$20.2	<b>\$33.3</b>	\$21.8
Montana	<b>19.9</b>	13.1	<b>6.6</b>	4.4	<b>6.6</b>	4.4
Nebraska	<b>61.9</b>	32.6	<b>4.4</b>	2.3	<b>5.2</b>	2.7
Nevada	<b>82.1</b>	53.2	<b>13.7</b>	8.9	<b>16.4</b>	10.6
New Hampshire	<b>368.5</b>	184.3	<b>61.4</b>	30.7	<b>61.4</b>	30.7
New Jersey	<b>1,481.9</b>	740.9	<b>64.4</b>	32.2	<b>64.4</b>	32.2
New Mexico	<b>32.4</b>	23.4	<b>10.8</b>	7.8	<b>10.8</b>	7.8
New York	<b>3,697.5</b>	1,848.7	<b>102.7</b>	51.4	<b>105.6</b>	52.8
North Carolina	<b>505.6</b>	339.5	<b>25.3</b>	17.0	<b>25.3</b>	17.0
North Dakota	<b>22.0</b>	11.0	<b>7.3</b>	3.7	<b>7.3</b>	3.7
Ohio	<b>741.1</b>	467.6	<b>43.6</b>	27.5	<b>46.3</b>	29.2
Oklahoma	<b>66.8</b>	41.7	<b>5.1</b>	3.2	<b>6.1</b>	3.8
Oregon	<b>83.3</b>	52.1	<b>5.6</b>	3.5	<b>5.6</b>	3.5
Pennsylvania	<b>1,236.3</b>	646.0	<b>30.2</b>	15.8	<b>31.7</b>	16.6
Rhode Island	<b>142.3</b>	74.8	<b>47.4</b>	24.9	<b>71.2</b>	37.4
South Carolina	<b>529.3</b>	376.9	<b>37.8</b>	26.9	<b>37.8</b>	26.9
South Dakota	<b>22.4</b>	12.7	<b>1.7</b>	1.0	<b>1.9</b>	1.1
Tennessee	<b>80.6</b>	53.1	<b>4.5</b>	3.0	<b>6.7</b>	4.4
Texas	<b>1,891.4</b>	1,100.6	<b>18.5</b>	10.8	<b>18.9</b>	11.0
Utah	<b>32.4</b>	22.6	<b>6.5</b>	4.5	<b>8.1</b>	5.6
Vermont	<b>48.1</b>	25.9	<b>48.1</b>	25.9	<b>48.1</b>	25.9
Virginia	<b>201.7</b>	100.8	<b>33.6</b>	16.8	<b>33.6</b>	16.8
Washington	<b>425.9</b>	212.9	<b>30.4</b>	15.2	<b>32.8</b>	16.4
West Virginia	<b>104.5</b>	77.7	<b>10.5</b>	7.8	<b>13.1</b>	9.7
Wisconsin	<b>183.3</b>	108.8	<b>9.2</b>	5.4	<b>9.6</b>	5.7
Wyoming	<b>0.5</b>	0.3	<b>0.5</b>	0.3	<b>0.5</b>	0.3

**TABLE 3A-9. (continued)**

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. Excludes 111 DSH hospitals that did not submit a 2016 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our working definition of essential community services includes the following services: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services. For further discussion of the methodology and limitations, see Appendix 3B.

– Dash indicates that the category is not available.

<sup>1</sup> Hawaii did not report DSH spending in 2014.

<sup>2</sup> Massachusetts does not make DSH payments to hospitals because its Section 1115 demonstration allows the state to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be categorized as DSH or deemed DSH hospitals.

**Source:** MACPAC, 2019, analysis of CMS Medicaid Budget and Expenditure System, state plan rate year 2014 DSH audits, 2014 and 2016 Medicare cost reports, and the 2016 American Hospital Association annual survey.

**TABLE 3A-10. Medicaid Payments to DSH Hospitals as a Share of Costs, by State, SPRY 2014** **T 3A-10**

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
<b>Total</b>	<b>44%</b>	<b>79%</b>	<b>12%</b>	<b>13%</b>	<b>103%</b>	<b>68%</b>	<b>10%</b>	<b>11%</b>	<b>88%</b>
Alabama	56	73	19	33	<b>125</b>	55	14	25	<b>95</b>
Alaska	12	110	–	4	<b>114</b>	89	–	3	<b>92</b>
Arizona	39	44	27	5	<b>75</b>	39	24	4	<b>67</b>
Arkansas	6	74	18	25	<b>116</b>	60	14	20	<b>95</b>
California <sup>1</sup>	10	88	6	35	<b>129</b>	76	5	30	<b>112</b>
Colorado	72	69	30	8	<b>107</b>	60	26	7	<b>93</b>
Connecticut	15	77	3	4	<b>84</b>	75	3	4	<b>82</b>
Delaware	8	93	–	26	<b>119</b>	78	–	22	<b>100</b>
District of Columbia	23	89	0	15	<b>104</b>	84	0	15	<b>99</b>
Florida	28	91	15	4	<b>110</b>	75	13	3	<b>90</b>
Georgia	79	92	4	10	<b>106</b>	71	3	8	<b>82</b>
Idaho	53	99	2	4	<b>104</b>	84	1	4	<b>89</b>
Illinois <sup>2</sup>	26	77	28	11	<b>116</b>	67	24	10	<b>101</b>
Indiana	31	97	–	18	<b>116</b>	81	–	15	<b>96</b>
Iowa	6	84	6	10	<b>100</b>	78	6	10	<b>94</b>
Kansas	41	77	9	7	<b>93</b>	63	7	6	<b>76</b>
Kentucky	81	88	6	7	<b>101</b>	77	5	6	<b>89</b>
Louisiana	31	70	2	63	<b>134</b>	51	1	46	<b>98</b>
Maryland	13	107	–	12	<b>119</b>	89	–	10	<b>99</b>
Michigan	71	68	27	5	<b>100</b>	63	26	5	<b>94</b>
Minnesota <sup>3</sup>	35	85	6	1	<b>92</b>	82	6	1	<b>89</b>
Mississippi	53	83	19	15	<b>117</b>	68	16	12	<b>97</b>
Missouri	74	104	–	17	<b>120</b>	85	–	14	<b>99</b>
Montana	52	80	13	6	<b>100</b>	63	11	5	<b>79</b>

**TABLE 3A-10.** (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Nebraska	23%	79%	0%	4%	83%	66%	0%	3%	69%
Nevada	42	72	11	9	<b>91</b>	56	8	7	<b>71</b>
New Jersey	65	84	5	25	<b>114</b>	62	4	19	<b>85</b>
New Mexico	13	89	13	5	<b>107</b>	74	11	4	<b>89</b>
New York	91	77	3	14	<b>94</b>	72	3	13	<b>88</b>
North Carolina	53	71	34	9	<b>113</b>	57	27	7	<b>92</b>
North Dakota <sup>2</sup>	6	117	–	2	<b>119</b>	105	–	2	<b>107</b>
Ohio	68	84	6	8	<b>98</b>	77	6	7	<b>90</b>
Oklahoma	32	76	29	4	<b>110</b>	64	24	3	<b>91</b>
Oregon	90	98	3	3	<b>104</b>	89	3	3	<b>94</b>
Pennsylvania	91	59	14	9	<b>81</b>	49	11	7	<b>67</b>
Rhode Island	80	85	1	14	<b>100</b>	79	1	13	<b>93</b>
South Carolina	72	90	3	19	<b>112</b>	72	2	15	<b>89</b>
Tennessee <sup>3</sup>	43	85	24	1	<b>110</b>	72	20	1	<b>93</b>
Texas	29	80	23	18	<b>120</b>	58	16	13	<b>87</b>
Utah	69	87	32	4	<b>123</b>	68	25	3	<b>96</b>
Vermont	81	80	–	10	<b>90</b>	76	–	9	<b>86</b>
Virginia <sup>3</sup>	22	88	11	10	<b>108</b>	69	8	8	<b>85</b>
Washington	56	82	(0)	8	<b>89</b>	75	-0	7	<b>82</b>
Wisconsin	67	75	16	1	<b>93</b>	68	15	1	<b>84</b>
Wyoming	38	78	12	1	<b>90</b>	54	8	0	<b>63</b>

**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. This analysis includes 44 states and the District of Columbia and excludes Hawaii, Massachusetts, Maine, New Hampshire, South Dakota, and West Virginia. Institutions for mental diseases were also excluded. Base Medicaid payments include fee-for-service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on DSH audits). DSH payments and non-DSH supplemental payments may also be used to offset non-Medicaid costs, such as unpaid costs of care for uninsured patients. Costs for uninsured patients are uncompensated care costs for uninsured patients, net of payments received from them. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not sum due to rounding.

**TABLE 3A-10. (continued)**

— Dash indicates zero; 0 indicates a non-zero amount less than 0.5 percent.

<sup>1</sup> California public hospitals are eligible to receive DSH payments up to 175 percent of the hospital's Medicaid uninsured costs.

<sup>2</sup> Illinois and North Dakota reported SPRY 2014 DSH payments that exceeded hospital uncompensated care costs for Medicaid and uninsured patients on their as-filed DSH audits. Because DSH payments to an individual hospital cannot exceed hospital uncompensated care costs, some of these payments may be recouped when these states' DSH audits are finalized.

<sup>3</sup> Two DSH hospitals in Minnesota, all DSH hospitals in New Hampshire, three DSH hospitals in Tennessee, one DSH hospital in Virginia, and all DSH hospitals in West Virginia did not include payments from third-party payers when calculating Medicaid shortfall, so they are excluded from this analysis.

**Source:** MACPAC, 2019, analysis of SPRY 2014 as-filed Medicaid DSH audits.

## APPENDIX 3B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. Below we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

### Primary Data Sources

#### DSH audit data

We used state plan rate year 2014 DSH audit reports, the most recent data available, to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types. These data were provided by the Centers for Medicare & Medicaid Services (CMS) on an as-filed basis and may be subject to change as CMS completes its internal review of state DSH audit reports.

Overall, 2,825 hospitals receiving DSH payments are represented in our analyses of DSH audit data. We did not include DSH audit data provided by states for hospitals that did not receive DSH payments (81 hospitals were excluded under this criterion). Some hospitals received DSH payments from multiple states; we combined the data for duplicate hospitals so that each hospital would only appear once in the dataset.

#### Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded hospitals in U.S. territories, religious non-medical health care institutions, and hospitals participating in special Medicare demonstration projects (87 hospitals were excluded under these criteria). These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. Hospitals were matched based on their CMS certification number. A total of 2,714 DSH hospitals were included in these analyses. We excluded 111 DSH hospitals without matching 2016 Medicare cost reports.

When using Medicare cost reports to analyze hospital uncompensated care, we excluded hospitals that reported uncompensated care costs that were greater than hospital operating expenses. One hospital was excluded under this criterion.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that were more than 1.5 times the interquartile range above the highest quartiles or below the lowest quartile (445 hospitals were excluded under this criterion). Operating margins are calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by net patient revenue:  $(NPR - OE) \div NPR$ . Total margins, in contrast, include additional types of hospital revenue, such as state or local subsidies and revenue from other facets of hospital operations (e.g., parking lot receipts).

## Working Definition of Essential Community Services

The statute requires that MACPAC's analysis include data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education and the continuum of primary through quaternary care, including the provision of trauma care and public health services.

In this report, we use the same working definition to identify such hospitals that was used in MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. This working definition is based on a two-part test:

- Is the hospital a deemed DSH hospital?
- Does the hospital provide at least one essential service?

### Deemed DSH hospital status

According to the Social Security Act (the Act), hospitals must meet one of two criteria to qualify as a deemed DSH hospital: (1) a Medicaid inpatient utilization rate greater than one standard deviation above the mean for hospitals in the state, or (2) a low-income utilization rate greater than 25 percent (§ 1923(b)(1) of the Act). Because deemed DSH hospitals are statutorily required to receive DSH payments, we excluded from our analysis hospitals that did not receive DSH payments in 2014.

Calculation of the Medicaid inpatient utilization rate threshold for each state requires data from all hospitals in that state, and we relied on Medicare cost reports to make those calculations and to determine which hospitals exceeded this threshold. A major limitation of this approach is that Medicaid inpatient utilization reported on Medicare cost reports does not include services

provided to Medicaid enrollees that were not paid for by Medicaid (e.g., Medicare-funded services for individuals who are dually eligible for Medicare and Medicaid). However, the Medicaid DSH definition of Medicaid inpatient utilization includes services provided to anyone who is eligible for Medicaid, even if Medicaid is not the primary payer. Thus, our identification of deemed DSH hospitals may omit some hospitals with high utilization by dually eligible beneficiaries and overstate the extent to which hospitals with low utilization by dually eligible beneficiaries (e.g., children's hospitals) exceed the threshold.

The low-income utilization rate threshold for deemed DSH hospitals is the same for all states (25 percent), so we were able to use Medicaid DSH audit data to determine whether hospitals met this criterion. However, about one-quarter of DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions limited our ability to identify all deemed DSH hospitals.

### Provision of essential community services

Because the term essential community services is not otherwise defined in statute or regulation, we identified a number of services that could be considered essential community services using available data from 2016 Medicare cost reports and the 2016 American Hospital Association (AHA) annual survey (Table 3B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the AHA annual survey.



**TABLE 3B-1.** Essential Community Services, by Data Source **T 3B-1**

Data source	Service type
American Hospital Association annual survey	Burn services
	Dental services
	HIV/AIDS care
	Neonatal intensive care units
	Obstetrics and gynecology services
	Primary care services
	Substance use disorder services
	Trauma services
Medicare cost reports	Graduate medical education
	Inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital)

For this report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. We also included certain hospital types if they were the only hospital in their geographic area to provide certain types of services. These hospital types included critical access hospitals because they are often the only hospital within a 25-mile radius.

## Projections of DSH Allotments

Unreduced DSH allotments for FY 2023 were calculated by increasing prior year allotments based on inflation. We used the projections of the Consumer Price Index for All Urban Consumers in

the Congressional Budget Office's August economic baseline (CBO 2018). Unreduced allotments increase each year for all states except Tennessee, whose DSH allotment is specified in statute (§ 1923(f)(6)(A)(vi) of the Social Security Act).

We estimated DSH allotment reductions under current law using the DSH allotment reduction methodology that CMS proposed in July 2017 (CMS 2017). We used a variety of data sources to estimate the factors used in CMS's methodology and the most recently available data (Table 3B-2). We then calculated reductions based on these factors using a model for estimating DSH allotment reductions that Dobson DaVanzo & Associates and KNG Health previously developed for MACPAC (MACPAC 2016).

**TABLE 3B-2.** Data Sources for Factors Used in the CMS DSH Allotment Reduction Model **T 3B-2**

DSH allotment reduction factor	Data source (year)
Low DSH	Specified in statute (N/A)
Uninsured percentage	American Community Survey (2017)
High volume of Medicaid inpatients	Medicare cost reports (2014) and DSH audits (2014)
High level of uncompensated care	DSH audits (2014)
Budget neutrality	CMS Financial Management Group (2014)

**Notes:** CMS is the Centers for Medicare & Medicaid Services. DSH is disproportionate share hospital. N/A is not applicable.