Chapter 1:

Improving the Structure of Disproportionate Share Hospital Allotment Reductions

Improving the Structure of Disproportionate Share Hospital Allotment Reductions

Recommendations

1.1 If Congress chooses to proceed with disproportionate share hospital (DSH) allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in fiscal year (FY) 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.

1.2 In order to minimize the effects of disproportionate share hospital (DSH) allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.

1.3 In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

Key Points

- Under current law, DSH allotments will be reduced by $4 billion in FY 2020 and $8 billion a year in FYs 2021–2025.
- Although such cuts could affect the financial viability of safety-net hospitals, our analysis responded to Congressional interest in restructuring funding in a budget-neutral way.
- The Commission's recommendations aim to advance three policy goals:
  - improving the relationship between DSH allotments and measures related to hospital uncompensated care costs;
  - applying reductions to states independent of state policy choices; and
  - phasing in changes in an orderly way.
- If DSH allotment reductions take effect, phasing them in gradually will give states and hospitals more time to respond.
- Reducing unspent DSH funding first minimizes the amount of reductions to DSH funds that are currently paid to providers.
- Basing DSH allotment reductions on the number of non-elderly low-income individuals in a state reduces variations in DSH allotments based on historical spending. This measure is related to hospital uncompensated care costs and is independent of state policy choices.
- Relative to current law, these recommendations result in larger reductions for states with unspent DSH funds and smaller reductions for states with low DSH allotments. These effects are independent of a state's Medicaid expansion status.

CHAPTER 1: Improving the Structure of Disproportionate Share Hospital Allotment Reductions

Medicaid disproportionate share hospital (DSH) payments are statutorily required payments intended to offset hospitals' uncompensated care costs for Medicaid-enrolled and uninsured patients and to support the financial stability of safety-net hospitals. Total state DSH spending is limited by federal allotments, which vary widely by state. DSH allotments were first made available in fiscal year (FY) 1993 based on each state's DSH spending in FY 1992, and they currently have little meaningful relationship to the level of uncompensated care in a state.

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) included reductions to DSH allotments under the assumption that the expected increase in the number of people with health insurance due to state Medicaid expansions and the availability of subsidized health insurance on health insurance exchanges would lead to reductions in hospital uncompensated care and thereby lessen the need for DSH payments. DSH allotment reductions were initially scheduled to take effect in FY 2014, but they have been delayed several times. Under current law, DSH allotments are scheduled to be reduced by $4 billion in FY 2020 and $8 billion a year in FYs 2021–2025. For FY 2026 and beyond, allotments will return to their higher, unreduced amounts.

MACPAC's prior analyses have shown that hospitals continue to have substantial levels of uncompensated care even though the number of uninsured individuals has declined since 2013. As discussed further in Chapter 3 of this report, although increased coverage under the ACA has reduced hospital unpaid costs of care for uninsured individuals, there has been a net increase in hospital uncompensated costs for DSH hospitals because of an increase in Medicaid shortfall (the difference between a hospital's Medicaid payments and its costs of providing services to Medicaid-enrolled patients).

Hospital trade associations have been calling on Congress to delay DSH cuts once again, but doing so will require Congress to come up with cuts elsewhere to offset the budgetary impact of such delays. This has led to congressional interest in MACPAC conducting analyses of and providing advice on policies that would mitigate the effects of allotment reductions on providers and rationalize the distribution of reductions across states. Although the Commission is concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety-net hospitals, the work we have done over the past year has focused on budget-neutral ways to restructure funding under current law.

This chapter presents the Commission's analyses of and recommendations for changing the structure of DSH allotment reductions to advance the following policy goals:

- improving the relationship between DSH allotments and measures related to hospital uncompensated care costs;
- applying reductions to states that are independent of state policy choices; and
- phasing in changes in an orderly way.

Specifically, the Commission makes three recommendations:

- If Congress chooses to proceed with DSH allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.

- In order to minimize the effects of DSH allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.
- In order to reduce the wide variation in state DSH allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

These recommendations draw on MACPAC's analysis of multiple sources of data on hospital payment and financing as well as qualitative work that included interviews with DSH hospital executives, state officials, and other stakeholders, and a roundtable discussion on the future of DSH policy that brought together perspectives of states, the Centers for Medicare & Medicaid Services (CMS), hospitals, researchers, and consumer advocates.

The analyses in this chapter focus on DSH allotments to states, but the Commission plans to continue examining other DSH policies in the future, such as the targeting of DSH payments to providers within each state and the use of DSH funding to promote access to care in appropriate settings.[1] The Commission will consider these DSH policies and others in relation to other types of Medicaid payments to hospitals as part of its long-term hospital payment work plan (MACPAC 2018).

Current Structure of DSH Allotment Reductions

In response to a rapid growth in DSH spending, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) in 1991.[2] The law required CMS to establish state-specific caps (referred to as allotments) on the amount of federal funds that could be used to make DSH payments beginning in FY 1993. The allotments were initially 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. Additional background information about DSH policy and the current variation in state DSH allotments is provided in Chapter 3 of this report.

In FY 2019, $12.6 billion in federal funds were allotted for DSH payments. The schedule of reductions under current law is $4 billion in FY 2020 and $8 billion each year for FYs 2021–2025. The reductions under this schedule are larger and extend over a longer period of time than those scheduled by the ACA. For example, under the ACA, DSH allotment reductions were scheduled to begin at $0.5 billion in FY 2014 and were scheduled to end at $4 billion in FY 2020.

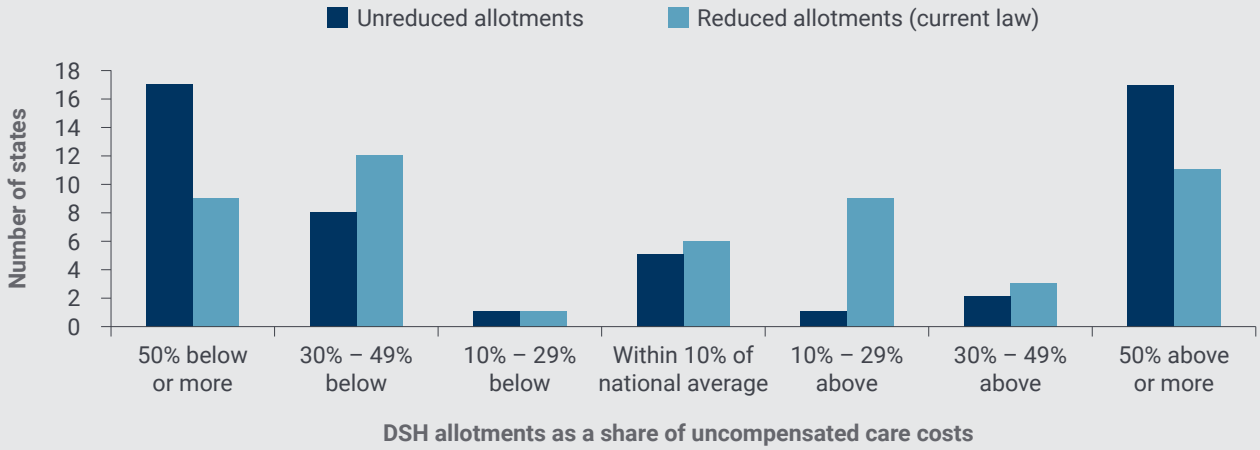
To implement these reductions, CMS developed a methodology for distributing DSH allotment reductions among states using criteria specified in statute (§ 1923(f)(7) of the Social Security Act (the Act)). The statute requires CMS to apply greater DSH reductions to states with lower uninsured rates, states that do not target their DSH payments to hospitals with high levels of uncompensated care, and states that do not target their DSH payments to hospitals that serve a high share of Medicaid-enrolled patients.[3] The statute also directs CMS to apply smaller reductions to states that are statutorily designated as low-DSH states because they had low levels of DSH spending relative to other states in FY 2000.[4] In 2013, CMS finalized

a methodology for the DSH reductions that had initially been scheduled to take effect in FYs 2014 and 2015, but it did not finalize a methodology for subsequent years (CMS 2013). In July 2017, CMS proposed changes to this methodology that would have applied for FY 2018 and beyond, but the proposed rule was never finalized (CMS 2017). However, because the statutory factors that CMS is required to consider in its reduction methodology have not changed, we do not expect that CMS will develop a new methodology for the FY 2020 cuts.[5]

Although the statute requires CMS to base allotment reductions on factors other than historical DSH spending, CMS's methodology is projected to preserve much of the variation in DSH funding that exists today. For example, before and after DSH reductions, there is no meaningful relationship between DSH allotments and hospital uncompensated care costs (Figure 1-1). In addition, even though the targeting factors in CMS's methodology are intended to encourage states to target DSH payments to hospitals that need them most, these factors are unlikely to change state policies and may even result in larger reductions for some states that do target DSH payments to deemed DSH hospitals, that is, hospitals that are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients (MACPAC 2017b).

MACPAC provided comments on CMS's proposed reduction formula in August 2017, but these comments were limited to regulatory changes that CMS could make under current law (MACPAC 2017b). In order to change the factors used in the DSH allotment reduction formula, Congress would need to change the factors listed in the statute (§ 1923(f)(7) of the Act).

FIGURE 1-1. DSH Allotments as a Share of Hospital Uncompensated Care Costs Relative to the National Average, FY 2023



Notes: DSH is disproportionate share hospital. FY is fiscal year. DSH allotments as a share of hospital uncompensated care in the state were calculated using 2016 Medicare cost reports, which define uncompensated care as charity care and bad debt. The number of states includes the District of Columbia. In FY 2023, federal unreduced allotments are projected to equal 40 percent of 2016 hospital uncompensated care costs, and reduced allotments are projected to equal 17 percent of 2016 hospital uncompensated care costs. Additional information about the relationship between DSH allotments and hospital uncompensated care costs is provided in Chapter 3 of this report.

Source: MACPAC, 2019, analysis of CBO 2018, 2014 as-filed DSH audits, the CMS Medicaid Budget and Expenditure System, and Medicare cost reports.

Policy Goals

MACPAC identified three policy goals to guide its deliberations on how to improve the distribution of DSH allotment reductions among states:

- improving the relationship between DSH allotments and measures related to hospital uncompensated care costs;
- applying reductions to states that are independent of state policy choices; and
- phasing in changes in an orderly way.

Relating DSH allotments to hospital uncompensated care costs

The Commission has long held that DSH funding should be better targeted to states that have higher levels of uncompensated care, consistent with the original statutory intent. DSH payments were initially established in 1981 to account for "the situation of hospitals which serve a disproportionate number of low-income patients with special needs" (§ 1902(a)(13)(A)(iv) of the Act), and in 1993, Congress established hospital-specific limits for DSH payments based on a hospital's overall uncompensated care costs for Medicaid-enrolled and uninsured patients.

Although hospitals can use the DSH funding that they receive for various purposes, DSH hospital executives whom we interviewed during the summer and fall of 2016 reported that DSH funds were primarily used to offset hospital uncompensated care costs. Some DSH hospitals also reported using DSH funds to support the development of particular programs for low-income patients or to improve the overall financial viability of their health system, but these uses of DSH funding are more difficult to quantify (MACPAC 2017c).

Applying reductions independent of state policy choices

It is the Commission's view that the development of DSH policy should be considered in terms of all types of payments that hospitals receive. States can make a number of different types of Medicaid payments to hospitals, including base payments for services and non-DSH supplemental payments. However, from a hospital's perspective, the total amount of Medicaid payments received is more important than the amount received from DSH or any other Medicaid payment stream.

The close relationship between state DSH payment policies and other state policy decisions was a key theme raised at an expert roundtable on the future of DSH policy that MACPAC convened in the fall of 2017. For example, California's decision to target its DSH payments to designated public hospitals in 2005 was accompanied by increases in non-DSH supplemental payments to hospitals that were previously receiving DSH payments. The states, hospitals, and other stakeholders participating in the roundtable cautioned that large changes in state DSH funding could cause some states to reconsider their other coverage, financing, and payment policies (MACPAC 2017d).

The amounts and types of hospital uncompensated care costs are directly affected by state coverage choices. For example, hospitals in states that have expanded Medicaid report lower unpaid costs of care for uninsured individuals but higher Medicaid shortfall than hospitals in states that have not expanded Medicaid. Deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients, reported negative operating margins before DSH payments in both expansion and non-expansion states in 2016.[6]

Other factors also affect hospital uncompensated care costs. For example, policies that promote the use of high-deductible health plans may reduce the number of uninsured individuals but increase hospital bad debt expenses for patients who have insurance but are unable to pay their deductibles.[7] In addition, policies to change Medicaid base payment rates affect the amount of Medicaid shortfall that hospitals report.

Phasing in changes in an orderly way

Because DSH is an important source of revenue for many safety-net hospitals, cuts in DSH funding may disrupt the services that these hospitals provide. For example, in 2016, DSH payments accounted for about 4 percent of hospital operating costs for deemed DSH hospitals. Without DSH payments, these hospitals would have reported operating margins of negative 6 percent in the aggregate. Several of the DSH hospitals that we profiled noted that if their DSH funding were reduced, they might need to cut services or staff to maintain their financial viability (MACPAC 2017c).

During our expert roundtable, which occurred one month before the FY 2018 DSH cuts had been scheduled to take effect, hospital executives reported that uncertainty about future levels of DSH funding was affecting their ability to adequately plan for the future (MACPAC 2017d).

During the summer of 2018, MACPAC interviewed state officials and stakeholders in five states to learn more about the development of Medicaid hospital payment policies, including the time needed to implement changes. Many of the new payment policies that we examined took several years to implement. For example, Louisiana's process of converting DSH payments to increased base payment rates to providers took about 3 years, including 9 months for stakeholder consultation, 8 months for payment design, and 10 months for implementation of changes to policies, contracts, and information systems (Marks et al. 2018).

Commission Recommendations

Because DSH allotment reductions are currently scheduled to take effect in FY 2020, the Commission focused its efforts in 2018 on assessing a range of policy options to better distribute DSH reductions assuming no further delays. We limited our analyses to changes that would be budget neutral for the federal government and did not evaluate the question of whether the total amount of DSH funding under current law should change.

The Commission's recommendations, rationale, and implications are described below. Additional information on the potential state-by-state effects of the recommended policy is provided in Appendix 1A of this report.

Recommendation 1.1

If Congress chooses to proceed with disproportionate share hospital (DSH) allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.

Rationale

If DSH allotment reductions take effect, phasing in DSH reductions gradually will help to mitigate disruptions for DSH hospitals by providing more time to plan for potential changes before the full amount of reductions takes effect. Phasing in reductions will also give states time to adjust other types of Medicaid hospital payment policies to account for DSH funding changes if they so choose.

The recommended DSH reduction allotment amounts reflect the Commission's intent to change the schedule and distribution of available DSH funding without changing federal spending. Because the Congressional Budget Office (CBO) does not assume that extending reductions results in dollar-for-dollar federal savings, the amount of funding reduced in FYs 2026–2029 must be larger than the amount of DSH funding added in FYs 2020–2022 for total federal spending to remain unchanged.

Design considerations. The specific amount of reductions in each year could be calibrated to further minimize the change in federal spending based on CBO's final estimate of the costs and

savings of specific legislation. Although the Commission intended this policy to be budget-neutral, CBO estimates that this recommendation would result in federal budget savings ranging from $1.0 billion to $5.0 billion over the FY 2019–2029 budget window. Any savings from CBO's final estimate of legislation to implement the Commission's recommendations could be used to reduce the final amount of reductions after they are phased in or to phase in reductions more gradually.

Under current law, reductions are applied against unreduced DSH allotments, which increase annually based on inflation (Figure 1-2). DSH allotment reductions do not change the amount of this inflation-based increase even though the total amount of available DSH funding is lower. For example, under current law, the portion of inflation-based DSH allotment increases attributable to reduced DSH allotment amounts is projected to be $297 million in FY 2023. In the scenarios below, the Commission assumed that these additional funds would be directed toward states with historically low DSH allotments, but these funds could be used for other purposes.

The Commission's recommendation focuses on the current 10-year budget window used by CBO. In FY 2030 and subsequent years, DSH allotments would return to their higher, unreduced amount. At that time, Congress would be able to examine the early effects of DSH allotment reductions and decide how to proceed with DSH policy in the future.

Under current law, Tennessee does not have a DSH allotment for FY 2026 and beyond.[8] Under the scenarios that we analyzed, we assumed that Tennessee, like other states, would be given a permanent DSH allotment that would increase annually based on inflation.[9]

FIGURE 1-2. Federal DSH Funding Under Various Policy Options, FYs 2019–2029 (billions)

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

Source: MACPAC, 2019, analysis of CBO 2018 and the CMS Medicaid Budget and Expenditure System.

Implications

Federal spending. CBO estimates that this policy will reduce federal spending by $1.0 billion to $5.0 billion over the FY 2020–2029 budget window.

States. Compared to current law, this policy will provide states with additional time to change state hospital payment policies in order to mitigate the full effects of DSH reductions.

Enrollees. It is difficult to predict how the change will affect enrollees because access to hospital services is also affected by how states and hospitals respond to DSH allotment reductions. However, phasing in DSH reductions may reduce the number of providers that respond to these cuts with an immediate reduction of services.

Providers. Providers will have smaller reductions in DSH funding in FYs 2020–2022, but larger reductions in FYs 2026–2028. The introduction of this phase-in period will provide more time for providers to adapt to the reduced levels of DSH funding.

Recommendation 1.2

In order to minimize the effects of disproportionate share hospital (DSH) allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.

Rationale

Reducing unspent DSH funds first minimizes the amount of reductions to DSH funds that are currently paid to providers. In FY 2016, $1.2 billion in federal DSH allotments went unspent, an amount that has been relatively consistent over the past several years.[10]

In some states, unspent DSH funds cannot be spent because the state's DSH allotment exceeds the total amount of hospital uncompensated care in the state.[11] In FY 2016, about half of unspent DSH allotments were attributable to four states (Connecticut, New Hampshire, New Jersey, and Pennsylvania) and the District of Columbia, all of which had FY 2016 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported by hospitals on 2016 Medicare cost reports.[12] These states also accounted for half of unspent DSH funds in FY 2015.

Design considerations. Congress can implement this policy by changing the statutory factors that CMS uses to distribute DSH allotment reductions as opposed to changing the total amount of reductions required by statute. In the scenarios that MACPAC analyzed, we assumed that reductions would be applied to unspent DSH funding first, before distributing remaining reductions among states according to other factors in the reduction methodology.

To project unspent DSH funding in the future, we averaged unspent DSH funding for the three most recent fiscal years available (FYs 2014–2016).[13] We did this because even though the share of state DSH allotments that are unspent year-to-year is relatively consistent for most states, averaging unspent funds in recent years helps smooth any year-to-year variation. We calculated unspent DSH funding using spending reported to CMS in the Medicaid Budget and Expenditure System, which records DSH spending net of any prior period adjustments.[14]

We did not analyze the effects of applying reductions to allotments that continue to be unspent after reductions take effect in FY 2020. It is difficult to project unspent funds in the future because they will be affected by changes in hospital uncompensated care and changes in state Medicaid payment policies. However, Congress could consider changing current law to allow unspent DSH funds to be made available to other states in a process similar to the process currently used for unspent State Children's Health Insurance Program (CHIP) allotments.[15]

A statutory provision that provides authority for CMS to apply DSH allotment reductions through a quarterly disallowance of DSH payments (§ 1923(f)(7)(A)(i)(II) of the Act) could be removed to help clarify that reductions to unspent DSH funding do not affect DSH payments currently made to providers. Striking this provision from the Act would not change current CMS practice: in previous rulemaking, CMS clarified that it will not recoup DSH payments through this process and that DSH allotment reductions will not necessarily result in a corresponding reduction in DSH payments if a state has unspent DSH funds (CMS 2013).

Implications

Federal spending. Applying reductions to unspent DSH funding first is likely to increase federal spending because it distributes more DSH funds to states that are likely to spend the additional amounts. CBO did not provide an estimate for this recommendation as a stand-alone policy separate from the recommendation to phase in the allotment reductions more gradually.

States. This policy will minimize the effects of reductions on states that currently spend their full DSH allotments.

Enrollees. It is difficult to predict how the change may affect enrollees because access to hospital services is also affected by how states and hospitals respond to DSH allotment reductions. However, by minimizing the effects of reductions on providers, this policy may reduce the number of providers that reduce services immediately in response to DSH reductions.

Providers. This policy will have less of an impact on providers than current law because it minimizes the effect of reductions on DSH funds that are currently spent on DSH payments to them.

Recommendation 1.3

In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

Rationale

The Commission has long held that state DSH allotments should better relate to current measures of need rather than to historical spending. Hospital uncompensated care costs are one indication of a state's need for DSH funding, because DSH payments to an individual hospital cannot exceed a hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients. However, a state's need for DSH funding can also be defined by its demographic characteristics. For example, when DSH payments were first established in 1981, they were intended to support hospitals that served "low-income patients with special needs" (§ 1902(a)(13)(A)(iv) of the Act).

The DSH allotment reduction methodology currently prescribed in statute is projected to preserve much of the historical variation in DSH payments. The Commission provided comments on CMS's proposed reduction formula in August 2017 and considered recommending further changes to this methodology, but ultimately concluded that a new statutory formula was needed (MACPAC 2017b). Although CMS's methodology incorporates some current measures of need, such as the share of a state's population that is uninsured, it does not meaningfully improve the relationship between DSH allotments and these factors.

The Commission considered the approach of distributing DSH allotment reductions based on hospital uncompensated care costs in each state, but rejected it because of concerns about the accuracy and completeness of available data. Medicare cost reports provide data on uncompensated care costs for all hospitals in a state, but the definition of uncompensated

care used does not align with the Medicaid DSH definition. In addition, stakeholders have raised concerns about the accuracy of these data (CMS 2015). Medicaid DSH audits contain more accurate information on uncompensated care costs, but they are only available for DSH hospitals and are subject to a three-year data lag.

Instead, the Commission focused its analyses on potential proxy measures for uncompensated care costs that are related to the number of people in a state who are likely to have uncompensated care costs. The Commission examined three potential measures that could be used for this purpose:

- the number of uninsured individuals;
- the number of Medicaid-enrolled and uninsured individuals; and
- the number of non-elderly low-income individuals.

Because uncompensated care costs are affected by hospital costs as well as the number of people who receive uncompensated care, we adjusted each measure based on a statewide composite of the Medicare wage index. Regardless of whether this specific wage-adjustment formula is used, the Commission recommends that the new allotment formula account for differences in hospital costs in different geographic areas.

To evaluate each of the three potential measures, we examined each measure's relationship to hospital uncompensated care costs and the potential effects of the policy on states that expanded Medicaid and those that did not. Based on these analyses, the Commission ruled out using the number of Medicaid enrollees and uninsured individuals because it is not well correlated with hospital uncompensated care costs and is subject to change based on state policy choices. The Commission had a robust discussion about whether allotments should be based on the number of uninsured individuals or on the number of non-elderly low-income individuals in a state, and ultimately decided to recommend using the non-elderly low-income measure.

The number of uninsured individuals and the number of non-elderly low-income individuals in a state are both factors that are moderately correlated with hospital uncompensated care costs (Table 1-1). The number of uninsured individuals

TABLE 1-1. Correlation between Potential DSH Allotment Factors and Total Hospital Uncompensated Care T 1-1

Potential DSH allotment factors	Correlation to total uncompensated care reported on Medicare cost reports (CY 2016)	Correlation to uncompensated care for deemed DSH hospitals reported on DSH audits (SFY 2014)
Number of uninsured individuals	0.87	0.68
Number of Medicaid-enrolled and uninsured individuals	0.60	0.59
Number of non-elderly low-income individuals	0.69	0.67

Notes: DSH is disproportionate share hospital. CY is calendar year. SFY is state fiscal year. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Medicare cost reports define uncompensated care as charity care and bad debt. Medicaid DSH audits define uncompensated care as the sum of unpaid costs of care for uninsured individuals and Medicaid shortfall. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients. Correlations between measures and levels of uncompensated care are represented by Pearson's correlation coefficient. A coefficient of 0 represents no linear correlation and a coefficient of 1 represents a perfect linear correlation. Potential DSH allotment factors were adjusted to account for differences in labor costs in different geographic areas using a statewide composite of the Medicare wage index. CY 2016 data for the factors were compared to uncompensated care reported on 2016 Medicare cost reports, and CY 2014 data for the factors were compared to uncompensated care reported on SFY 2014 DSH audits.

Source: MACPAC, 2019, analysis of Census 2019, CMS 2018a, CMS-64 enrollment data for quarter ending September 30, 2016 as of September 18, 2018, 2014 as-filed DSH audits, and Medicare cost reports.

correlates best with uncompensated care for uninsured individuals reported on Medicare cost reports. However, this measure of uncompensated care does not include Medicaid shortfall, which is part of the DSH definition of uncompensated care. The two measures are similarly correlated to uncompensated care reported on DSH audits, which include Medicaid shortfall and unpaid costs of care for uninsured individuals.

We examined the potential state effects of distributing reductions based on each factor by making a common set of assumptions about how reductions might be applied in order to gradually improve the relationship between DSH allotments and a target, rebased amount (discussed further below). In the future, CMS or Congress could establish different parameters, but for now, our analyses provide a point of comparison that can be used to assess the potential effects of different factors on the amount of reductions for different states.

Among the scenarios we analyzed, basing allotments only on the number of uninsured individuals will result in the largest reductions for Medicaid expansion states, and basing allotments on the number of Medicaid-enrolled and uninsured individuals will result in the smallest reductions for expansion states in the aggregate (Table 1-2). Basing allotments on the number of non-elderly low-income individuals would result in a distribution of reductions that is between the other options. (Under all scenarios, we assumed the amount of reductions under current law, which is $8 billion, or 57 percent of states' unreduced allotment amounts.)[16]

State decisions about whether to expand Medicaid under the ACA have a substantial effect on the number of uninsured individuals and Medicaid enrollees in a state. For example, between 2013 and 2017, states that expanded Medicaid had a 44 percent decline in the number of uninsured individuals, while states that did not expand Medicaid had a 26 percent decline. The number of Medicaid enrollees increased in states that expanded Medicaid, and the increase in Medicaid enrollees has been larger than the decline in the number of uninsured individuals in these states in the aggregate.

In contrast, the number of non-elderly low-income individuals is less affected by state policy choices. For example, between 2013 and 2017, the change in the number of non-elderly low-income individuals in states that expanded Medicaid was a 9.2 percent decline, which was similar to the change in states that did not expand Medicaid (a 9.1 percent decline). Because the number of non-elderly low-income individuals varies less year-to-year than other measures, basing allotments on this factor provides states and hospitals more certainty about future levels of DSH funding if coverage policies change.

TABLE 1-2. Aggregate Percentage Change in DSH Allotments under Various Scenarios, FY 2023 **T 1-2**

Medicaid expansion status as of December 31, 2016	Status quo	Allotments based on number of uninsured individuals	Allotments based on number of Medicaid-enrolled and uninsured individuals	Allotments based on number of non-elderly low-income individuals
Total	-57%	-57%	-57%	-57%
Expansion states	-61	-64	-57	-59
Non-expansion states	-50	-43	-58	-55

Notes: DSH is disproportionate share hospital. FY is fiscal year. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level.

Source: MACPAC, 2019, analysis of Census 2019, CBO 2018, CMS 2018a, CMS-64 enrollment data for quarter ending September 30, 2016 as of September 18, 2018, 2014 as-filed DSH audits, the CMS Medicaid Budget and Expenditure System, and Medicare cost reports.

It is important to note that insurance status will continue to be a factor in other aspects of DSH policy. For example, hospital unpaid costs of care for uninsured individuals affect the total amount of DSH payments that an individual hospital can receive, and many states use this measure as a factor for determining how DSH funds are distributed within a state.[17]

Design considerations. To estimate the state-level effects of this recommendation, we made several assumptions about how reductions might be applied to gradually improve the relationship between DSH allotments and the number of non-elderly low-income individuals in a state. (More details about the specific assumptions that we used to estimate the effects of different scenarios are included in Appendix 1B of this report.) However, the Commission is not recommending specific parameters for this policy. Different parameters would change the effects of reductions on particular states, but the total amount of reductions would stay the same because the total amount of DSH allotment reductions is fixed.

In our analyses, we defined low-income as having a family income of less than 200 percent of the federal poverty level (FPL), which is the definition of low-income currently used in the CHIP statute (§ 2110(c)(4) of the Act).[18] The majority of uninsured individuals have family incomes below 200 percent FPL and more than two-thirds of non-elderly low-income individuals are uninsured or enrolled in Medicaid or other public coverage (Berchick et al. 2018). We used American Community Survey (ACS) five-year estimates because they are more accurate than the ACS one-year estimates, thus reducing the possibility of changes due to normal statistical variation (Census 2018).

To improve the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, we assumed that states would receive reductions to their DSH allotments based on how their unreduced allotments compared to a target, fully rebased allotment amount. We also assumed that states with allotments below the rebased amount would receive small increases to their allotments equal to the portion of inflation-based DSH allotment increases that are attributable to allotment reductions (discussed as a design consideration for Recommendation 1.1, above).

To minimize disruption for states with allotments above the rebased amount, we assumed upper bounds on the amount of reductions as well as on the amount of increases that a state could receive each year. CMS's current reduction formula establishes an upper bound of a 90 percent reduction in DSH payments, but to ensure that reductions are phased in more gradually, we assumed a maximum reduction amount of 30 percent per year. To mitigate the costs of applying an upper bound on DSH allotment reductions, we assumed a 5 percent upper bound on increases to DSH allotments and applied any excess reductions to unspent DSH allotments below the rebased amount.

The upper and lower bounds affect the overall pace of rebasing. Under the approach we analyzed, 26 states would have allotments within 10 percent of the rebased amount by FY 2023. By FY 2029, 45 states and the District of Columbia would have allotments within 10 percent of the rebased amount.

The details of the reduction methodology could be specified in statute or delegated to CMS to define, through regulation within statutorily defined parameters. The rulemaking process would give CMS the opportunity to solicit comments from stakeholders on the specific details of the reduction methodology. However, because DSH allotment reductions are scheduled to take effect in FY 2020, which begins October 1, 2019, the amount of time CMS has to finalize a new regulation is shorter than the amount of time CMS had to finalize the DSH allotment reduction methodology after the passage of the ACA.

Implications

Federal spending. CBO did not estimate this recommendation as a stand-alone policy separate from the recommendations to phase in the

allotment reductions more gradually and to apply the allotment reductions first to states that would not be projected to spend their entire allotments.

States. Compared to current law, this policy will result in larger DSH allotment reductions for states with above average DSH allotments per non-elderly low-income individual and smaller reductions for states with below-average DSH allotments per non-elderly low-income individual. This policy does not change the total amount of reductions for all states.

Enrollees. It is difficult to predict how the change may affect enrollees because access to hospital services is also affected by how states and hospitals respond to DSH allotment reductions. The proposed rebasing policy does not change the total amount of reductions but it changes which states are most affected.

Providers. This policy will affect providers differently based on their states, but the total amount of reductions in DSH funding is unchanged. We project that most states will be able to continue to make the same amount of DSH payments to deemed DSH hospitals as under current law if they target remaining DSH funds to these providers.

State-by-State Effects

Below we review the estimated effects of the recommendations relative to current law and total Medicaid hospital spending when allotment reductions are fully phased in during FY 2023. Complete information about the state-by-state effects is provided in Appendix 1A of this report. More information about the assumptions we used to estimate how CMS might apply reductions to gradually improve the relationship between DSH allotments and the number of non-elderly low-income individuals in a state are described in Appendix 1B of this report.

Recommendations compared to current law

Compared to current law, our recommendations result in larger DSH allotment reductions for states with unspent DSH funding. For example, in FY 2023, the total DSH allotment reductions for states with more than 50 percent of their DSH allotment unspent is projected to be $617 million, which is about twice as much as the amount of reductions for these states projected under current law ($327 million). However, the net effect on DSH payments to providers in these states will be smaller than the cut to DSH allotments, because these states were not previously spending their full DSH allotment.

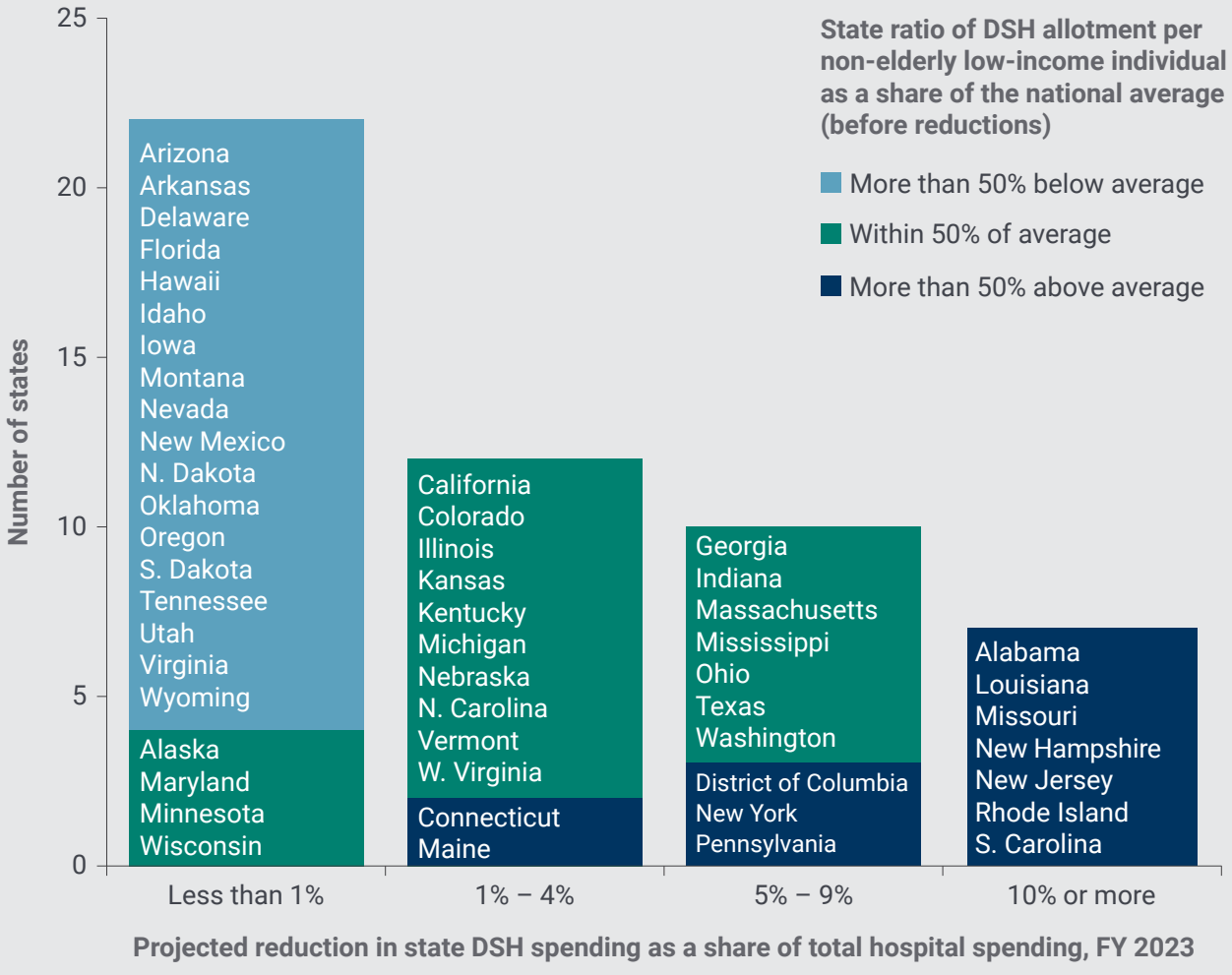
The recommendations also result in smaller reductions for states with low ratios of DSH allotments per non-elderly low-income individual. For example, total DSH funding for states with a ratio of allotments per non-elderly low-income individual below 50 percent of the national average is projected to be almost twice as large under the proposed policy as under the status quo in FY 2023 ($597 million for the status quo versus $1.0 billion under the proposed policy). States that are statutorily designated as low-DSH states also receive small reductions under CMS's current methodology, but states that receive the biggest percentage point increase in DSH funding under the recommended policy relative to the status quo are those that have low ratios of DSH allotments per non-elderly low-income individual but do not meet the current definition of a low-DSH state (e.g., Arizona, Florida, and Virginia).

Reductions relative to total Medicaid hospital spending

The Commission's recommendations assume the same level of funding as under current law, but it is important to consider DSH funding in the context of total Medicaid hospital spending. In FY 2023, the total amount of reductions scheduled is $8 billion, which is more than half of state DSH allotments, but only 5 percent of total projected Medicaid hospital spending.

Under the Commission's recommendations, 34 states are projected to have DSH payment reductions that are less than 5 percent of total Medicaid hospital spending, including all states with ratios of DSH allotments per non-elderly low-income individual less than 50 percent of the national average (Figure 1-3). These states include all 17 states that are statutorily designated as low-DSH states because they had low levels of DSH spending relative to other states in FY 2000. An additional 17 states that do not meet the definition of low-DSH states are also projected to have DSH payment reductions that are less than 5 percent of total Medicaid hospital spending because they have relatively low ratios of DSH allotments per non-elderly low-income individual.

FIGURE 1-3. Projected Reduction in State DSH Spending as a Share of Total Medicaid Hospital Spending under MACPAC Recommendations, FY 2023



Notes: DSH is disproportionate share hospital. FY is fiscal year. Reductions in DSH spending exclude reductions applied to unspent DSH funding. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Total Medicaid hospital spending includes fee-for-service base payments, supplemental payments, and an estimate of managed care payments to hospitals. The number of states includes the District of Columbia.

Source: MACPAC, 2019, analysis of Census 2019, CBO 2018, CMS 2018a, OACT 2018, 2014 as-filed DSH audits, and the CMS Medicaid Budget and Expenditure System.

Seven states are projected to have reductions in DSH spending greater than or equal to 10 percent of their total Medicaid hospital spending in FY 2023 (Table 1-3). All of these states are projected to receive reductions up to the upper limit that we assumed in our analysis (30 percent per year, which is a 76 percent cumulative reduction by FY 2023) because they have particularly high DSH allotments relative to the number of non-elderly low-income individuals in their state. Among these states, Alabama and Rhode Island are projected to have FY 2023 DSH reductions that are smaller than under current law, while other states in this group are projected to have larger reductions than under current law.

Some states may be able to offset some of the effects of DSH allotment reductions by increasing other types of Medicaid payments to hospitals (Box 1-1). For example, Rhode Island reported $145 million in Medicaid shortfall for DSH hospitals in state fiscal year 2014, which is more than the $119 million reduction in DSH spending for Rhode Island projected in FY 2023 under the Commission's recommendations (state and federal funds combined). States could also minimize the effects of reductions on particular types of hospitals, such as deemed DSH hospitals, by targeting remaining DSH funds to them rather than broadly distributing DSH payments to all hospitals in the state. However, these types of changes could take several years for states to implement and may be difficult to finance if states have to change the source of non-federal share used for these payments.

Louisiana is currently in the process of shifting $379 million in DSH payments to base rate increases for hospitals (an amount equal to 12 percent of total hospital payments in FY 2016). This policy is intended to reduce the state's reliance on supplemental payments because base payments are more closely tied to services that are provided

TABLE 1-3. Characteristics of States with Projected Reductions in DSH Payments Greater Than or Equal To 10 Percent of Medicaid Hospital Spending under MACPAC Recommendations, FY 2023

T 1-3

State	Projected reduction in DSH spending, millions (percent of total Medicaid hospital spending)		Medicaid shortfall for DSH hospitals, millions (SPRY 2014)	Share of DSH payments to deemed DSH hospitals (SPRY 2014)
	Current law	MACPAC recommendations		
Alabama	$416 (15%)	$412 (14%)	$124	6%
Louisiana[1]	662 (14)	1,009 (21)	525	73
Missouri	448 (10)	604 (13)	–[2]	49
New Hampshire	–[3]	109 (15)	N/A[3]	23
New Jersey	719 (12)	970 (16)	393	82
Rhode Island	137 (12)	119 (10)	145	17
South Carolina	349 (14)	442 (17)	164	39

Notes: DSH is disproportionate share hospital. FY is fiscal year. SPRY is state plan rate year. N/A is not applicable. Total Medicaid hospital spending includes fee-for-service base payments, supplemental payments, and an estimate of managed care payments to hospitals.

– Dash indicates zero.

[1] Louisiana is currently planning to reduce DSH spending by $379 million in 2019 and shift these funds to base-rate increases for hospitals. This change in policy is not reflected in the estimates of projected reductions in DSH spending above.

[2] Missouri did not report any Medicaid shortfall in the aggregate on its SPRY 2014 DSH audit.

[3] Under current law, the projected reduction in DSH payments for New Hampshire is less than the amount of DSH funding that is projected to be unspent, so we do not project a reduction in DSH payments to providers.

Source: MACPAC, 2019, analysis of Census 2019, CBO 2018, CMS 2018a, OACT 2018, 2014 as-filed DSH audits, and the CMS Medicaid Budget and Expenditure System.

BOX 1-1. Types of Medicaid Payments Used to Pay for Costs of Care Provided to Medicaid-Enrolled Patients

States make a number of different types of payments to hospitals and have broad flexibility to design their own payment methods. However, each type of Medicaid payment is subject to its own unique rules and limitations. Common types of Medicaid payments to hospitals include:

Base payments. In fee-for-service (FFS) and managed care delivery systems, base payments pay for specific services provided to Medicaid enrollees. Different base rates can be applied for different types of hospitals, but ultimately, payments are based on Medicaid utilization and delivery of services.

Upper payment limit (UPL) payments. UPL payments are lump-sum supplemental payments that are intended to fill in the difference between FFS base payments and the amount that Medicare would have paid for the same service (See note). States can make additional UPL payments to providers as long as aggregate FFS payments to a class of providers is below a reasonable estimate of the amount that Medicare would have paid.

Directed payments. In managed care, states can direct plans to use a portion of their capitation rate to increase payments to providers. Directed payments must be based on utilization and delivery of services, distributed based on the same terms for all providers in a class, and advance at least one of the goals in the state's quality strategy. Directed payments also cannot be contingent on the provider's willingness to provide intergovernmental transfer financing.

Disproportionate share hospital (DSH) payments. DSH payments are statutorily required payments for hospitals that serve a high share of Medicaid-enrolled and low-income patients. DSH payments to an individual hospital cannot exceed the hospital's uncompensated care costs, defined as the sum of Medicaid shortfall and hospital unpaid costs of care for uninsured patients.

Additional information on all types of Medicaid payments to hospitals is provided in MACPAC's issue brief, *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2019). Additional information on UPL payments is provided in Chapter 2 of this report.

Note: Although the term UPL payments is not defined in statute or regulation, we use this term to distinguish supplemental payments that are subject to the UPL from those that are not, such as DSH payments and supplemental payments authorized under Section 1115 demonstrations.

to Medicaid enrollees. Although Louisiana plans to make the same total amount of payments to hospitals under the new policy, some stakeholders we spoke with during the summer of 2018 were concerned that the distribution of payments might change. DSH payments in the state are distributed based on hospital uncompensated care costs, while base payments are distributed based on Medicaid utilization (Marks et al. 2018).

In SPRY 2014, about $2.4 billion in DSH payments (14 percent of total DSH payments) were made to institutions for mental diseases (IMDs), which are eligible to receive Medicaid payment for services provided to individuals age 21–64 only under limited circumstances. IMD services for Medicaid-eligible patients that cannot otherwise be paid for by Medicaid are reported as uncompensated care costs for Medicaid DSH purposes. Medicaid

managed care organizations can make payments for some services provided to these individuals under the in-lieu of services provision (42 CFR 438.6(e)). CMS has recently expanded opportunities for states to pay for IMD services using Section 1115 waiver authority. These policies may reduce the amount of uncompensated care that these facilities report in the future (CMS 2018b).

Next Steps

If DSH allotment reductions take effect as scheduled, the Commission will monitor the effects of these reductions on states, providers, and enrollees. While we know that DSH funds are an important source of revenue for many safety-net hospitals, little information is available to suggest how states and hospitals will respond.

Because some states may respond to DSH allotment reductions by changing other Medicaid payments to hospitals, we will continue to examine Medicaid hospital payments holistically. The Commission has outlined a long-term hospital payment work plan that will consider all types of Medicaid payments to hospitals in relation to the statutory goals of efficiency, economy, quality, and access (MACPAC 2018).

Endnotes

[1] Chapter 3 of MACPAC's March 2017 report reviews approaches for improving the targeting of DSH payments to providers (MACPAC 2017a).

[2] The total amount of DSH payments increased from $1.3 billion in 1990 to $17.7 billion in 1992 (Holahan et al. 1998).

[3] Additional information about the factors in CMS's current DSH allotment reduction methodology is provided in Chapter 3 of this report.

[4] 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. CMS's reduction methodology allocates a smaller proportion of the total DSH allotment reductions to low-DSH states.

[5] To implement DSH allotment reductions under current law, CMS would need to finalize its 2017 DSH reduction rule or propose a new rule to finalize its methodology.

[6] In 2016, operating margins for deemed DSH hospitals in expansion states were negative 9.2 percent before DSH payments, and operating margins for deemed DSH hospitals in non-expansion states were negative 1.2 percent before DSH payments. Deemed DSH hospitals in expansion states also reported lower operating margins before DSH payments in 2013 (negative 8.5 percent) than deemed DSH hospitals in non-expansion states (negative 1.2 percent). Additional information about hospital margins and the limits of available data are provided in Chapter 3 of this report.

[7] Bad debt expenses are expected payment amounts that a hospital is not able to collect from patients who, according to the hospital's determination, have the financial capacity to pay. Bad debt for individuals with insurance is not included in the Medicaid DSH definition of uncompensated care.

[8] Under current law, the DSH allotment for Tennessee is fixed in statute at $53.1 million until FY 2025 and then returns to $0 in FY 2026. Tennessee does not have a permanent DSH allotment under current law because the state used its DSH funding in the budget neutrality calculations of its Section 1115 waiver when DSH limits were first established.

[9] The ACA made a similar change for Hawaii, which previously did not have a permanent DSH allotment for the same reasons as Tennessee.

[10] Our 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 in their Section 1115 waivers. Although DSH allotments for these states are reported as unspent in the CMS Medicaid Budget and Expenditure System (MBES), we treated these funds as spent in our analyses. In our analyses, we did not apply any other special adjustments for states that use DSH funding in the budget neutrality assumptions for their Section 1115 waivers.

[11] By law, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care.

[12] 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 DSH definition of uncompensated care.

[13] In general, states have up to two years to spend DSH funds from their allotment for a given year. However, in some circumstances, states may withhold DSH funds and make DSH payments at a later date. For example, Texas withheld 3.5 percent of all DSH payments beginning in FY 2014 pending the outcome of litigation related to the calculation of Medicaid shortfall for DSH audits (HMA 2016).

[14] For example, if DSH payments to a hospital were recouped as a result of the findings of a state's DSH audit, these recouped funds would be reported as a prior period adjustment and would be reported as unspent in the CMS MBES.

[15] For additional information about the process for allocating unspent funds in CHIP, see MACPAC's issue brief, *Federal CHIP funding: When Will States Exhaust Allotments?* (MACPAC 2017e).

[16] These scenarios also assume implementation of MACPAC's other recommendations to phase in reductions gradually and to apply reductions to unspent DSH funding first. Additional information about the methodology used to estimate DSH allotment reductions under various scenarios is provided in Appendix 1B of this report.

[17] Based on MACPAC's review of state DSH targeting policies in 2016, about half of states (24) distributed DSH payments based on hospital uncompensated costs (MACPAC 2017a).

[18] The current federal poverty measure does not account for differences in cost of living in different geographic areas, but the U.S. Census Bureau does not regularly report state-level data that can be used to make this adjustment. For example, the U.S. Census Bureau calculates a supplemental poverty measure annually that considers the costs of food, clothing, shelter, and utilities in different geographic areas, but these data are not reported at the state level (Fox 2018).

[19] To implement DSH allotment reductions that were initially scheduled to take effect October 1, 2013, CMS issued a proposed rule in September 2013 and a final rule in September 2014.

References

Berchick, E., E.R. Hood, and J.C. Barnett. 2018. *Health insurance coverage in the United States: 2017*. Current population reports, P60-264. Washington, DC: U.S. Government Printing Office. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. FY 2019 IPPS final rule homepage. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. Letter from Mary Mayhew to state Medicaid directors regarding "Opportunities to design innovative service delivery systems for adults with a serious mental illness or children with a serious emotional disturbance." November 13, 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Medicaid program: State disproportionate share hospital allotment reductions. Proposed rule. *Federal Register* 82, no. 144 (July 28): 33155–35171. https://www.federalregister.gov/d/2017-15962.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Medicaid program: State disproportionate share hospital allotment reductions. Final rule. *Federal Register* 78, no. 181 (September 18): 57293–57313. https://www.federalregister.gov/a/2013-22686.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Medicare program: Hospital inpatient prospective payment systems

for acute care hospitals and the long-term care hospital prospective payment system policy changes and fiscal year 2016 rates; revisions of quality reporting requirements for specific providers, including changes related to the electronic health record incentive program; extensions of the Medicare-dependent, small rural hospital program and the low-volume payment adjustment for hospitals. Final rule. *Federal Register* 80, no. 158 (August 17): 49325–49886. https://www.federalregister.gov/d/2015-19049.

Congressional Budget Office (CBO). 2018. *An update to the economic outlook: 2018 to 2028*. Washington, DC: CBO. https://www.cbo.gov/publication/54318.

Fox, L. 2018. *The supplemental poverty measure: 2017*. Current population reports, P60-265. Suitland, MD: U.S. Census Bureau. https://www.census.gov/library/publications/2018/demo/p60-265.html.

Health Management Associates (HMA). 2016. *Evaluation of uncompensated care and Medicaid payments in Texas hospitals and the role of Texas' uncompensated care pool*. Austin, TX: Texas Health and Human Services Commission. https://hhs.texas.gov/reports/2016/08/evaluation-uncompensated-care-medicaid-payments-texas-hospitals-role-texas-uc-pool.

Holahan, J., B.K. Bruen, and D. Liska. 1998. *The decline in Medicaid spending growth in 1996: Why did it happen?* Washington, DC: Urban Institute. http://webarchive.urban.org/UploadedPDF/410365.pdf.

Marks, T., K. Gifford, S. Perlin, et al. 2018. *Factors affecting the development of Medicaid hospital payment policies: Findings from structured interviews in five states*. Final report to the Medicaid and CHIP Payment and Access Commission. Washington, DC: Health Management Associates. https://www.macpac.gov/publication/factors-affecting-the-development-of-medicaid-hospital-payment-policies-findings-from-structured-interviews-in-five-states.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *Medicaid base and supplemental payments to hospitals*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Medicaid hospital payment: Policy issues and Commission analytic plan. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-hospital-payment-policy-issues-and-commission-analytic-plan/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017a. Chapter 3: Improving the targeting of disproportionate share hospital payments to providers. In *Report to Congress on Medicaid and CHIP*. March 2017. Washington, DC: MACPAC. https://www.macpac.gov/publication/improving-the-targeting-of-disproportionate-share-hospital-payments-to-providers/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017b. Letter from Penny Thompson to Thomas E. Price regarding "CMS-2394-P Medicaid program: Disproportionate share hospital allotment reductions." August 28, 2017. https://www.macpac.gov/publication/comments-on-proposed-dsh-reduction-rule/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017c. *Profiles of disproportionate share hospitals*. Washington, DC: MACPAC. https://www.macpac.gov/publication/profiles-of-disproportionate-share-hospitals/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017d. Themes from expert roundtable on DSH payments and next steps for MACPAC work. October 2017. Washington, DC: MACPAC. https://www.macpac.gov/publication/themes-from-expert-roundtable-on-dsh-payments-and-next-steps-for-macpac-work/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017e. *Federal CHIP funding: When will states exhaust allotments*. July 2017. Washington, DC: MACPAC. https://www.macpac.gov/publication/federal-chip-funding-when-will-states-exhaust-allotments/.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2018. National health expenditures historical and projections: 1960–2026. Baltimore, MD: OACT.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

U.S. Census Bureau (Census). 2019. American Community Survey. Suitland, MD: Census. https://factfinder.census.gov.

U.S. Census Bureau (Census). 2018. American community survey: When to use 1-year, 3-year, or 5-year estimates. September 6. Suitland, MD: Census. https://www.census.gov/programs-surveys/acs/guidance/estimates.html.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on improving the structure of disproportionate share hospital allotment reductions. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on the recommendations in this chapter on January 24, 2019, voting on all three recommendations as one package.

Improving the Structure of Disproportionate Share Hospital Allotment Reductions

1.1 If Congress chooses to proceed with disproportionate share hospital (DSH) allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in FY 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.

1.2 In order to minimize the effects of disproportionate share hospital (DSH) allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.

1.3 In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

Yes:	Bella, Burwell, Carter, Cerise, Davis, Douglas, George, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno	16	Yes
No:	Gordon	1	No
		0	Not voting

APPENDIX 1A: State-Level Data

TABLE 1A-1. State-Level Factors in Recommended DSH Allotment Reduction Formula T 1A-1

State	Average share of DSH allotment unspent (FYs 2014–2016)	Number of non-elderly low-income individuals, millions (CYs 2013–2017)	Statewide composite of the Medicare wage index (FY 2019)
Total	**9%**	**88.9**	**N/A**
Alabama	0	1.6	0.8
Alaska	50	0.2	1.2
Arizona	0	2.2	1.1
Arkansas	20	1.0	0.8
California	—[1]	11.5	1.4
Colorado	0	1.3	1.0
Connecticut	67	0.7	1.3
Delaware	20	0.2	1.1
District of Columbia	10	0.2	1.0
Florida	3	6.0	0.9
Georgia	0	3.3	0.9
Hawaii	56	0.3	1.3
Idaho	0	0.5	0.9
Illinois	3	3.3	1.0
Indiana	11	1.9	1.0
Iowa	37	0.7	0.9
Kansas	0	0.8	0.9
Kentucky	0	1.4	0.9
Louisiana	3	1.6	0.8
Maine	74	0.3	1.0
Maryland	32	1.1	1.0
Massachusetts	—[1]	1.3	1.4
Michigan	10	2.8	1.0
Minnesota	66	1.2	1.1
Mississippi	0	1.1	0.8
Missouri	13	1.7	0.9
Montana	0	0.3	1.0
Nebraska	16	0.5	0.9
Nevada	0	0.9	1.1
New Hampshire	65	0.2	1.1
New Jersey	19	1.8	1.2
New Mexico	2	0.8	0.9
New York	0	5.2	1.2

TABLE 1A-1. (continued)

State	Average share of DSH allotment unspent (FYs 2014–2016)	Number of non-elderly low-income individuals, millions (CYs 2013–2017)	Statewide composite of the Medicare wage index (FY 2019)
North Carolina	1%	3.1	0.9
North Dakota	91	0.2	1.0
Ohio	0	3.2	0.9
Oklahoma	30	1.2	0.9
Oregon	1	1.2	1.2
Pennsylvania	24	3.0	1.0
Rhode Island	0	0.2	1.1
South Carolina	1	1.5	0.9
South Dakota	93	0.2	1.0
Tennessee	3	2.1	0.8
Texas	4	8.7	0.9
Utah	3	0.8	1.0
Vermont	14	0.1	1.0
Virginia	27	1.8	0.9
Washington	7	1.7	1.1
West Virginia	28	0.6	0.8
Wisconsin	68	1.4	1.0
Wyoming	1	0.1	1.0

Notes: FY is fiscal year. CY is calendar year. N/A is not applicable. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. The statewide Medicare wage index was developed based on a weighted average of each hospital's final Medicare wage index and the number of provider hours used in the hospital's wage index calculation.

— Dash indicates zero; 0% indicates a non-zero amount less than 0.5 percent that rounds to zero.

[1] We considered DSH funding for California and Massachusetts to be fully spent in our analysis because these states use their DSH allotment in the budget neutrality assumptions in their Section 1115 waivers.

Source: MACPAC, 2019, analysis of Census 2019, CMS 2018a, and the CMS Medicaid Budget and Expenditure System.

TABLE 1A-2. DSH Allotment Changes under Status Quo and MACPAC Recommendations, FY 2023 (federal funds, millions) T 1A-2

State	Unreduced allotment amount	Status quo		MACPAC recommendations		Percentage point change in DSH reductions (Recommended policy minus status quo)	Average share of DSH allotment unspent (FYs 2014–2016)	Unreduced DSH allotment per non-elderly low-income individual (wage adjusted) as a share of the national average
		Dollar change	Percent change	Dollar change	Percent change			
Total	**$13,925**	**-$8,000**	**-57%**	**-$8,000**	**-57%**	**—**	**9%**	**100%**
Alabama	390	-299	-77	-297	-76	1%	0	210
Alaska	26	-4	-14	-13	-50	-36	50	84
Arizona	129	-73	-57	17	13	70	0	37
Arkansas	55	-14	-26	-7	-13	13	20	44
California	1,391	-728	-52	-330	-24	29	—[1]	56
Colorado	117	-58	-50	-33	-28	21	0	59
Connecticut	254	-139	-55	-197	-78	-23	67	191
Delaware	11	-2	-17	1	10	27	20	32
District of Columbia	78	-51	-65	-61	-78	-13	10	298
Florida	254	-134	-53	50	20	73	3	31
Georgia	341	-147	-43	-154	-45	-2	0	78
Hawaii	12	-2	-13	-1	-12	1	56	23
Idaho	21	-3	-15	4	21	37	0	28
Illinois	273	-106	-39	-60	-22	17	3	54
Indiana	271	-155	-57	-153	-56	1	11	98
Iowa	50	-8	-16	-13	-27	-11	37	48
Kansas	52	-32	-61	-9	-17	43	0	52
Kentucky	184	-127	-69	-104	-57	12	0	99
Louisiana	870	-454	-52	-667	-77	-24	3	449
Maine	133	-49	-37	-112	-84	-47	74	266
Maryland	97	-58	-60	-29	-30	30	32	58
Massachusetts	387	-315	-81	-274	-71	11	—[1]	147
Michigan	336	-254	-76	-159	-47	28	10	81
Minnesota	95	-14	-15	-44	-46	-31	66	50
Mississippi	194	-87	-45	-136	-70	-25	0	145

TABLE 1A-2. (continued)

State	Unreduced allotment amount	Status quo		MACPAC recommendations		Percentage point change in DSH reductions (Recommended policy minus status quo)	Average share of DSH allotment unspent (FYs 2014–2016)	Unreduced DSH allotment per non-elderly low-income individual (wage adjusted) as a share of the national average
		Dollar change	Percent change	Dollar change	Percent change			
Missouri	$601	-$370	-62%	-$475	-79%	-18%	13%	264%
Montana	14	-3	-21	3	21	42	0	33
Nebraska	36	-7	-20	-7	-20	-0	16	53
Nevada	59	-13	-22	5	8	30	0	39
New Hampshire	203	-107	-52	-186	-92	-39	65	548
New Jersey	817	-516	-63	-658	-81	-17	19	243
New Mexico	26	-4	-16	5	21	36	2	24
New York	2,039	-1,300	-64	-1,550	-76	-12	0	219
North Carolina	374	-227	-61	-189	-50	10	1	86
North Dakota	12	-1	-9	-7	-62	-53	91	51
Ohio	516	-415	-81	-332	-64	16	0	120
Oklahoma	46	-7	-16	2	3	19	30	28
Oregon	57	-13	-22	12	21	43	1	28
Pennsylvania	712	-514	-72	-521	-73	-1	24	159
Rhode Island	83	-72	-87	-63	-76	11	0	205
South Carolina	416	-251	-60	-316	-76	-16	1	206
South Dakota	14	-1	-7	-8	-54	-47	93	42
Tennessee[2]	59	–	–	11	20	20	3	22
Texas	1,214	-512	-42	-688	-57	-14	4	99
Utah	25	-6	-25	5	20	44	3	22
Vermont	29	-24	-85	-19	-68	17	14	132
Virginia	111	-74	-67	-19	-17	49	27	44
Washington	235	-179	-76	-106	-45	31	7	78
West Virginia	86	-54	-63	-55	-64	-1	28	118
Wisconsin	120	-14	-12	-61	-51	-39	68	57
Wyoming	0	0	-18	0	21	39	1	1

TABLE 1A-2. (continued)

Notes: DSH is disproportionate share hospital. FY is fiscal year. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. DSH allotments per non-elderly low-income individual were adjusted to account for differences in labor costs in different geographic areas using a statewide composite of the Medicare wage index.

— Dash indicates zero; $0 or -$0 indicates an amount between $0.5 million and -$0.5 million that rounds to zero. 0% or -0% indicates an amount between 0.5% and -0.5% that rounds to zero.

[1] We considered DSH funding for California and Massachusetts to be fully spent in our analysis because these states use their DSH allotment in the budget neutrality assumptions in their Section 1115 waivers.

[2] Under current law, DSH allotments for Tennessee are fixed in statute and are not subject to DSH allotment reductions. In this analysis, we assumed that DSH allotment increases and reductions would be applied to Tennessee in the same manner as other states.

Source: MACPAC, 2019, analysis of Census 2019, CBO 2018, CMS 2018a, 2014 as-filed DSH audits, and the CMS Medicaid Budget and Expenditure System.

TABLE 1A-3. Reductions in DSH Spending as a Share of Total Medicaid Payments to Hospitals under Status Quo and MACPAC Recommendations, FY 2023 (millions, state and federal funds)

T 1A-3

State	Projected total Medicaid hospital spending	Status quo		MACPAC recommendations		Medicaid shortfall reported for all DSH hospitals in state (SPRY 2014)	Share of DSH payments to deemed DSH hospitals (SPRY 2014)
		Dollar change	Percent change	Dollar change	Percent change		
Total	**$240,603**	**-$12,267**	**-5%**	**-$12,088**	**-5%**	**$12,266**	**70%**
Alabama	**2,858**	-416	-15	-412	-14	124	6
Alaska	**800**	–	–	–	–	–	68
Arizona	**5,841**	-105	-2	–	–	817	100
Arkansas	**1,548**	-5	-0	–	–	23	100
California	**39,570**	-1,456	-4	-660	-2	380	97
Colorado	**3,962**	-116	-3	-66	-2	29	63
Connecticut	**2,444**	–	–	-52	-2	236	20
Delaware	**825**	–	–	–	–	18	100
District of Columbia	**956**	-61	-6	-76	-8	45	100
Florida	**10,134**	-208	-2	–	–	–	86
Georgia	**4,411**	-217	-5	-227	-5	148	56
Hawaii	**958**	–	–	–	–	–	N/A
Idaho	**647**	-4	-1	–	–	–	56
Illinois	**7,866**	-192	-2	-101	-1	–	100
Indiana	**3,230**	-189	-6	-186	-6	47	61
Iowa	**1,752**	–	–	–	–	50	100
Kansas	**1,448**	-55	-4	-16	-1	94	38
Kentucky	**3,287**	-177	-5	-145	-4	205	70
Louisiana	**4,768**	-662	-14	-990	-21	525	73
Maine	**811**	–	–	-21	-3	8	100
Maryland	**3,626**	-54	-1	–	–	–	60
Massachusetts	**6,964**	-631	-9	-548	-8	–	N/A
Michigan	**6,498**	-345	-5	-198	-3	264	41
Minnesota	**3,149**	–	–	–	–	190	92
Mississippi	**1,985**	-114	-6	-178	-9	–	66
Missouri	**4,506**	-448	-10	-609	-14	–	49
Montana	**897**	-5	-1	–	–	18	15
Nebraska	**567**	-2	-0	-3	-0	150	85
Nevada	**1,408**	-20	-1	–	–	156	95
New Hampshire	**723**	–	–	-107	-15	–[1]	23
New Jersey	**5,910**	-719	-12	-1,004	-17	393	82
New Mexico	**2,220**	-5	-0	–	–	–	80

TABLE 1A-3. (continued)

State	Projected total Medicaid hospital spending	Status quo		MACPAC recommendations		Medicaid shortfall reported for all DSH hospitals in state (SPRY 2014)	Share of DSH payments to deemed DSH hospitals (SPRY 2014)
		Dollar change	Percent change	Dollar change	Percent change		
New York	**$33,100**	-$2,597	-8%	-$3,096	-9%	$4,284	73
North Carolina	**7,531**	-333	-4	-276	-4	–	71
North Dakota	**323**	–	–	–	–	–	34
Ohio	**8,952**	-658	-7	-526	-6	$809	33
Oklahoma	**2,437**	–	–	–	–	–	36
Oregon	**2,760**	-19	-1	–	–	–	52
Pennsylvania	**8,851**	-661	-7	-676	-8	1,977	53
Rhode Island	**1,149**	-137	-12	-119	-10	145	17
South Carolina	**2,578**	-349	-14	-441	-17	164	39
South Dakota	**318**	–	–	–	–	49	43
Tennessee[2]	**3,586**	–	–	–	–	–	66
Texas	**20,070**	-808	-4	-1,109	-6	–	83
Utah	**894**	-8	-1	–	–	–	6
Vermont	**661**	-37	-6	-28	-4	77	43
Virginia	**2,819**	-89	-3	–	–	9	91
Washington	**3,643**	-324	-9	-178	-5	563	63
West Virginia	**1,567**	-40	-3	-41	-3	–[1]	60
Wisconsin	**2,616**	–	–	–	–	263	52
Wyoming	**179**	0	0	–	–	7	29

Notes: DSH is disproportionate share hospital. FY is fiscal year. SPRY is state plan rate year. N/A is data not available. Reductions in DSH spending exclude reductions applied to unspent DSH funding. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Total Medicaid hospital spending includes fee-for-service base payments, supplemental payments, and an estimate of managed care payments to hospitals. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income individuals.

— Dash indicates zero; $0 or -$0 indicates an amount between $0.5 million and -$0.5 million that rounds to zero. 0% or -0% indicates an amount between 0.5% and -0.5% that rounds to zero.

[1] Medicaid shortfall is not reported for New Hampshire and West Virginia because these states did not include payments from third-party payers when calculating Medicaid shortfall.

[2] Under current law, DSH allotments for Tennessee are fixed in statute and are not subject to DSH allotment reductions. Under the rebasing scenarios, we assumed that DSH allotment increases and reductions would be applied to Tennessee in the same manner as other states.

Source: MACPAC, 2019, analysis of Census 2019, CBO 2018, CMS 2018a, OACT 2018, 2014 as-filed DSH audits, and the CMS Medicaid Budget and Expenditure System.

APPENDIX 1B: Methodology for Estimating the Effects of the Disproportionate Share Hospital Allotment Reduction Recommendations

To estimate the effects of the disproportionate share hospital (DSH) allotment reduction recommendations in this chapter, we first estimated unreduced DSH allotments under current law using the methodology described in Appendix 3B of this report. Then, we estimated the amount of reduced allotments under the recommended methodology by adjusting the schedule of allotment reductions and the methodology for distributing reductions among states.

Data sources

There are three factors in the recommended reduction methodology:

- the number of non-elderly low-income individuals in a state;
- a statewide composite of the Medicaid wage index; and
- projected unspent DSH funding.

We defined non-elderly low-income individuals as those under age 65 with family incomes below 200 percent of the federal poverty level (FPL). We calculated this measure using the 2013–2017 five-year estimates from the American Community Survey (ACS), which are the most reliable data available (Census 2018).

We calculated a statewide composite of the Medicare wage index using data from the fiscal year (FY) 2019 Medicare inpatient prospective payment system final rule. Specifically, we calculated the composite using a weighted average of hospitals' final Medicare wage index and the number of provider hours used in the hospital's wage index calculation.

We projected unspent DSH funding by averaging the share of DSH allotments that were unspent in a state from FY 2014 through FY 2016. Because states have up to two years to spend DSH allotment for a given year, FY 2016 is the most recent year of unspent DSH funding available. Because Massachusetts and California use their DSH allotment in the budget neutrality calculation for their Section 1115 demonstrations, we did not consider DSH allotments in these states to be unspent.

To examine the effects of distributing allotment reductions using other measures, we also examined data on the number of uninsured individuals in a state and the number of Medicaid enrollees in a state. We calculated the number of uninsured individuals using 2017 ACS data, the most recent data available, and we calculated the number of Medicaid enrollees using Form CMS-64 enrollment reports. Although the ACS also includes estimates of Medicaid enrollment, we used administrative data submitted to the Centers for Medicare & Medicaid Services (CMS) because it is more accurate. However, one limitation of this approach is that we could not separately identify non-elderly Medicaid enrollees using CMS-64 data. In future years, more detailed Medicaid enrollment information should be available through the Transformed Medicaid Statistical Information System (T-MSIS).

Allotment reduction method

To estimate the effects of distributing allotments in a way that would gradually improve the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, we first calculated what state allotments would be if they were fully rebased according to this factor. Then, we applied several adjustments to gradually phase in reductions based on the rebased amount.

The rebasing target for each state was calculated by multiplying the number of non-elderly low-income individuals in the state by the national average of DSH funding per non-elderly low-income individual. This amount was adjusted to account for geographic variation in hospital costs by multiplying the amount by the statewide composite of the Medicare wage index.

To phase in rebasing along with allotment reductions, we assumed that most of the reductions would be applied to states with allotments above the rebased amount. We also assumed that states with allotments below the rebased amount would receive small increases to their allotments equal to the portion of inflation-based DSH allotment increases that are attributable to allotment reductions (Table 1B-1). However, in FY 2025 and subsequent years, the amount of this inflation-based increase is larger than the amount of funds needed to fully rebase DSH allotments for states with historically low ratios of DSH allotments per non-elderly low-income individual, so we assumed that the excess funds would be applied as larger inflation-based increases for all states.

To distribute reductions among states, we first applied reductions to projected unspent DSH funds for states with allotments above the rebased amount. At this step, allotments were not reduced below the rebased amount, even if the state had more of its DSH funding that was projected to be unspent.

Next, we applied any remaining reductions to states proportionally based on the difference between their unreduced allotment and the rebased allotment amount (after accounting for reductions due to unspent DSH funding). Similarly, we applied increases to states with allotments below the rebased amount proportionally based on the difference between the state's unreduced allotment and the rebased amount.

Finally, we compared the percentage change in each state's DSH allotment to the upper bounds assumed in our analysis. For reductions, we assumed an upper bound of 30 percent a year, excluding reductions applied to unspent DSH funding (resulting in a cumulative reduction of 76 percent by FY 2023). For allotment increases, we assumed an upper bound of 5 percent a year (resulting in a cumulative increase of 22 percent by FY 2023).

TABLE 1B-1. Inflation-Based DSH Allotment Increases Attributable to DSH Allotment Reductions (millions) T 1B-1

Year	Aggregate DSH allotment reduction amounts under recommended policy	Portion of inflation-based DSH allotment increases attributable to reduced allotment amounts
FY 2020	$2,000	N/A
FY 2021	4,000	$50
FY 2022	6,000	150
FY 2023	8,000	297
FY 2024	8,000	489
FY 2025	8,000	678
FY 2026	8,000	866
FY 2027	8,000	1,054
FY 2028	8,000	1,243
FY 2029	8,000	1,431

Notes: DSH is disproportionate share hospital. FY is fiscal year. N/A is not applicable.

Source: MACPAC, 2019, analysis of CBO 2018.

Reduction amounts or increases in excess of these upper bounds were pooled together and distributed to other states. Excess reductions were first applied to states that were projected to spend less than their rebased allotments, up to the amount of the estimated unspent funding. Excess reductions or decreases were then distributed to other states proportionally based on their revised allotment amounts after the other steps in the rebasing methodology were performed.

Projections of total Medicaid hospital spending

To compare reductions to total Medicaid hospital spending in FY 2023, we projected state Medicaid hospital spending using state Medicaid spending data for FY 2017 and estimates about the growth in Medicaid hospital spending from the CMS Office of the Actuary that are used in National Health Expenditure (NHE) projections (OACT 2018). We included fee-for-service spending on Medicaid base payments, DSH and non-DSH supplemental payments, and an estimate of managed care payments to hospitals in each state. This managed care spending estimate was based on total managed care spending reported by the state and the assumption used in CMS's NHE projections that one-third of managed care payments are attributable to hospital expenditures (after subtracting administrative costs included in the capitation rate, which we assumed were 10 percent of the total capitation rate). For Vermont, we applied the same method to estimate hospital spending in the public managed care organization authorized under the state's Section 1115 demonstration (which is reported as other care services on CMS expenditure reports).

One limitation of this approach is that it does not account for the fact that hospital spending accounts for a lower share of managed care spending in states that include long-term services and supports (LTSS) in managed care. We could not separately estimate hospital spending for enrollees receiving LTSS in managed care because FY 2017 Medicaid claims and encounter data are not available.

The estimates of state hospital spending that we calculated using this method were similar to the amounts that states reported during MACPAC's interviews about the development of Medicaid hospital payment policies in five states (Table 1B-2). In Arizona, our estimate was higher than actual spending, likely because the state includes LTSS in managed care and thus spends a lower than average share of managed care spending on hospitals. In Louisiana, Michigan, and Mississippi, our estimates were lower than actual spending, likely because these states made large directed payments and pass-through payments to hospitals in managed care, which are not reported in other sources.

For all states, the approach that we used was more accurate than using Medicaid payment data reported on Medicare cost reports, which do not appear to include complete information on Medicaid supplemental payments. Nationally, CMS's NHE reported that states spent a total of $189.8 billion on hospital services in FY 2016, but hospitals only reported a total of $120.8 billion in Medicaid revenue on Medicare cost reports (OACT 2018).

TABLE 1B-2. Total Medicaid Hospital Spending Estimated Using Various Sources for Selected States, FY 2016 (millions) T 1B-2

State	Actual payments reported by states during interviews	Total payments estimated by MACPAC based on CMS-64 net expenditures		Total payments reported on Medicare cost reports	
		Estimated payments	Percent difference from actual	Reported payments	Percent difference from actual
	A	B	C = (B – A) ÷ A	D	E = (D – A) ÷ A
Arizona	$3,267	$3,980	22%	$1,860	-43%
Louisiana	3,069	2,841	-7	2,344	-24
Michigan	5,413	4,828	-11	4,073	-25
Mississippi	1,699	1,566	-8	1,435	-16
Virginia	1,969	1,969	0	1,828	-7

Source: MACPAC, 2019, analysis of Marks et al. 2018, CMS-64 net expenditure data as of July 20, 2018, and Medicare cost reports.