Chapter 1:

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 disproportionate share hospital (DSH) allotments to states and the three factors that Congress has asked the Commission to study:
  - 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.
- We find that the number of uninsured individuals and amount of uncompensated care are increasing nationally.
  - In 2018, 28.5 million people were uninsured. This was an increase of 1.9 million people (7.4 percent) from 2017 and the first statistically significant increase since 2009.
  - Hospitals reported $39.9 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2017. This was an increase of $2.7 billion (7.3 percent) from FY 2016. Although these data show an upward trend, because of a recent change in Medicare cost report definitions, uncompensated care data from these years cannot be directly compared with the amount of uncompensated care reported prior to the implementation of coverage expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).
  - According to the American Hospital Association annual survey, Medicaid shortfall for all U.S. hospitals was $22.9 billion in 2017. This was an increase of $2.9 billion (14.5 percent) from 2016. As a result of ongoing litigation about the DSH definition of Medicaid shortfall, many states changed how they reported Medicaid shortfall on their DSH audits in state plan rate year 2015, which makes it difficult to examine hospital-level shortfall data.
- At this writing, FY 2020 DSH allotments are scheduled to be reduced by $4 billion beginning on May 23, 2020.
  - DSH allotment reductions are scheduled to increase to $8 billion in FY 2021, with cuts continuing through FY 2025.
  - Under the ACA, Congress established a schedule for reducing federal DSH allotments to account for an anticipated decrease in uncompensated care. DSH allotment reductions were originally scheduled to go into effect in FY 2014, but these reductions have been delayed multiple times.
  - State DSH allotments are based on state DSH spending in FY 1992 and vary widely by state. The DSH allotment reduction methodology in statute is projected to preserve much of this variation.

CHAPTER 1: 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 (§ 1900 of the Social Security Act).

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 in 1992. 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, 2.75 million people, or 8.5 percent of the U.S. population, were uninsured in 2018, an increase of 1.9 million people since 2017. The increase in the number of uninsured individuals between 2017 and 2018 was the first statistically significant increase since 2009.
- Hospitals reported $39.9 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2017. This represented a $2.7 billion increase from FY 2016, and a 0.2 percentage point increase in uncompensated care as a share of hospital operating expenses. Because of a recent change in Medicare cost report definitions, uncompensated care data from these years cannot be directly compared with the amount of uncompensated care reported in 2013. However, we are no longer observing the large declines in uncompensated care that we observed immediately after the implementation of coverage expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).
- Hospitals reported $22.9 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey for 2017, a 14.5 percent increase from the amount reported in 2016. Since 2013, the amount of Medicaid shortfall

for all hospitals has increased by $9.7 billion (AHA 2019, 2017, 2015). As a result of ongoing litigation about the DSH definition of Medicaid shortfall, many states have changed how they report Medicaid shortfall on their DSH audits, which makes it difficult to examine hospital-level shortfall data.

- In FY 2017, deemed DSH hospitals, which serve a high proportion of Medicaid enrollees and low-income patients, continued to report lower aggregate operating margins than other hospitals (-1.8 percent for deemed DSH hospitals versus 0.2 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 (6.8 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 project FY 2020 DSH allotments before and after implementation of federal DSH allotment reductions. DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid and the health insurance 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 and, most recently, the Further Consolidated Appropriations Act, 2020 (P.L. 116-94) delayed the implementation of the reductions until May 23, 2020. Under current law, a reduction of $4 billion will take effect in FY 2020 (amounting to 31 percent of unreduced allotments), and the reduction amount will increase to $8 billion in FY 2021 (or 61 percent of unreduced allotments). Allotment reductions total $8 billion for each of FYs 2022–2025, representing more than half of states' unreduced allotment amounts.

In 2019, MACPAC made several legislative recommendations to improve the Medicaid DSH program—including a recommendation for a statutory clarification to the definition of Medicaid shortfall and a package of three recommendations affecting how pending DSH allotment reductions should be structured—none of which have been enacted (Box 1-1) (MACPAC 2019a, 2019b). Although the Commission expressed concern that the magnitude of DSH cuts under current law could affect the financial viability of some safety-net hospitals, our analyses focused on budget-neutral ways to restructure available funding.

In MACPAC's first DSH report, we recommended that the Secretary of the U.S. Department of Health and Human Services (the Secretary) collect additional hospital-specific data on Medicaid payments to hospitals to inform future analyses of DSH policy and broader oversight of Medicaid payments to hospitals (MACPAC 2016). On November 18, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to require states to collect and report many of the data elements that MACPAC recommended, including the amounts of supplemental payments to hospitals and the sources of non-federal financing for these payments. The rule also proposes to strengthen the requirement for states to recover federal funding associated with DSH overpayments identified in annual DSH audits (CMS 2019a). MACPAC provided comments on this proposed rule in January 2020, expressing support for the measures to improve transparency while raising concerns about other provisions of the rule that could jeopardize enrollees' access to care (MACPAC 2020a).

BOX 1-1. Prior MACPAC Recommendations Related to Disproportionate Share Hospital Policy

February 2016

Improving data as the first step to a more targeted disproportionate share hospital policy

- The Secretary of the U.S. Department of Health and Human Services should collect and report hospital-specific data on all types of Medicaid payments for all hospitals that receive them. In addition, the Secretary should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the provider level.

March 2019

Improving the structure of disproportionate share hospital allotment reductions

- 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.
- 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.
- 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.

June 2019

Treatment of third-party payments in the definition of Medicaid shortfall

- To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

The Commission also 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, and complete data on these payments are not yet available.[1]

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.[2] 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 (Matherlee 2002, Holahan et al. 1998).[3]

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 1-2). 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.[4]

BOX 1-2. 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 and those that did not provide obstetric services to the general population in 1987).

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).

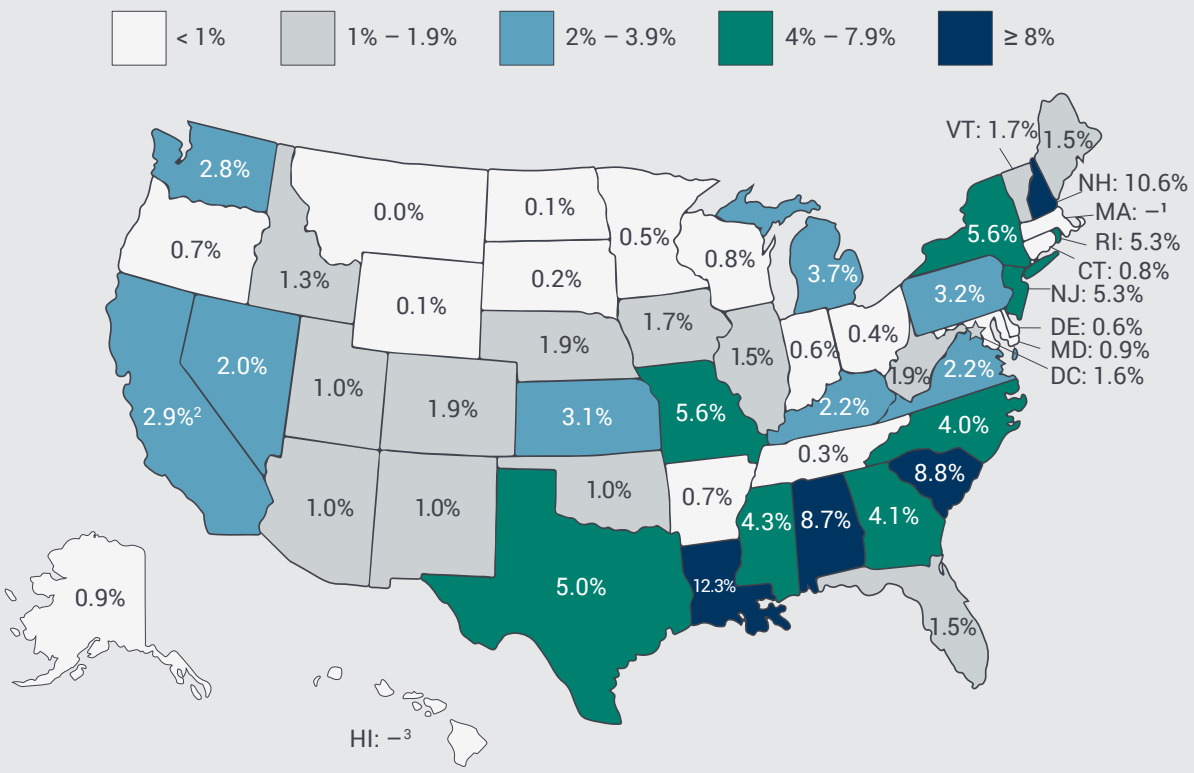
Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

In FY 2018, federal funds allotted to states for DSH payments totaled $12.3 billion. State-specific 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).

Total federal and state DSH payments were $18.2 billion in FY 2018 and accounted for 3.1 percent of total Medicaid benefit spending.[5] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1.0 percent in 17 states to 12.3 percent in Louisiana (Figure 1-1).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year; $1.4 billion in federal DSH allotments for FY 2017 went unspent as of the end of FY 2019.[6,7] 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

FIGURE 1-1. DSH Spending as a Share of Total Medicaid Benefit Spending, by State, FY 2018



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

— Dash indicates zero; 0.0 percent indicates an amount less than 0.05 percent that rounds to zero.

[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it to use all of its DSH funding for the state's safety-net care pool instead.

[2] 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 waiver.

[3] Hawaii did not report DSH spending in FY 2018, but this state has reported DSH spending in prior years.

Source: MACPAC, 2020, analysis of CMS-64 Financial Management Report net expenditure data as of June 17, 2019.

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 2017, half of unspent DSH allotments were attributable to four states (Connecticut, Maine, New Jersey, and Pennsylvania). Each of these states, excluding Maine, had FY 2017 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on FY 2017 Medicare cost reports.[8]

In state plan rate year (SPRY) 2015, 45 percent of U.S. hospitals received DSH payments (Table 1-1).[9] 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.[10] Public teaching hospitals in urban settings received more than half 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.[11] In SPRY 2015, Maine made DSH payments exclusively to IMDs, and DSH payments to IMDs amounted to more than half of DSH spending in three states (Alaska, Connecticut, and Maryland).[12] (Additional information about Medicaid policies affecting IMDs can be found in MACPAC's December 2019 report to Congress, *Oversight of Institutions for Mental Diseases* (MACPAC 2019d).

The proportion of hospitals receiving DSH payments varies widely by state. In SPRY 2015, three states made DSH payments to fewer than 10 percent of the hospitals in their state (Arkansas, Iowa, and Maine) and three states made DSH payments to more than 90 percent of hospitals in their state (New York, Oregon, and Rhode Island).

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 2015, about 14 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just under one-third (30 percent) of DSH hospitals but accounted for nearly two-thirds (66 percent) of all DSH payments, receiving $12.1 billion in DSH payments. States vary in how they distribute DSH payments to deemed DSH hospitals, from less than 10 percent of DSH payments to deemed DSH hospitals in five states (Alabama, Arkansas, Hawaii, Utah, and Wyoming) to 100 percent in three states (Arizona, Delaware, 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., New Mexico); conversely, some states that distribute DSH payments across most hospitals still target the largest share of DSH payments to deemed DSH hospitals (e.g., New Jersey) (Figure 1-2). State 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.[13] More information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

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. Over 90 percent of the hospitals that received DSH payments in SPRY 2015 also received DSH payments in SPRY 2014. But about 25 percent of hospitals receiving DSH payments in both SPRY 2014 and SPRY 2015 reported that the amount they received in SPRY 2015 differed from the amount they received in SPRY 2014 by more than 50 percent, although the changes included both increases and decreases.

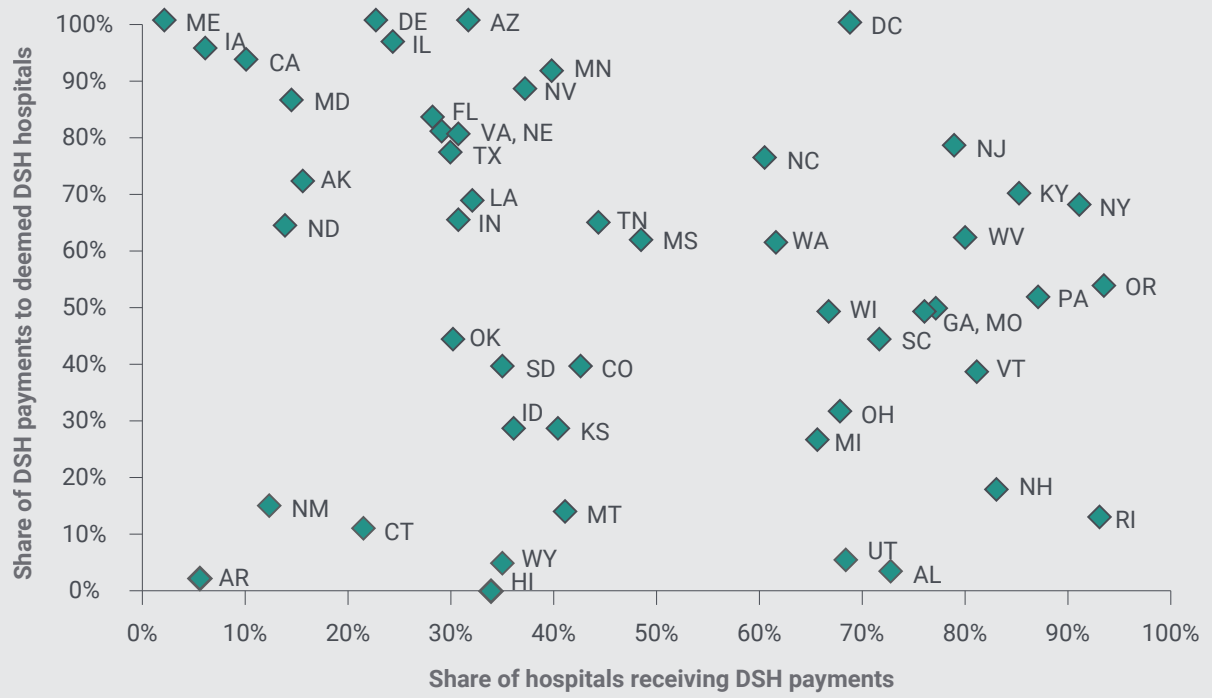
TABLE 1-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2015

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as percentage of all hospitals in category	
Total	**2,720**	**6,041**	**45%**	**$18,137**
Hospital type				
Short-term acute care hospitals	1,880	3,312	57	**14,568**
Critical access hospitals	584	1,349	43	**374**
Psychiatric hospitals	152	583	26	**2,874**
Long-term hospitals	21	421	5	**38**
Rehabilitation hospitals	29	278	10	**8**
Children's hospitals	54	98	55	**275**
Urban or rural				
Urban	1,480	3,574	41	**16,334**
Rural	1,240	2,467	50	**1,802**
Hospital ownership				
For-profit	436	1,832	24	**1,232**
Non-profit	1,582	2,958	53	**5,580**
Public	702	1,251	56	**11,325**
Teaching status				
Non-teaching	1,890	4,815	39	**4,830**
Low-teaching hospital	482	767	63	**3,128**
High-teaching hospital	348	459	76	**10,179**
Deemed DSH status				
Deemed	822	822	100	**12,051**
Not deemed	1,898	5,219	36	**6,085**

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 70 DSH hospitals that did not submit a fiscal year 2017 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, 2020, analysis of FY 2017 Medicare cost reports and SPRY 2015 as-filed Medicaid DSH audits.

FIGURE 1-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2015



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. 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. 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 demonstration waiver under Section 1115 of the Social Security Act allows it to use all of its DSH funding for the state's safety-net care pool instead.

Source: MACPAC, 2020, analysis of 2017 Medicare cost reports and SPRY 2015 as-filed Medicaid DSH audits.

Changes in the Number of Uninsured Individuals

According to the Current Population Survey Annual Social and Economic Supplement, 27.5 million people were uninsured in 2018 (8.5 percent of the U.S. population), a statistically significant increase from the number and share in 2017 (25.6 million or 7.9 percent) (Table 1-2).[14] This number does not include individuals who were uninsured for part of the year.[15] Statistically significant increases were observed for children, adults below age 65, individuals of Hispanic origin, and individuals with incomes above 300 percent of the federal poverty level.

The uninsured rate in states that did not expand Medicaid under the ACA to adults under age 65 with incomes at or below 138 percent of the federal poverty level was nearly twice as high as the uninsured rate in states that expanded Medicaid. In 2018, Utah, Nebraska, and Idaho passed ballot initiatives authorizing the expansion of Medicaid, but these coverage expansions had not taken effect and are thus not represented in the 2018 uninsured data. Additionally, Virginia and Maine expanded Medicaid beginning in 2019; these expansions are expected to reduce the number of uninsured individuals in these states.

TABLE 1-2. Uninsured Rates by Selected Characteristics, United States, 2017 and 2018

Characteristic	2017	2018	Percentage point change (2018 less 2017)	
All uninsured	**7.9%**	**8.5%**	**0.5%**	*
Age group				
Under age 19	5.0	5.5	0.6	*
Age 19–64	11.0	11.7	0.8	*
Over age 64	1.0	0.9	0.0	
Race and ethnicity				
White non-Hispanic	5.2	5.4	0.2	
Black non-Hispanic	9.3	9.7	0.4	
Asian non-Hispanic	6.4	6.8	0.5	
Hispanic (any race)	16.2	17.8	1.6	*
Income-to-poverty ratio				
Below 100 percent	15.9	16.3	0.4	
100–199 percent	13.0	13.6	0.6	
200–299 percent	10.7	10.8	0.1	
300–399 percent	7.1	8.1	1.0	*
At or above 400 percent	2.7	3.4	0.8	*
Medicaid expansion status in state of residence				
Non-expansion	12.0	12.2	0.2	
Expansion	6.5	6.5	0.1	

Notes: Uninsured rates by Medicaid expansion status are based on the American Community Survey. Uninsured rates for other groups are based on the Current Population Survey. Medicaid expansion status reflects state expansion decisions as of January 1, 2018. Numbers do not add due to rounding.

* Indicates change is statistically different from zero at the 90 percent confidence level.

Source: MACPAC, 2020, analysis of Berchick, et al. 2019.

The 1.9 million increase in the number of uninsured individuals in 2018 mirrored the 2.0 million decline in individuals enrolled in Medicaid and the State Children's Health Insurance Program that year. The decline in Medicaid enrollment was statistically significant, but there was no statistically significant change in the percentage of individuals with other forms of public or private coverage between 2017 and 2018 (Berchick et al. 2019).[16]

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 May 2019, the Congressional Budget Office (CBO) projected that the number of uninsured individuals would increase to 30 million in 2019 and to 32 million in 2020. CBO's projections incorporate estimates of the effects of the repeal of the ACA's individual mandate tax penalty that took effect in 2019. CBO estimates that by 2021, 7 million more individuals will be uninsured than would have been if the individual mandate penalty had not been repealed (CBO 2019).

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 1-3). 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, which is 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 by CMS until about five years after DSH payments are made.[17]

Below, we review the most recent uncompensated care data available for all hospitals in 2017 as well as additional information about Medicaid shortfall reported for DSH hospitals in SPRY 2015.

Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $39.9 billion in charity care and bad debt in FY 2017, 4.3 percent of hospital operating expenses. This is a $2.7 billion (7 percent) increase from FY 2016, and a 0.2 percentage point increase as a share of hospital operating expenses.

Due to recent changes in Medicare cost report instructions, uncompensated care reported on FY 2017 Medicare cost reports cannot be compared to data before the implementation of the ACA. The changes to the cost report instructions became effective in FY 2017, and may have had a particularly marked effect on uncompensated care costs reported that year.[18] Moreover, we are no longer observing the large declines in uncompensated care that we observed immediately after the implementation of the ACA coverage expansions. For example, charity care and bad debt reported on Medicare costs reports declined by $8.6 billion (23 percent) between 2013 and 2015 (MACPAC 2018a).[19]

As a share of hospital operating expenses, charity care and bad debt varied widely by state in FY 2017 (Figure 1-3). In the aggregate, hospitals in states that expanded Medicaid under the ACA before October 1, 2017, reported uncompensated care that was less than half of what was reported in non-expansion states (2.8 percent of hospital operating expenses in Medicaid expansion states versus 7.2 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 FY 2017, about 44 percent of uncompensated care reported was for charity care for uninsured individuals ($17.6 billion), 18 percent was charity care for insured individuals ($7.4 billion), and 37 percent was for bad debt expenses for both insured and uninsured individuals ($14.9 billion).[20] Uncompensated care for uninsured individuals is 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

BOX 1-3. Data Sources and Definitions for Uncompensated Care Costs

Data Sources

American Hospital Association (AHA) annual survey. An annual survey of hospitals 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 except 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 2015, 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. Medicare cost reports include costs of care provided to both uninsured individuals and patients with insurance who cannot pay deductibles, co-payments, or coinsurance.

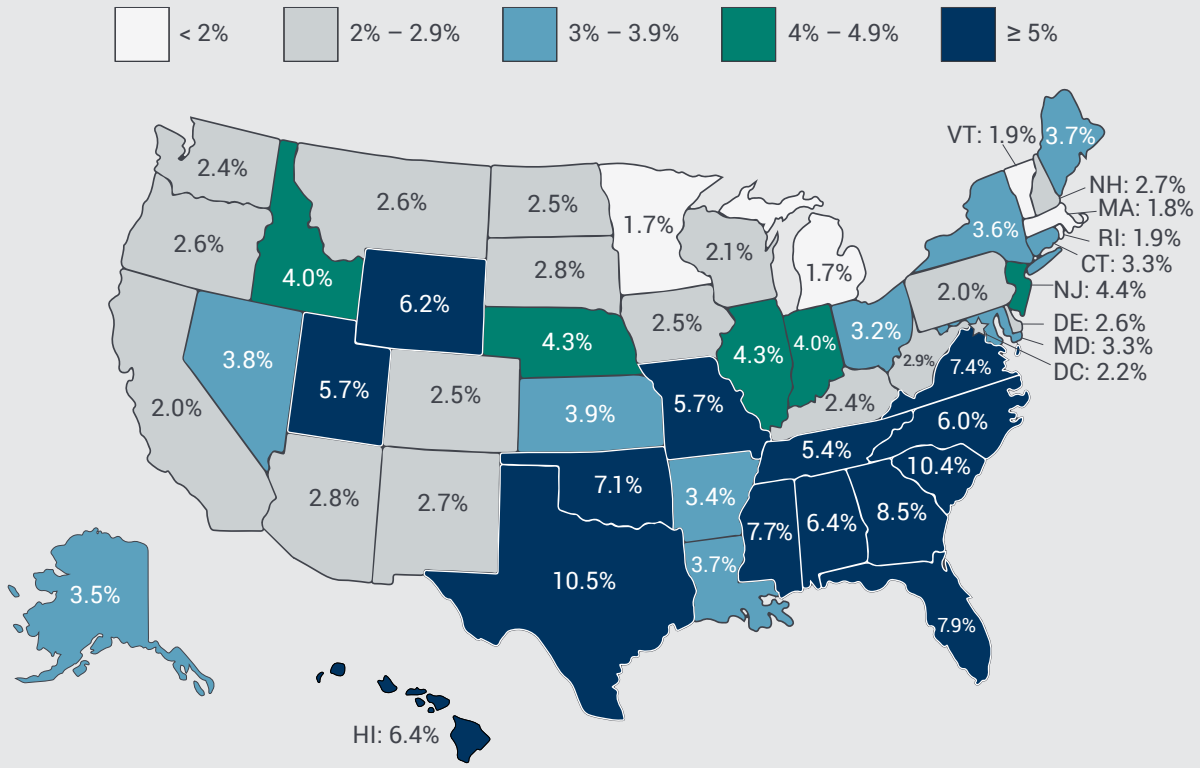
Bad debt. Expected payment amounts that a hospital is not able to collect from patients who are determined to have the financial capacity to pay according to the hospital's charity care policy.

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 most 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. Ongoing litigation has challenged how third-party payments should be counted for Medicaid-eligible patients with third-party coverage.

FIGURE 1-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2017



Note: FY is fiscal year.

Source: MACPAC, 2020, analysis of FY 2017 Medicare cost reports.

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

Medicaid shortfall is 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.[21] According to the American Hospital Association (AHA) annual survey, Medicaid shortfall in 2017 for all U.S. hospitals totaled $22.9 billion, an increase of $2.9 billion from 2016. The aggregate Medicaid payment-to-cost ratio reported on the AHA survey was 87 percent in 2017, a modest decline from the 88 percent payment-to-cost ratio reported in 2016 (AHA 2019, 2017).

Previously, MACPAC found wide variation in the amount of Medicaid shortfall for DSH hospitals reported on DSH audits.[22] For example, in SPRY 2014, 15 states reported no Medicaid shortfall for DSH hospitals and 12 states reported shortfall that exceeded 50 percent of total DSH hospital uncompensated care. Although Medicaid base payments for hospital services are typically below hospital costs, many states make large non-DSH supplemental payments that reduce or eliminate the amount of Medicaid shortfall reported on DSH audits (MACPAC 2019a).

As a result of ongoing litigation about the DSH definition of Medicaid shortfall, many states have changed how they report Medicaid shortfall on their DSH audits, which makes it difficult to examine hospital-level shortfall data. At issue in

these lawsuits is how Medicaid shortfall should be counted for Medicaid-eligible patients with third-party coverage.

Since at least 2010, CMS has held that third-party payments should be counted when calculating Medicaid shortfall, but several hospitals argued that CMS did not have the statutory authority to consider third-party payments in the calculation of Medicaid shortfall and filed lawsuits against CMS to clarify the definition. In March 2018, the U.S. District Court for the District of Columbia ruled that third-party payments should not be counted. In August 2019, the U.S. Court of Appeals for the District of Columbia reversed the district court decision, allowing CMS to enforce its prior policy with respect to all hospital services furnished on or after June 2, 2017. However, there is still some legal uncertainty, because the plaintiffs in this case have requested a rehearing. There is another pending lawsuit on this matter in the U.S. Court of Appeals for the Fifth Circuit, where CMS has appealed a district court order enjoining enforcement of the 2017 rule in Mississippi (Eyman 2019). MACPAC's June 2019 report to Congress discussed the history of the DSH definition of Medicaid shortfall, examined the potential effects of this litigation, and recommended a statutory change (MACPAC 2019a).

Overall, 21 states reported SPRY 2015 DSH uncompensated care costs with and without third-party payments, which allows us to quantify the effects that each policy would have on different types of hospitals. For DSH hospitals in these 21 states, not counting third-party payments more than doubled the amount of uncompensated care reported. Total uncompensated care was $33.6 billion (14 percent of DSH hospital costs) before subtracting third-party payments, and $15.0 billion (6 percent of DSH hospital costs) when those payments were taken into account (Table 1-3).

TABLE 1-3. DSH Hospital Uncompensated Care Costs Under Different Calculation Methods, by Hospital Type, SPRY 2015

Hospital characteristics	Number of hospitals in analysis	Total uncompensated care costs (billions)		Increase in uncompensated care costs (billions)	
		After counting third-party payments	Without counting third-party payments	Dollar increase	Percent increase
		A	B	C = B – A	D = (B – A) / A
Total	**1,467**	**$15.0**	**$33.6**	**$18.6**	**124%**
Hospital type					
Children's hospitals	30	0.3	0.9	0.7	232
Critical access hospitals	335	0.3	0.7	0.4	172
Short-term acute care hospitals	999	12.7	30.1	17.4	137
Deemed DSH status					
Deemed	447	8.1	16.0	8.0	99
Not deemed	1,020	6.9	17.6	10.7	155

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. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Analysis is limited to DSH hospitals in the 21 states that reported uncompensated care costs with and without third-party payments on their SPRY 2015 DSH audits. Uncompensated care costs reported on DSH audits include Medicaid shortfall and hospital unpaid costs of care for uninsured individuals. Numbers do not add due to rounding.

Source: MACPAC, 2020, analysis of SPRY 2015 as-filed Medicaid DSH audits and FY 2017 Medicare cost reports.

The percent increase in uncompensated care due to not counting third-party payments was largest for children's hospitals, likely because they serve a high proportion of Medicaid-eligible individuals with private insurance, including many low-birthweight babies.[23] Critical access hospitals also reported a greater percent increase in uncompensated care than short-term acute care hospitals. This effect may be attributable to the fact that critical access hospitals serve a high share of patients dually eligible for Medicare and Medicaid because rural areas have a higher proportion of individuals age 65 and older than urban areas (Kirby and Muhuri 2018).

The results of these analyses should be interpreted with caution because most states did not break out third-party payments made to DSH hospitals on their SPRY 2015 DSH audits.[24] However, as shown above, if a state does not subtract third-party payments from Medicaid costs, its hospitals' reported uncompensated care will be substantially larger. Because many states distribute DSH payments to hospitals based on the amount of uncompensated care reported on DSH audits, changes to the DSH definition of uncompensated care could affect the distribution of DSH payments within states.[25] For example, based on our analysis showing that uncompensated care for deemed DSH hospitals does not increase as much as it does for hospitals that do not meet the deemed DSH criteria when third-party payments are not counted, not counting third-party payments would likely result in lower DSH payments to deemed DSH hospitals in many states.

Hospital margins

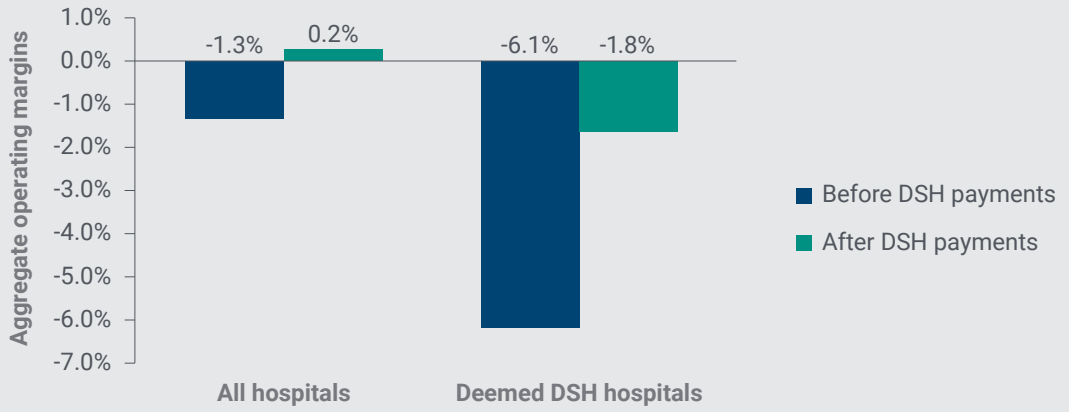
Changes in hospital uncompensated care costs have the potential to affect hospital margins. For example, deemed DSH hospitals report higher uncompensated care costs and lower operating and total margins on average. However, margins are an imperfect measure of a hospital's financial health and might not be reported reliably on Medicare cost reports.

In FY 2017, aggregate operating margins were positive across all hospitals after counting DSH payments (0.2 percent) and were 0.6 percentage points higher than in FY 2016. By contrast, deemed DSH hospitals reported negative aggregate operating margins both before and after counting DSH payments (-6.1 percent and -1.8 percent, respectively) (Figure 1-4).

Hospitals' total margins include revenue not directly related to patient care (Appendix 1B). The aggregate total margins for all hospitals after DSH payments was 6.8 percent in FY 2017, which was 0.8 percentage points lower than in FY 2016. Before counting DSH payments and other government appropriations, deemed DSH hospitals reported an aggregate total margin of 0 percent in FY 2017. However, after counting these payments and appropriations, deemed DSH hospitals reported positive aggregate total margins of 6.2 percent, comparable to the aggregate total margins reported for all hospitals (Figure 1-5).

Many factors affect a hospital's margin, such as changes in the prices that a hospital can negotiate because of its competitive position in its market and changes in its costs (Bai and Anderson 2016). Moreover, hospitals that are struggling financially might decide to cut unprofitable services, which would increase their margins in the short term; hospitals that are doing well financially might make additional investments, which could decrease their margins in the short term.

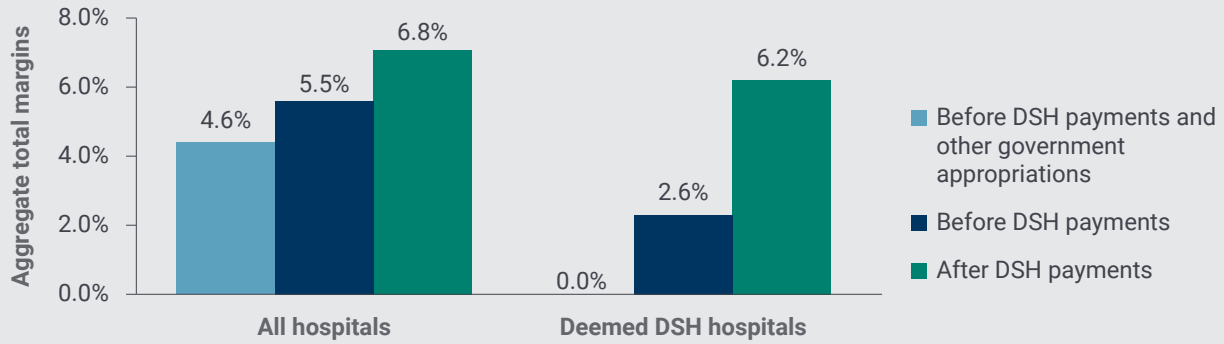
FIGURE 1-4. Aggregate Hospital Operating Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2017



Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure income from patient care divided by net patient revenue. Operating margins before DSH payments in FY 2017 were estimated using state plan rate year (SPRY) 2015 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 1B.

Source: MACPAC, 2020, analysis of FY 2017 Medicare cost reports and SPRY 2015 DSH audit data.

FIGURE 1-5. Aggregate Hospital Total Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2017



Notes: DSH is disproportionate share hospital. FY is fiscal year. 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 FY 2017 were estimated using state plan rate year (SPRY) 2015 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 1B.

Source: MACPAC, 2020, analysis of FY 2017 Medicare cost reports and SPRY 2015 DSH audit data.

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 definition based on the types of services suggested in the statutory provision calling for MACPAC's study and the limits of available data (Box 1-4).[26]

Using data from FY 2017 Medicare cost reports and the 2017 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2015, 91 percent provided at least one of the services included in MACPAC's definition of essential community services, 72 percent provided

BOX 1-4. Identifying Hospitals with High Levels of Uncompensated Care That Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations

MACPAC's authorizing 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 (§ 1900 of the Social Security Act). Based on the types of services suggested in the statute and the limits of available data, we included the following services in our 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 1B for further discussion of our methodology and its limitations.

two of these services, and 57 percent provided three or more of these services. By contrast, among non-deemed hospitals, 43 percent provided three or more of these services.

Because policymakers have been particularly concerned recently about maternal mortality and access to obstetric care in rural areas, we took a deeper look in this report on the extent to which DSH hospitals provide obstetric services. Medicaid has long played a key role in providing maternity-related services to pregnant women, financing 43 percent of births in 2018 (MACPAC 2020c). Nine percent of rural counties experienced a loss of all hospital obstetric services between 2004 and 2014 and 54 percent of all rural counties lacked access to hospital obstetric services in 2014 (Hung et al. 2017).[27] In addition, 120 rural hospitals have closed since 2010 (NCRHRP 2020).

To receive DSH payments, hospitals must have at least two obstetricians with staff privileges who provide services to Medicaid enrollees, but rural hospitals can satisfy this requirement by having non-obstetric physicians who can perform non-emergency obstetric procedures (§ 1923(d) of the Social Security Act). The DSH obstetric requirement does not apply to children's hospitals or hospitals that did not provide obstetric services to the general population as of 1987 (a category consisting primarily of IMDs). Although states can support rural hospitals in a number of ways, DSH payments are an important revenue source, accounting for $1.8 billion in payments to rural hospitals in SPRY 2015.[28]

Overall, we found that of the rural hospitals that received DSH payments in SPRY 2015, 70 percent reported on the AHA annual survey that they had an obstetric unit, which was lower than the share of urban DSH hospitals providing obstetric services (85 percent). In addition, only 28 percent of rural DSH hospitals were equipped to provide obstetric services for complicated births (level 2 and above), which was lower than the share of urban DSH hospitals that were able to provide higher level obstetric services for complicated births (81 percent).

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.

In December 2019, the Further Consolidated Appropriations Act, 2020, delayed the implementation of the DSH reductions until May 23, 2020, without changing the amount of the FY 2020 reductions. Under current law, states can make DSH payments based on their unreduced allotment amounts, but as discussed below, states would need to reconcile FY 2020 DSH payments to their lower, reduced allotment amount beginning May 23.

DSH allotment reductions are applied against unreduced DSH allotments; that is, the amounts that 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 allotment reductions scheduled. Thus, under current law, state DSH allotments will return to their higher, unreduced DSH allotment amounts in FY 2026. Unreduced allotments increase each year based on the Consumer Price Index for All Urban Consumers, and these inflation-based increases will apply even in years when DSH allotment reductions take effect.

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). It also 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 1-5).

On September 25, 2019, CMS finalized the DHRM for distributing reductions among states, which is similar to the methodology proposed in 2017 (CMS 2019b, 2017b). Under CMS's methodology, the $4 billion in DSH allotment reductions for FY 2020 are projected to affect states differently, with estimated state allotment reductions ranging from 3.5 percent to 56.9 percent of states' unreduced allotment amounts. Smaller reductions are applied to states with historically low DSH allotments (referred

BOX 1-5. 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 September 2019, the Centers for Medicare & Medicaid Services (CMS) finalized the DHRM. 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 fiscal year (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 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 define 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 waivers under Section 1115 of the Social Security Act as of July 2009. Specifically, DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments were targeted to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care.

to as low-DSH states) and larger reductions are applied to states with lower uninsured rates. However, the methodology does not meaningfully improve the relationship between DSH allotments and levels of hospital uncompensated care or any other factor that Congress asked MACPAC to consider. (Complete state-by-state information on DSH allotment reductions and other factors are included in Appendix 1A.)

For FY 2020, we used the DSH allotment reductions CMS has estimated for each state. In each of FYs 2021 through 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 uninsured rates across states.

We also compared FY 2020 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 1A.

Reduced DSH allotments compared to unreduced DSH allotments

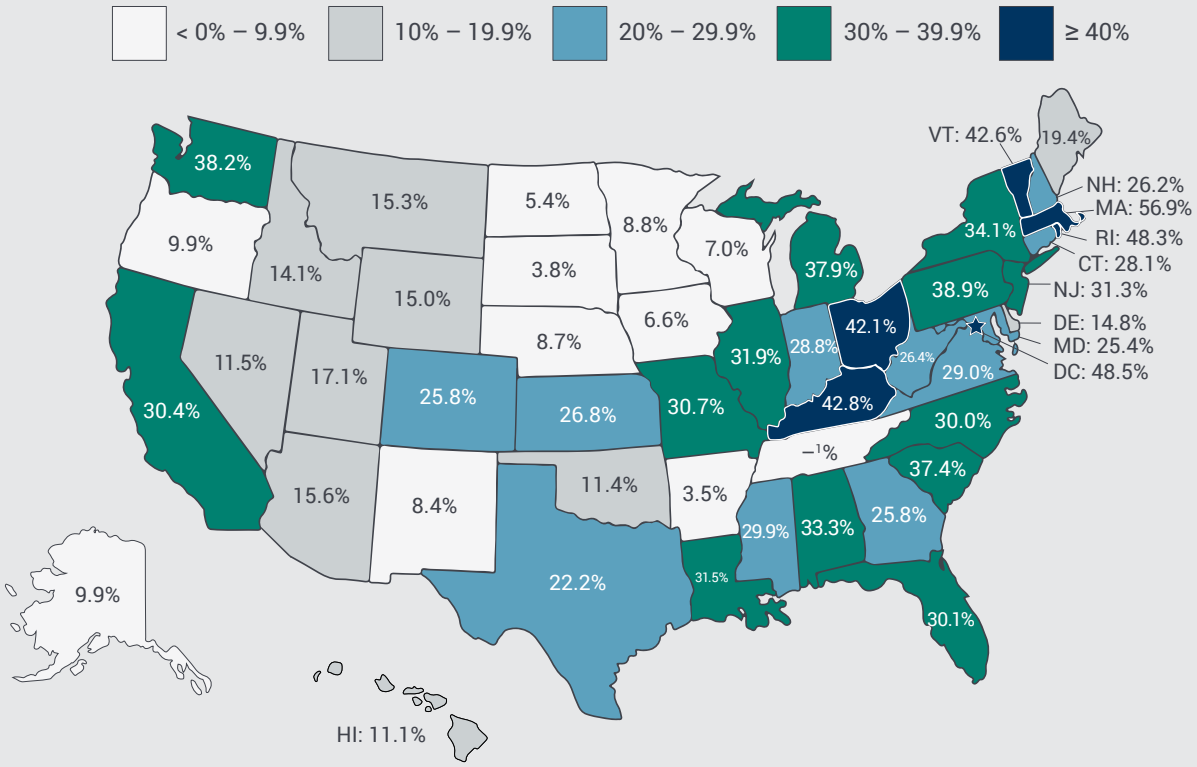
The $4 billion in DSH allotment reductions scheduled to take effect in FY 2020 are projected to affect states differently, with estimated reductions ranging from 3.5 percent to 56.9 percent of unreduced allotment amounts (Figure 1-6). Because of the low-DSH factor, the projected percentage reduction in DSH allotments for the 17 states that meet the low-DSH criteria (8.8 percent in the aggregate) is about one-quarter that of the other states (32.4 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 as of January 1, 2018 (34.3 percent in the aggregate) than for states that did not expand Medicaid (28.1 percent in the aggregate).

The Further Consolidated Appropriations Act, 2020, delays the DSH reductions until May 23, 2020, without reducing the size of the $4 billion allotment reduction required under current law. Although this provision has likely led most states to make interim DSH payments to hospitals under the assumption that the DSH reductions will not take effect, the provision does not eliminate the uncertainty around the availability of DSH funding. If the DSH reductions go into effect on May 23 as scheduled under current law, states will need to reconcile any interim DSH payments to the final, reduced DSH allotment amount. In some cases, states may need to recover DSH payments from hospitals in order to avoid exceeding their aggregate DSH allotments.

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 18 states are projected to have FY 2020 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2017, which means that these states could make DSH payments from their reduced FY 2020 allotment equal to the payments that they made from their FY 2017 allotment.[29]

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. States may also take different approaches to reductions, with some states applying them to all DSH hospitals and others reducing DSH payments only to specific hospitals. Because the final CMS DHRM 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 their DSH allotment reductions in future years.[30] 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. States may be able to offset some of the effects of DSH allotment reductions by increasing other types of Medicaid payments to providers. However, each type of Medicaid payment is subject to its own unique rules and limitations.

FIGURE 1-6. 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.

– Dash indicates zero.

[1] 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, 2020, analysis of preliminary unreduced and reduced allotment amounts as of October 15, 2019, provided by CMS.

For example, aggregate fee-for-service (FFS) payments to hospitals, excluding DSH payments, cannot exceed a reasonable estimate of what Medicare would have paid for the same service, referred to as the upper payment limit.[31]

Relationship of DSH allotments to the statutorily required factors

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

Changes in number of uninsured individuals. Unreduced FY 2020 DSH allotments range from less than $100 per uninsured individual in six states to more than $1,000 per uninsured individual in nine states and the District of Columbia. Nationally, the average FY 2020 DSH allotment per uninsured individual is $449.

Amount and sources of hospital uncompensated care costs. As a share of hospital charity care and bad debt costs reported on FY 2017 Medicare cost reports, unreduced FY 2020 federal DSH allotments range from less than 10 percent in eight states to more than 80 percent in three states and the District

of Columbia. Nationally, these allotments are equal to 32 percent of hospital charity care and bad debt costs. At the state level, total unreduced FY 2020 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in 10 states and the District of Columbia. 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.[32]

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 definition of essential community services.

Value-Based Payment Approaches to Using DSH Funding

The Commission is interested in reforms to Medicaid payment that drive system change toward greater efficiency and improved health outcomes. In contrast to traditional payment models that are based on the volume of care provided, value-based payment models are intended to reward providers based on delivering lower cost and higher quality care. California's Global Payment Program (GPP), which converts DSH payments to a global payment that encourages the delivery of high-value medical services, is one such model.

In December 2015, California received approval for a demonstration waiver under Section 1115 of the Social Security Act to distribute DSH funding as a global payment that incentivizes hospitals to reduce avoidable hospital use and allows hospitals to use DSH funding for physician services and other costs of care for uninsured individuals that would not normally count for DSH purposes. MACPAC highlighted this approach in its March 2017 report and has been monitoring the implementation of the program by speaking with hospitals, state officials, and evaluators of this program. In June 2019, California released its final evaluation of this program for the demonstration period. Below we summarize key findings about the foundation of this program, its implementation, and its outcomes, as well as implications for other states.

Foundation of the GPP

California's GPP is part of a series of payment reforms for public hospitals that California began more than 10 years before the approval of the GPP:

- In 2005, California targeted DSH payments to designated public hospitals as one of numerous changes to its hospital payment policies. These large health systems serve a high share of Medicaid and uninsured individuals and provide the non-federal share for DSH payments. To offset the loss of payments to the 105 privately owned hospitals that were previously receiving DSH payments, the state created a new upper payment limit (UPL) supplemental payment for these hospitals (CHCF 2006).[33]
- At the same time, California adopted a certified public expenditure model to finance inpatient hospital services provided by designated public hospitals (CHCF 2006). Under this financing arrangement, hospitals certify their costs for the services they provide and receive federal funding for these costs at the state's federal matching rate. Although hospitals continue to have unreimbursed Medicaid costs, this policy reduces the amount of Medicaid shortfall that hospitals report on DSH audits.
- Also in 2005, California received approval for a Section 1115 waiver to create a safety-net

care pool that that included an uncompensated care pool to pay for costs of care for uninsured patients that were not paid for by DSH. The safety-net care pool replaced previous UPL supplemental payments that otherwise would have been reduced when the state expanded managed care (Harbage and Ryan 2006).

- In 2010, California received approval for a Delivery System Reform Incentive Payment program, which incentivized designated public hospitals to expand primary care and reduce hospital utilization.
- California expanded Medicaid eligibility in 2010, and in 2014, the state fully adopted the ACA Medicaid expansion. As a result, hospital unpaid costs of care for uninsured patients fell and public hospitals and health systems redirected resources toward improving value-based care for the uninsured.

Implementation of the GPP

In December 2015, California received approval from CMS for a Section 1115 demonstration waiver that included the GPP. This waiver allowed the state to combine its DSH allotment and its Section 1115 uncompensated care pool into one global budget. CMS then calculated global payment amounts for each of the 12 participating designated public hospitals based on the hospital system's costs of care for uninsured patients, including the costs of physician services and other costs that would not normally count for DSH purposes.[34] Overall, for the health systems participating in the GPP, these non-hospital costs accounted for about 51 percent of all uncompensated care costs for uninsured individuals reported in the baseline year (Timbie et al. 2019).

Over the course of the demonstration, hospitals are incentivized to provide care outside of the hospital setting and reduce avoidable hospital use. For a hospital to receive its full global payment, it must provide a certain number of services to uninsured patients, which are tracked based on a point system. In later years of the demonstration, potentially avoidable services such as emergency department visits, earn fewer points.

Results

California's final evaluation of its GPP demonstration reflects data from the first three years of operation. Although the demonstration is ongoing, the data indicate that outcomes are positive on most of the dimensions the evaluators assessed (Timbie et al. 2019):

Health system improvements. All of the public hospital systems participating in the GPP reported building and strengthening infrastructure to deliver care to uninsured individuals as a result of the GPP incentives. Improved care coordination (particularly between mental and physical health providers) and improved data collection to track services provided to uninsured individuals were the most common strategies used.

Improved access to services. On average, by the third year of implementation, the number of uninsured individuals served by public hospital systems increased by 6 percent and the use of non-emergent outpatient physical health services by uninsured individuals increased by 12 percent.

Reduced avoidable hospital use. On average, by the third year of implementation, the use of inpatient hospital care by uninsured individuals declined by 15 percent and emergency department visits by uninsured individuals declined by 14 percent.

Implications for other states

Other states can apply for Section 1115 waivers to implement approaches similar to California's GPP, but we are not aware of other states that are currently interested in doing so. Because of the uncertainty surrounding the pending DSH allotment reductions, states may not be willing to make major changes to their DSH policies at this time.[35]

Although California's health care market is unique, many hospitals across the country are becoming part of integrated health systems that provide primary care and other services outside

the hospital setting, similar to California's public health systems. For example, 69.7 percent of U.S. hospitals were part of health systems in 2016, and hospitals within these health systems accounted for 91.6 percent of all U.S. hospital discharges (AHRQ 2019). However, the non-hospital services that these health systems provide do not count toward hospital uncompensated care costs that are eligible for DSH payments.

Other states and providers could also encounter various implementation challenges if they pursued an approach similar to California's GPP. For example, some executives of hospitals participating in the GPP expressed concerns that they might not meet the service delivery targets necessary to earn the GPP payments they hoped to receive. They also noted that it is difficult to monitor utilization of services and measure quality of care for uninsured patients because these patients might not have a usual source of care and face a number of social risk factors unrelated to health care delivery (MACPAC 2017).

Endnotes

[1] 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 2020b).

[2] Medicare also makes DSH payments. Hospitals are eligible for Medicare DSH payments if their Medicaid and Supplemental Security Income (SSI) patient utilization rate exceeds 15 percent (MACPAC 2017). Historically, the amount of Medicare DSH payments a hospital was eligible to receive was based solely on a hospital's Medicaid and SSI patient utilization, but since 2014, the ACA has required that most Medicare DSH payments be based on a hospital's uncompensated care relative to other Medicare DSH hospitals. In addition, the ACA linked the total amount of funding for Medicare DSH payments to the uninsured rate (MACPAC 2016).

[3] Medicaid fee-for-service (FFS) payments for hospitals cannot exceed a reasonable estimate of what Medicare would have paid in the aggregate. Medicaid DSH payments are not subject to this upper payment limit, but Medicaid DSH payments to an individual hospital are limited to that hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

[4] 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).

[5] DSH spending in FY 2018 includes spending funded from prior year allotments. 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.

[6] States are required to submit claims for federal Medicaid funding within two years after the payment is made. However, states can sometimes claim federal match for adjusted DSH payments that are made after the initial two-year window (*Virginia Department of Medical Assistance Services*, DAB No. 1838 (2002)), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2002/dab1838.html.

[7] 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.

[8] 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.

[9] 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.

[10] 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).

[11] The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities 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)).

[12] 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 state's DSH payment to IMDs and other mental health facilities in FY 1995 or 33 percent of the state's FY 1995 DSH allotment.

[13] 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 2017).

[14] The Census Bureau notes that due to differences in measurement, health insurance coverage in calendar years 2017 and 2018 should not be compared to earlier years processed with a legacy system (Berchick et al. 2019). The CPS estimate for the uninsured rate in 2017 is also lower than the rate estimated in the CPS survey published in September 2018 (Berchick et al. 2018).

[15] There are a variety of ways to count the number of uninsured individuals. Estimates in this chapter that are based on the CPS reflect the number of people without health insurance for the entire calendar year.

[16] Additional information on potential drivers of the decline in Medicaid and CHIP enrollment in 2017 and 2018 is provided in MACPAC's issue brief, *Changes in Medicaid and CHIP Enrollment* (MACPAC 2019e)

[17] 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).

[18] 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. Hospitals that partially discount charges to uninsured or underinsured patients report higher uncompensated care costs on the Medicare cost reports under the new formula (MedPAC 2018, CMS 2017a).

[19] 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. Hospitals have retroactively adjusted their 2015 cost reports to comply with the new definitions, but they are not required to update uncompensated care data from 2013 (MACPAC 2019f).

[20] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 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. CMS began to audit charity care and bad debt costs reported on Medicare cost reports in the fall of 2018 (CMS 2018).

[21] For Medicaid-eligible patients with third-party coverage, most of the costs of care for these patients are paid by other payers because Medicaid is a payer of last resort.

[22] The amount of Medicaid shortfall reported on the AHA annual survey differs from the amount of Medicaid shortfall for DSH hospitals reported on DSH audits because of differences in the set of hospitals included in each data source and because of differences in how shortfall is calculated (Nelb et al. 2016). For example, on the AHA survey, Medicaid payments are reported after subtracting health care-related taxes, but on DSH audits health care-related taxes are not subtracted from payments (AHA 2018).

[23] Low-birthweight babies are eligible for SSI, which confers automatic eligibility for Medicaid as well. Because low-birthweight babies often have complex medical needs that require long hospital stays, a small number of low-birthweight babies can have a large effect on overall hospital costs.

[24] Nineteen states provided their Medicaid costs only after subtracting the total third-party payments received by DSH hospitals, while eight states and the District of Columbia provided their Medicaid costs without subtracting third-party payments. Tennessee provided Medicaid costs after subtracting third-party payments for all but three hospitals

(Delta Medical Center, Parkwest Medical Center, and Takoma Regional Hospital) for which third-party payments were not subtracted. Massachusetts does not make DSH payments, and does not submit a DSH audit.

[25] In 2018, about half of states (24) distributed DSH payments based on hospital uncompensated care costs (MACPAC 2018b).

[26] In Chapter 3 of MACPAC's March 2017 report to Congress, the Commission analyzed other criteria that could be used to identify hospitals that should receive DSH payments (MACPAC 2017).

[27] The study identified rural counties using the Office of Management and Budget designations and included 1,984 rural U.S. counties or county equivalents in the analysis.

[28] Additional information on all types of Medicaid payments to rural hospitals is provided in MACPAC's issue brief, *Rural Hospitals and Medicaid Payment Policy* (MACPAC 2018c).

[29] For states to spend the same amount of DSH funding in FY 2020 as they spent in FY 2017, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[30] 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).

[31] 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 2020b).

[32] 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 can pay for with Medicaid DSH funds.

[33] 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. States can make additional UPL payments to providers as long as aggregate FFS payments to a class of providers are below a reasonable estimate of the amount that Medicare would have paid.

[34] Total payments under the GPP cannot exceed the sum of the state's DSH allotment (about $1.3 billion in FY 2020) and other Medicaid waiver funding that the state had previously used to pay for uncompensated care (about $236 million).

[35] One condition of obtaining federal approval for any demonstration that waives provisions of the Medicaid statute, including DSH, is demonstrating that the waiver is unlikely to result in higher federal costs than there would have been absent the demonstration. The federal DSH funding for California that finances the GPP will be reduced if and when the national allotment reductions go into effect, and the state is at risk for the use of non-federal funds to make up for the resulting shortfall.

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APPENDIX 1A: State-Level Data

TABLE 1A-1. State DSH Allotments, FYs 2020 and 2021 (millions)

State	FY 2020		FY 2021	
	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$15,443.3**	**$8,828.9**	**$8,923.4**	**$5,142.2**
Alabama	**333.4**	240.0	**175.7**	126.5
Alaska	**42.9**	21.5	**39.3**	19.6
Arizona	**142.7**	99.9	**119.9**	83.9
Arkansas	**68.1**	48.7	**67.3**	48.1
California	**1,784.8**	892.4	**1,051.0**	525.5
Colorado	**160.6**	80.3	**108.8**	54.4
Connecticut	**336.1**	168.1	**212.9**	106.5
Delaware	**15.6**	9.0	**13.3**	7.7
District of Columbia	**52.7**	36.9	**10.5**	7.3
Florida	**266.0**	163.5	**158.2**	97.3
Georgia	**346.4**	233.1	**234.5**	157.8
Hawaii	**18.9**	10.1	**17.0**	9.1
Idaho	**23.5**	16.5	**20.2**	14.2
Illinois	**341.4**	171.2	**190.1**	95.3
Indiana	**270.5**	178.1	**168.2**	110.7
Iowa	**70.3**	43.0	**67.0**	41.0
Kansas	**59.6**	35.3	**39.3**	23.2
Kentucky	**135.1**	97.0	**37.7**	27.1
Louisiana	**821.3**	549.1	**464.3**	310.4
Maine	**155.0**	98.9	**121.5**	77.5
Maryland	**133.1**	66.5	**91.2**	45.6
Massachusetts	**307.1**	153.5	**73.1**	36.5
Michigan	**300.4**	192.4	**124.7**	79.9
Minnesota	**159.3**	79.7	**147.9**	73.9
Mississippi	**162.5**	125.1	**97.5**	75.0
Missouri	**585.0**	384.1	**341.1**	223.9
Montana	**17.4**	11.2	**14.7**	9.5
Nebraska	**55.2**	30.2	**51.3**	28.1
Nevada	**74.9**	47.9	**67.1**	42.9
New Hampshire	**276.2**	138.1	**185.0**	92.5
New Jersey	**1,034.0**	517.0	**588.7**	294.4
New Mexico	**30.0**	21.8	**28.0**	20.3

TABLE 1A-1. (continued)

State	FY 2020		FY 2021	
	Total (state and federal)	Federal	Total (state and federal)	Federal
New York	**$2,477.4**	$1,238.7	**$1,261.4**	$630.7
North Carolina	**360.3**	241.5	**215.0**	144.1
North Dakota	**21.1**	10.6	**20.4**	10.2
Ohio	**436.8**	275.3	**131.1**	82.6
Oklahoma	**56.8**	37.5	**50.9**	33.6
Oregon	**77.9**	47.7	**71.3**	43.6
Pennsylvania	**766.9**	400.7	**297.4**	155.4
Rhode Island	**74.3**	39.3	**14.7**	7.8
South Carolina	**339.2**	239.8	**145.4**	102.8
South Dakota	**21.6**	12.4	**21.2**	12.2
Tennessee[1]	**81.4**	53.1	**81.4**	53.1
Texas	**1,429.6**	870.5	**1,058.5**	644.5
Utah	**27.9**	19.0	**22.9**	15.6
Vermont	**28.0**	15.1	**7.9**	4.3
Virginia	**145.4**	72.7	**89.6**	44.8
Washington	**267.3**	133.6	**108.7**	54.4
West Virginia	**77.6**	58.1	**51.8**	38.8
Wisconsin	**173.2**	102.8	**164.5**	97.7
Wyoming	**0.5**	0.2	**0.4**	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 (beginning May 23, 2020) and by $8 billion in FY 2021, and this table reflects those reductions.

[1] 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, 2020, analysis of CBO 2019 and the preliminary unreduced and reduced allotment amounts as of October 15, 2019, provided by CMS.

TABLE 1A-2. FY 2020 DSH Allotment Reductions, by State (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in federal DSH allotments
Total	**$22,513.3**	**$12,828.9**	**$7,070.0**	**$4,000.0**	**31.2%**
Alabama	**499.6**	359.6	**166.2**	119.6	33.3
Alaska	**47.6**	23.8	**4.7**	2.4	9.9
Arizona	**169.1**	118.4	**26.4**	18.5	15.6
Arkansas	**70.6**	50.4	**2.5**	1.8	3.5
California	**2,563.9**	1,282.0	**779.1**	389.5	30.4
Colorado	**216.3**	108.2	**55.8**	27.9	25.8
Connecticut	**467.8**	233.9	**131.7**	65.8	28.1
Delaware	**18.3**	10.6	**2.7**	1.6	14.8
District of Columbia	**102.3**	71.6	**49.6**	34.7	48.5
Florida	**380.5**	233.9	**114.5**	70.4	30.1
Georgia	**467.0**	314.3	**120.6**	81.2	25.8
Hawaii	**21.3**	11.4	**2.4**	1.3	11.1
Idaho	**27.3**	19.2	**3.9**	2.7	14.1
Illinois	**501.4**	251.4	**160.0**	80.2	31.9
Indiana	**379.6**	250.0	**109.2**	71.9	28.8
Iowa	**75.2**	46.1	**5.0**	3.0	6.6
Kansas	**81.5**	48.2	**21.9**	13.0	26.9
Kentucky	**236.1**	169.6	**101.0**	72.5	42.8
Louisiana	**1,199.2**	801.8	**377.9**	252.7	31.5
Maine	**192.5**	122.8	**37.4**	23.9	19.4
Maryland	**178.3**	89.2	**45.2**	22.6	25.4
Massachusetts	**713.3**	356.7	**406.2**	203.1	56.9
Michigan	**483.8**	309.9	**183.4**	117.5	37.9
Minnesota	**174.7**	87.3	**15.4**	7.7	8.8
Mississippi	**231.7**	178.3	**69.2**	53.2	29.9
Missouri	**843.9**	554.0	**258.8**	169.9	30.7
Montana	**20.5**	13.3	**3.1**	2.0	15.3
Nebraska	**60.5**	33.1	**5.3**	2.9	8.7
Nevada	**84.6**	54.1	**9.7**	6.2	11.5
New Hampshire	**374.4**	187.2	**98.2**	49.1	26.2
New Jersey	**1505.6**	752.8	**471.6**	235.8	31.3
New Mexico	**32.8**	23.8	**2.8**	2.0	8.4

TABLE 1A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in federal DSH allotments
New York	**$3,756.7**	$1,878.3	**$1,279.3**	$639.6	34.1%
North Carolina	**514.7**	345.0	**154.4**	103.5	30.0
North Dakota	**22.3**	11.2	**1.2**	0.6	5.4
Ohio	**753.8**	475.1	**317.0**	199.8	42.1
Oklahoma	**64.1**	42.3	**7.3**	4.8	11.4
Oregon	**86.5**	52.9	**8.6**	5.2	9.9
Pennsylvania	**1,256.1**	656.3	**489.2**	255.6	38.9
Rhode Island	**143.6**	76.0	**69.3**	36.7	48.3
South Carolina	**541.7**	383.0	**202.5**	143.2	37.4
South Dakota	**22.4**	12.9	**0.9**	0.5	3.8
Tennessee[1]	**81.4**	53.1	**–**	–	–
Texas	**1,836.5**	1,118.2	**406.9**	247.8	22.2
Utah	**33.6**	22.9	**5.7**	3.9	17.1
Vermont	**48.9**	26.3	**20.8**	11.2	42.6
Virginia	**204.9**	102.4	**59.5**	29.7	29.0
Washington	**432.7**	216.3	**165.4**	82.7	38.2
West Virginia	**105.3**	78.9	**27.8**	20.8	26.4
Wisconsin	**186.2**	110.5	**13.0**	7.7	7.0
Wyoming	**0.5**	0.3	**0.1**	0.0	15.0

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.

— Dash indicates zero; 0.0 indicates an amount less than $0.05 million that rounds to zero.

[1] 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, 2020, analysis of CBO 2019 and the preliminary unreduced and reduced allotment amounts as of October 15, 2019, provided by CMS.

TABLE 1A-3. Number of Uninsured Individuals and Uninsured Rate, by State, 2017–2018

State	2017		2018		Difference in uninsured (2018–2017)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**28,019**	**8.7%**	**28,554**	**8.9%**	**535**	**0.2%**
Alabama	449	9.4	481	10.0	32	0.6
Alaska	98	13.7	90	12.6	-8	-1.1
Arizona	695	10.1	750	10.6	55	0.5
Arkansas	232	7.9	244	8.2	12	0.3
California	2,797	7.2	2,826	7.2	29	0.0
Colorado	414	7.5	422	7.5	8	0.0
Connecticut	194	5.5	187	5.3	-7	-0.2
District of Columbia	26	3.8	22	3.2	-4	-0.6
Florida	2,676	12.9	2,728	13.0	52	0.1
Georgia	1,375	13.4	1,411	13.7	36	0.3
Hawaii	53	3.8	56	4.1	3	0.3
Idaho	172	10.1	193	11.1	21	1.0
Illinois	859	6.8	875	7.0	16	0.2
Indiana	536	8.2	545	8.3	9	0.1
Iowa	146	4.7	147	4.7	1	0.0
Kansas	249	8.7	250	8.8	1	0.1
Kentucky	235	5.4	248	5.6	13	0.2
Louisiana	383	8.4	363	8.0	-20	-0.4
Maine	107	8.1	106	8.0	-1	-0.1
Maryland	366	6.1	357	6.0	-9	-0.1
Massachusetts	190	2.8	189	2.8	-1	0.0
Michigan	510	5.2	535	5.4	25	0.2
Minnesota	243	4.4	244	4.4	1	0.0
Mississippi	352	12.0	354	12.1	2	0.1
Missouri	548	9.1	566	9.4	18	0.3
Montana	88	8.5	86	8.2	-2	-0.3
Nebraska	157	8.3	158	8.3	1	0.0
Nevada	333	11.2	336	11.2	3	0.0
New Hampshire	77	5.8	77	5.7	0	-0.1
New Jersey	688	7.7	655	7.4	-33	-0.3
New Mexico	187	9.1	196	9.5	9	0.4

TABLE 1A-3. (continued)

State	2017		2018		Difference in uninsured (2018–2017)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
New York	1,113	5.7%	1,041	5.4%	-72	-0.3%
North Carolina	1,076	10.7	1,092	10.7	16	0.0
North Dakota	56	7.5	54	7.3	-2	-0.2
Ohio	686	6.0	744	6.5	58	0.5
Oklahoma	545	14.2	548	14.2	3	0.0
Oregon	281	6.8	293	7.1	12	0.3
Pennsylvania	692	5.5	699	5.5	7	0.0
Rhode Island	48	4.6	42	4.1	-6	-0.5
South Carolina	542	11.0	522	10.5	-20	-0.5
South Dakota	77	9.1	85	9.8	8	0.7
Tennessee	629	9.5	675	10.1	46	0.6
Texas	4,817	17.3	5,003	17.7	186	0.4
Utah	282	9.2	295	9.4	13	0.2
Vermont	28	4.6	25	4.0	-3	-0.6
Virginia	729	8.8	731	8.8	2	0.0
Washington	446	6.1	477	6.4	31	0.3
West Virginia	109	6.1	114	6.4	5	0.3
Wisconsin	309	5.4	313	5.5	4	0.1
Wyoming	70	12.3	59	10.5	-11	-1.8

Notes: Delaware is not included because of data collection issues identified after the release of 2017 data products.

0.0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero.

Source: Berchick et al. 2019.

TABLE 1A-4. State Levels of Uncompensated Care, FYs 2016–2017

State	Total hospital uncompensated care costs, 2016		Total hospital uncompensated care costs, 2017		Difference in total hospital uncompensated care costs (2017 less 2016)	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	$37,170	4.2%	$39,875	4.3%	$2,705	0.2%
Alabama	636	6.2	680	6.4	44	0.2
Alaska	75	3.9	65	3.5	-10	-0.5
Arizona	425	2.9	412	2.8	-14	-0.2
Arkansas	219	3.5	223	3.4	5	-0.1
California	1,919	1.8	2,230	2.0	312	0.2
Colorado	386	2.7	358	2.5	-28	-0.2
Connecticut	242	2.2	371	3.3	129	1.1
Delaware	73	2.6	76	2.6	3	0.0
District of Columbia	68	2.0	80	2.2	12	0.2
Florida	3,553	7.6	3,731	7.9	177	0.2
Georgia	1,868	8.1	2,078	8.5	210	0.4
Hawaii	44	1.3	221	6.4	177	5.1
Idaho	192	4.2	198	4.0	6	-0.1
Illinois	1,582	4.2	1,635	4.3	53	0.1
Indiana	819	3.8	885	4.0	65	0.2
Iowa	190	2.2	232	2.5	42	0.4
Kansas	317	3.8	342	3.9	26	0.0
Kentucky	302	2.3	335	2.4	33	0.1
Louisiana	863	6.6	493	3.7	-370	-2.9
Maine	192	3.5	213	3.7	21	0.2
Maryland	510	3.4	510	3.3	0	-0.1
Massachusetts	600	2.3	483	1.8	-118	-0.5
Michigan	520	1.7	546	1.7	26	0.0
Minnesota	268	1.5	320	1.7	52	0.2
Mississippi	577	7.3	619	7.7	42	0.4
Missouri	1,119	5.7	1,146	5.7	27	-0.0
Montana	128	3.3	105	2.6	-23	-0.7

TABLE 1A-4. (continued)

State	Total hospital uncompensated care costs, 2016		Total hospital uncompensated care costs, 2017		Difference in total hospital uncompensated care costs (2017 less 2016)	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Nebraska	$255	4.2%	267	4.3%	$13	0.1%
Nevada	209	3.7	228	3.8	19	0.1
New Hampshire	126	2.8	131	2.7	5	-0.0
New Jersey	906	3.8	1,025	4.4	119	0.5
New Mexico	158	3.1	148	2.7	-10	-0.3
New York	2,582	3.7	2,630	3.6	48	-0.0
North Carolina	1,616	6.2	1,638	6.0	22	-0.2
North Dakota	84	2.2	97	2.5	13	0.2
Ohio	992	2.7	1,215	3.2	223	0.5
Oklahoma	642	6.5	718	7.1	76	0.5
Oregon	248	2.1	304	2.6	56	0.5
Pennsylvania	848	2.1	829	2.0	-18	-0.1
Rhode Island	79	2.2	69	1.9	-10	-0.3
South Carolina	1,100	8.8	1,343	10.4	243	1.6
South Dakota	100	2.6	112	2.8	12	0.2
Tennessee	835	4.9	970	5.4	136	0.6
Texas	5,951	10.1	6,443	10.5	493	0.4
Utah	384	5.7	401	5.7	18	-0.0
Vermont	42	1.8	47	1.9	5	0.1
Virginia	1,279	6.6	1,455	7.4	177	0.8
Washington	417	2.1	493	2.4	76	0.3
West Virginia	177	2.9	190	2.9	13	0.0
Wisconsin	356	1.8	434	2.1	78	0.3
Wyoming	100	6.2	101	6.2	1	-0.1

Notes: FY is fiscal year. 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. Analysis excludes 1,129 hospitals that did not provide uncompensated care cost information on the FY 2017 Medicare cost reports.

$0 indicates an amount between -$0.5 million and $0.5 million that rounds to zero; 0.0 percent or -0.0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero.

Source: MACPAC, 2020, analysis of FYs 2016 and 2017 Medicare cost reports.

TABLE 1A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria, by State, FY 2015

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
Total	**6,041**	**2,720**	**45%**	**822**	**14%**	**751**	**12%**
Alabama	115	84	73	7	6	6	5
Alaska	25	4	16	2	8	2	8
Arizona	112	36	32	36	32	30	27
Arkansas	100	6	6	1	1	1	1
California	412	43	10	40	10	33	8
Colorado	102	44	43	13	13	13	13
Connecticut	41	9	22	2	5	1	2
Delaware	13	3	23	3	23	3	23
District of Columbia	13	9	69	6	46	5	38
Florida	256	73	29	36	14	33	13
Georgia	167	128	77	27	16	20	12
Hawaii[1]	26	9	35	–	–	–	–
Idaho	49	18	37	7	14	6	12
Illinois	206	51	25	45	22	41	20
Indiana	168	52	31	15	9	15	9
Iowa	121	8	7	7	6	7	6
Kansas	152	62	41	13	9	12	8
Kentucky	116	99	85	38	33	35	30
Louisiana	211	68	32	36	17	31	15
Maine	37	1	3	1	3	1	3
Maryland	60	9	15	6	10	5	8
Massachusetts[2]	100	–	–	–	–	–	–
Michigan	164	108	66	12	7	11	7
Minnesota	144	58	40	15	10	15	10
Mississippi	110	54	49	14	13	14	13
Missouri	142	110	77	24	17	23	16
Montana	65	27	42	2	3	2	3
Nebraska	97	30	31	13	13	12	12
Nevada	53	20	38	5	9	4	8
New Hampshire	30	25	83	5	17	5	17
New Jersey	97	77	79	25	26	24	25

TABLE 1A-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
New Mexico	54	7	13%	4	7%	4	7%
New York	204	186	91	44	22	43	21
North Carolina	131	80	61	19	15	18	14
North Dakota	49	7	14	5	10	5	10
Ohio	234	160	68	19	8	18	8
Oklahoma	154	47	31	15	10	12	8
Oregon	63	59	94	18	29	18	29
Pennsylvania	223	204	88	41	18	35	15
Rhode Island	15	14	93	3	20	2	13
South Carolina	82	59	72	18	22	16	20
South Dakota	62	22	35	12	19	11	18
Tennessee	141	63	45	20	14	19	13
Texas	589	179	30	88	15	87	15
Utah	61	42	69	5	8	4	7
Vermont	16	13	81	1	6	1	6
Virginia	109	32	29	4	4	3	3
Washington	102	63	62	17	17	14	14
West Virginia	61	49	80	12	20	10	16
Wisconsin	146	98	67	20	14	20	14
Wyoming	31	11	35	1	3	1	3

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 70 DSH hospitals that did not submit a FY 2017 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 definition of essential community services includes the following services that we could identify based on the limits of available data: 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.

— Dash indicates zero.

[1] Based on available data on Medicaid inpatient and low-income utilization rates, no DSH hospitals in Hawaii appeared to meet the deemed DSH criteria in FY 2015.

[2] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it 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, 2020, analysis of state plan rate year 2015 DSH audits, FYs 2015 and 2017 Medicare cost reports, and the 2017 American Hospital Association annual survey.

TABLE 1A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals, by State, FY 2015

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
Total	**660,985**	**386,540**	**58%**	**134,261**	**20%**	**42,062**	**27,904**	**66%**	**14,145**	**34%**
Alabama	12,552	11,130	89	814	6	683	610	89	106	15
Alaska	1,230	486	40	341	28	98	45	46	38	39
Arizona	12,662	5,843	46	5,843	46	961	623	65	623	65
Arkansas	7,987	757	9	230	3	339	28	8	0	0
California	60,969	6,963	11	5,869	10	5,217	1,123	22	990	19
Colorado	8,490	4,003	47	1,191	14	604	358	59	161	27
Connecticut	7,423	1,485	21	222	3	531	100	19	54	10
Delaware	2,222	422	19	422	19	146	33	22	33	22
District of Columbia	2,519	2,107	84	980	39	258	244	94	125	49
Florida	46,218	19,159	41	10,622	23	2,777	1,721	62	1,280	46
Georgia	18,348	15,454	84	4,639	25	1,144	1,124	98	529	46
Hawaii[1]	2,196	1,227	56	–	–	168	89	53	–	–
Idaho	2,634	1,614	61	492	19	126	95	75	28	23
Illinois	26,460	10,074	38	8,872	34	1,836	1,016	55	894	49
Indiana	14,506	5,598	39	3,073	21	835	439	53	336	40
Iowa	6,742	1,673	25	1,303	19	340	179	53	148	43
Kansas	7,139	3,854	54	1,736	24	230	159	69	108	47
Kentucky	12,188	11,428	94	4,679	38	809	782	97	458	57
Louisiana	14,711	6,808	46	2,717	18	691	402	58	220	32
Maine	2,700	51	2	51	2	137	1	1	1	1
Maryland	11,049	1,620	15	1,449	13	796	45	6	37	5
Massachusetts[2]	16,715	–	–	–	–	1,377	–	–	–	–
Michigan	20,528	15,870	77	3,104	15	1,257	987	79	374	30
Minnesota	9,463	6,231	66	1,872	20	585	495	85	252	43
Mississippi	9,703	5,359	55	1,985	20	469	271	58	160	34
Missouri	15,044	12,097	80	1,900	13	915	583	64	165	18
Montana	2,578	1,695	66	154	6	76	69	90	10	13

TABLE 1A-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
Nebraska	4,686	3,127	67%	1,377	29%	165	156	95%	100	61%
Nevada	5,341	3,090	58	1,299	24	449	371	83	220	49
New Hampshire	2,353	2,127	90	743	32	93	90	97	52	56
New Jersey	18,907	17,324	92	5,167	27	1,087	1,056	97	434	40
New Mexico	3,781	864	23	259	7	321	75	23	11	3
New York	39,981	38,633	97	8,920	22	3,645	3,534	97	1,127	31
North Carolina	18,436	15,522	84	5,289	29	1,128	1,071	95	432	38
North Dakota	2,290	996	43	669	29	82	60	72	49	60
Ohio	26,562	23,053	87	5,025	19	1,668	1,512	91	663	40
Oklahoma	9,873	4,621	47	1,459	15	480	248	52	106	22
Oregon	5,483	5,152	94	1,565	29	413	407	99	184	44
Pennsylvania	31,615	30,141	95	5,951	19	1,686	1,659	98	596	35
Rhode Island	2,567	2,485	97	805	31	139	139	100	43	31
South Carolina	10,374	9,146	88	3,447	33	570	557	98	339	59
South Dakota	2,498	1,579	63	959	38	91	84	92	60	66
Tennessee	15,517	11,330	73	4,165	27	924	797	86	443	48
Texas	58,048	30,401	52	14,920	26	3,021	2,201	73	1,415	47
Utah	4,546	3,654	80	525	12	227	220	97	51	22
Vermont	975	809	83	340	35	53	51	96	30	55
Virginia	14,125	6,768	48	751	5	709	444	63	94	13
Washington	10,177	8,265	81	2,189	22	815	723	89	204	25
West Virginia	5,487	4,908	89	1,041	19	306	295	96	113	37
Wisconsin	11,321	8,967	79	2,784	25	559	517	92	249	45
Wyoming	1,246	570	46	52	4	24	14	57	2	7

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 70 DSH hospitals that did not submit a FY 2017 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 1B.

— Dash indicates zero; 0 indicates an amount less than 500 that rounds to zero; 0 percent indicates an amount less than 0.5 percent that rounds to zero.

[1] Based on available data on Medicaid inpatient and low-income utilization rates, no DSH hospitals in Hawaii appeared to meet the deemed DSH criteria in FY 2015.

[2] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it to use all of its 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, 2020, analysis of FYs 2015 and 2017 Medicare cost reports and state plan rate year 2015 DSH audits.

TABLE 1A-7. FY 2020 Unreduced DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual, by State

State	FY 2020 unreduced DSH allotment (millions)		FY 2020 unreduced DSH allotment per uninsured individual		FY 2020 unreduced DSH allotment per non-elderly low-income individual	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,513.3**	**$12,828.9**	**$788.4**	**$449.3**	**$253.2**	**$144.3**
Alabama	**499.6**	359.6	**1,038.7**	747.6	**317.4**	228.4
Alaska	**47.6**	23.8	**529.3**	264.7	**286.7**	143.3
Arizona	**169.1**	118.4	**225.5**	157.9	**78.6**	55.1
Arkansas	**70.6**	50.4	**289.5**	206.7	**68.7**	49.1
California	**2,563.9**	1,282.0	**907.3**	453.6	**223.0**	111.5
Colorado	**216.3**	108.2	**512.7**	256.3	**166.6**	83.3
Connecticut	**467.8**	233.9	**2,501.4**	1,250.7	**688.6**	344.3
Delaware	**18.3**	10.6	**338.8**	196.1	**84.6**	48.9
District of Columbia	**102.3**	71.6	**4,651.0**	3,255.7	**596.2**	417.4
Florida	**380.5**	233.9	**139.5**	85.7	**63.2**	38.9
Georgia	**467.0**	314.3	**331.0**	222.7	**143.4**	96.5
Hawaii	**21.3**	11.4	**380.6**	203.5	**76.6**	40.9
Idaho	**27.3**	19.2	**141.6**	99.6	**52.1**	36.6
Illinois	**501.4**	251.4	**573.1**	287.3	**152.6**	76.5
Indiana	**379.6**	250.0	**696.6**	458.6	**201.7**	132.8
Iowa	**75.2**	46.1	**511.9**	313.3	**101.1**	61.9
Kansas	**81.5**	48.2	**326.2**	193.0	**106.6**	63.1
Kentucky	**236.1**	169.6	**952.0**	683.7	**167.2**	120.1
Louisiana	**1,199.2**	801.8	**3,303.7**	2,208.9	**770.6**	515.2
Maine	**192.5**	122.8	**1,815.6**	1,158.4	**581.5**	371.0
Maryland	**178.3**	89.2	**499.5**	249.8	**155.6**	77.8
Massachusetts	**713.3**	356.7	**3,774.2**	1,887.1	**555.7**	277.8
Michigan	**483.8**	309.9	**904.2**	579.2	**171.3**	109.7
Minnesota	**174.7**	87.3	**715.9**	358.0	**150.8**	75.4
Mississippi	**231.7**	178.3	**654.4**	503.8	**209.9**	161.6
Missouri	**843.9**	554.0	**1,490.9**	978.8	**493.2**	323.8
Montana	**20.5**	13.3	**238.3**	154.3	**70.3**	45.6

TABLE 1A-7. (continued)

State	FY 2020 unreduced DSH allotment (millions)		FY 2020 unreduced DSH allotment per uninsured individual		FY 2020 unreduced DSH allotment per non-elderly low-income individual	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Nebraska	**$60.5**	$33.1	**$382.8**	$209.4	**$126.9**	$69.4
Nevada	**84.6**	54.1	**251.8**	161.0	**97.7**	62.5
New Hampshire	**374.4**	187.2	**4,862.8**	2,431.4	**1,697.9**	849.0
New Jersey	**1,505.6**	752.8	**2,298.6**	1,149.3	**836.3**	418.1
New Mexico	**32.8**	23.8	**167.1**	121.5	**43.4**	31.5
New York	**3,756.7**	1,878.3	**3,608.7**	1,804.4	**726.7**	363.3
North Carolina	**514.7**	345.0	**471.3**	315.9	**165.9**	111.2
North Dakota	**22.3**	11.2	**413.3**	206.9	**142.3**	71.2
Ohio	**753.8**	475.1	**1,013.2**	638.5	**238.3**	150.2
Oklahoma	**64.1**	42.3	**117.0**	77.3	**51.6**	34.0
Oregon	**86.5**	52.9	**295.1**	180.7	**74.8**	45.8
Pennsylvania	**1,256.1**	656.3	**1,797.0**	938.9	**412.7**	215.6
Rhode Island	**143.6**	76.0	**3,417.9**	1,809.8	**583.3**	308.9
South Carolina	**541.7**	383.0	**1,037.7**	733.7	**352.7**	249.3
South Dakota	**22.4**	12.9	**263.7**	151.9	**100.9**	58.1
Tennessee	**81.4**	53.1	**120.6**	78.7	**39.2**	25.6
Texas	**1,836.5**	1,118.2	**367.1**	223.5	**210.4**	128.1
Utah	**33.6**	22.9	**114.0**	77.8	**42.2**	28.8
Vermont	**48.9**	26.3	**1,954.1**	1,052.5	**350.8**	189.0
Virginia	**204.9**	102.4	**280.3**	140.1	**112.0**	56.0
Washington	**432.7**	216.3	**907.1**	453.5	**248.7**	124.4
West Virginia	**105.3**	78.9	**923.9**	692.4	**182.0**	136.4
Wisconsin	**186.2**	110.5	**595.0**	353.2	**134.5**	79.9
Wyoming	**0.5**	0.3	**9.0**	4.5	**3.9**	2.0

Notes: FY is fiscal year. DSH is disproportionate share hospital. 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, 2020, analysis of state plan rate year 2015 DSH audits, the CMS Medicaid Budget Expenditure System, Berchick, et al. 2019, and Census 2020.

TABLE 1A-8. FY 2020 Unreduced DSH Allotments as a Percentage of Hospital Uncompensated Care, by State, FY 2017

State	FY 2020 unreduced federal DSH allotment (millions)	FY 2020 unreduced federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2017	FY 2020 unreduced DSH allotment (state and federal, millions)	FY 2020 total unreduced DSH allotment as a percentage of hospital uncompensated care in the state, FY 2017
Total	**$12,828.9**	**32%**	**$22,513.3**	**56%**
Alabama	359.6	53	499.6	74
Alaska	23.8	37	47.6	74
Arizona	118.4	29	169.1	41
Arkansas	50.4	23	70.6	32
California	1,282.0	57	2,563.9	115
Colorado	108.2	30	216.3	60
Connecticut	233.9	63	467.8	126
Delaware	10.6	14	18.3	24
District of Columbia	71.6	89	102.3	128
Florida	233.9	6	380.5	10
Georgia	314.3	15	467.0	22
Hawaii	11.4	5	21.3	10
Idaho	19.2	10	27.3	14
Illinois	251.4	15	501.4	31
Indiana	250.0	28	379.6	43
Iowa	46.1	20	75.2	32
Kansas	48.2	14	81.5	24
Kentucky	169.6	51	236.1	70
Louisiana	801.8	163	1,199.2	243
Maine	122.8	58	192.5	90
Maryland	89.2	17	178.3	35
Massachusetts	356.7	74	713.3	148
Michigan	309.9	57	483.8	89
Minnesota	87.3	27	174.7	55
Mississippi	178.3	29	231.7	37
Missouri	554.0	48	843.9	74
Montana	13.3	13	20.5	20
Nebraska	33.1	12	60.5	23

TABLE 1A-8. (continued)

State	FY 2020 unreduced federal DSH allotment (millions)	FY 2020 unreduced federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2017	FY 2020 unreduced DSH allotment (state and federal, millions)	FY 2020 total unreduced DSH allotment as a percentage of hospital uncompensated care in the state, FY 2017
Nevada	$54.1	24%	$84.6	37%
New Hampshire	187.2	143	374.4	286
New Jersey	752.8	73	1,505.6	147
New Mexico	23.8	16	32.8	22
New York	1,878.3	71	3,756.7	143
North Carolina	345.0	21	514.7	31
North Dakota	11.2	12	22.3	23
Ohio	475.1	39	753.8	62
Oklahoma	42.3	6	64.1	9
Oregon	52.9	17	86.5	28
Pennsylvania	656.3	79	1,256.1	151
Rhode Island	76.0	110	143.6	208
South Carolina	383.0	29	541.7	40
South Dakota	12.9	12	22.4	20
Tennessee	53.1	5	81.4	8
Texas	1,118.2	17	1,836.5	29
Utah	22.9	6	33.6	8
Vermont	26.3	56	48.9	103
Virginia	102.4	7	204.9	14
Washington	216.3	44	432.7	88
West Virginia	78.9	42	105.3	55
Wisconsin	110.5	25	186.2	43
Wyoming	0.3	0	0.5	1

Notes: FY is fiscal year. DSH is disproportionate share hospital. Excludes 70 DSH hospitals that did not submit a Medicare cost report. Uncompensated care is calculated using 2017 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 an amount less than 0.5 percent that rounds to zero.

Source: MACPAC, 2020, analysis of state plan rate year 2015 DSH audits, the CMS Medicaid Budget Expenditure System, FY 2017 Medicare cost reports, and the 2017 American Hospital Association annual survey.

TABLE 1A-9. FY 2020 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service, by State

State	FY 2020 unreduced DSH allotment (millions)		FY 2020 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2020 unreduced DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,513.3**	**$12,828.9**	**$27.4**	**$15.6**	**$30.0**	**$17.1**
Alabama	**499.6**	359.6	**71.4**	51.4	**83.3**	59.9
Alaska	**47.6**	23.8	**23.8**	11.9	**23.8**	11.9
Arizona	**169.1**	118.4	**4.7**	3.3	**5.6**	3.9
Arkansas	**70.6**	50.4	**70.6**	50.4	**70.6**	50.4
California	**2,563.9**	1,282.0	**64.1**	32.0	**77.7**	38.8
Colorado	**216.3**	108.2	**16.6**	8.3	**16.6**	8.3
Connecticut	**467.8**	233.9	**233.9**	116.9	**467.8**	233.9
Delaware	**18.3**	10.6	**6.1**	3.5	**6.1**	3.5
District of Columbia	**102.3**	71.6	**17.1**	11.9	**20.5**	14.3
Florida	**380.5**	233.9	**10.6**	6.5	**11.5**	7.1
Georgia	**467.0**	314.3	**17.3**	11.6	**23.3**	15.7
Hawaii[1]	**21.3**	11.4	**–**	–	**–**	–
Idaho	**27.3**	19.2	**3.9**	2.7	**4.6**	3.2
Illinois	**501.4**	251.4	**11.1**	5.6	**12.2**	6.1
Indiana	**379.6**	250.0	**25.3**	16.7	**25.3**	16.7
Iowa	**75.2**	46.1	**10.7**	6.6	**10.7**	6.6
Kansas	**81.5**	48.2	**6.3**	3.7	**6.8**	4.0
Kentucky	**236.1**	169.6	**6.2**	4.5	**6.7**	4.8
Louisiana	**1,199.2**	801.8	**33.3**	22.3	**38.7**	25.9
Maine	**192.5**	122.8	**192.5**	122.8	**192.5**	122.8
Maryland	**178.3**	89.2	**29.7**	14.9	**35.7**	17.8
Massachusetts[2]	**713.3**	356.7	**–**	–	**–**	–
Michigan	**483.8**	309.9	**40.3**	25.8	**44.0**	28.2

TABLE 1A-9. (continued)

State	FY 2020 unreduced DSH allotment (millions)		FY 2020 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2020 unreduced DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Minnesota	**$174.7**	$87.3	**$11.6**	$5.8	**$11.6**	$5.8
Mississippi	**231.7**	178.3	**16.5**	12.7	**16.5**	12.7
Missouri	**843.9**	554.0	**35.2**	23.1	**36.7**	24.1
Montana	**20.5**	13.3	**10.2**	6.6	**10.2**	6.6
Nebraska	**60.5**	33.1	**4.7**	2.5	**5.0**	2.8
Nevada	**84.6**	54.1	**16.9**	10.8	**21.1**	13.5
New Hampshire	**374.4**	187.2	**74.9**	37.4	**74.9**	37.4
New Jersey	**1,505.6**	752.8	**60.2**	30.1	**62.7**	31.4
New Mexico	**32.8**	23.8	**8.2**	6.0	**8.2**	6.0
New York	**3,756.7**	1,878.3	**85.4**	42.7	**87.4**	43.7
North Carolina	**514.7**	345.0	**27.1**	18.2	**28.6**	19.2
North Dakota	**22.3**	11.2	**4.5**	2.2	**4.5**	2.2
Ohio	**753.8**	475.1	**39.7**	25.0	**41.9**	26.4
Oklahoma	**64.1**	42.3	**4.3**	2.8	**5.3**	3.5
Oregon	**86.5**	52.9	**4.8**	2.9	**4.8**	2.9
Pennsylvania	**1,256.1**	656.3	**30.6**	16.0	**35.9**	18.8
Rhode Island	**143.6**	76.0	**47.9**	25.3	**71.8**	38.0
South Carolina	**541.7**	383.0	**30.1**	21.3	**33.9**	23.9
South Dakota	**22.4**	12.9	**1.9**	1.1	**2.0**	1.2
Tennessee	**81.4**	53.1	**4.1**	2.7	**4.3**	2.8
Texas	**1,836.5**	1,118.2	**20.9**	12.7	**21.1**	12.9
Utah	**33.6**	22.9	**6.7**	4.6	**8.4**	5.7
Vermont	**48.9**	26.3	**48.9**	26.3	**48.9**	26.3
Virginia	**204.9**	102.4	**51.2**	25.6	**68.3**	34.1
Washington	**432.7**	216.3	**25.5**	12.7	**30.9**	15.5

TABLE 1A-9. (continued)

State	FY 2020 unreduced DSH allotment (millions)		FY 2020 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2020 unreduced DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
West Virginia	**$105.3**	$78.9	**$8.8**	$6.6	**$10.5**	$7.9
Wisconsin	**186.2**	110.5	**9.3**	5.5	**9.3**	5.5
Wyoming	**0.5**	0.3	**0.5**	0.3	**0.5**	0.3

Notes: FY is fiscal year. DSH is disproportionate share hospital. Excludes 70 DSH hospitals that did not submit a FY 2017 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of essential community services includes the following services based on the limits of available data: 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 1B.

– Dash indicates that the category is not applicable.

[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it 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.

[2] Based on available data on Medicaid inpatient and low-income utilization rates, no DSH hospitals in Hawaii appeared to meet the deemed DSH criteria in FY 2015.

Source: MACPAC, 2020, analysis of CMS Medicaid Budget Expenditure System, state plan rate year 2015 DSH audits, FYs 2015 and 2017 Medicare cost reports, and the 2017 American Hospital Association annual survey.

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APPENDIX 1B: 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 2015 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 are subject to change as CMS completes its internal review of state DSH audit reports.

Overall, 2,720 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 (89 hospitals were excluded under these criteria). These facilities submit Medicare cost reports but do not receive Medicaid 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 2,720 DSH hospitals were included in these analyses. We excluded 70 DSH hospitals without matching 2017 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 (422 hospitals were excluded from our analysis of FY 2017 margins 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) ÷ 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).

Definition of Essential Community Services

MACPAC's authorizing 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 (§ 1900 of the Social Security Act (the Act)).

In this report, we use the same definition to identify these hospitals that was used in MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. This 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 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 2015.

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-fifth 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 2017 Medicare cost reports and the 2017 American Hospital Association (AHA) annual survey (Table 1B-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.

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.

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

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

DSH allotment reductions from FY 2020 were calculated using projections provided by CMS after its DSH allotment reduction methodology was finalized in September 2019. DSH allotments for FY 2021 were calculated by increasing prior year allotments based on the Consumer Price Index for All Urban Consumers and doubling the amount of reductions, consistent with the current schedule of DSH allotment reductions in statute. Unreduced allotments increase each year for all states except Tennessee, whose DSH allotment is specified in statute (§ 1923(f)(6)(A)(vi) of the Act). Per the final rule, DSH allotment reductions are limited to 90 percent of each state's unreduced DSH allotment (CMS 2019). This reduction cap limits the reductions for two states and the District of Columbia in FY 2021, and their excess reduction amounts are proportionately allocated among the remaining states that do not exceed the reduction cap.

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