Chapter 5:

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 following three factors that Congress has asked the Commission to study:
  - the number of uninsured individuals;
  - the amount and sources of hospitals' uncompensated care costs; and
  - the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.
- We find that the number of uninsured individuals and unpaid costs of care for uninsured individuals are increasing nationally.
  - In 2019, 29.6 million people, or 9.2 percent of the U.S. population, were uninsured, an increase of 1.1 million people (3.9 percent) from 2018, the second consecutive annual increase.
  - Hospitals reported $40.7 billion in charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2018, an increase of $2.8 billion (7.1 percent) from FY 2017.
- Medicaid shortfall, the difference between the payments for care a hospital receives and its costs of providing services to Medicaid-enrolled patients, decreased $3.2 billion (14 percent) between 2017 and 2018 according to the American Hospital Association (AHA) annual survey. In 2018, total Medicaid shortfall for all U.S. hospitals was $19.7 billion.
- The COVID-19 pandemic is having a substantial effect on hospital finances due to increased costs of treating patients with COVID-19 and disruptions in care. Safety-net providers are particularly vulnerable to financial pressures because they typically have low operating margins. However, data are not yet available to examine the full effects of COVID-19 on hospital finances.
- Congress once again delayed DSH allotment reductions, pushing them off until FY 2024. The reductions are now scheduled for FYs 2024—2027; allotments will be reduced by $8 billion each year, or approximately 58 percent of unreduced allotment amounts.
- The Consolidated Appropriations Act, 2021 (P.L. 116-260) addressed a prior MACPAC recommendation related to DSH. Specifically, starting in FY 2022, the DSH definition of Medicaid shortfall for most hospitals will no longer include costs and payments for patients for whom Medicaid is not the primary payer.

CHAPTER 5: 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 the payments for care a hospital receives 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 (the 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 American Community Survey (ACS), 29.6 million people, or 9.2 percent of the U.S. population, were uninsured in 2019, an increase of 1.1 million people since 2018. This is the second year in a row the uninsured rate has increased.
- Hospitals reported $40.7 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2018. This represented a $2.8 billion increase from FY 2017, and a 0.1 percentage point increase in uncompensated care as a share of hospital operating expenses. Immediately after the coverage provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) went into effect, there were significant declines in uncompensated care. Since 2016, uncompensated care as a share of hospital operating expense has largely remained unchanged.
- Hospitals reported $19.7 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey for 2018, a 14 percent decline from the amount reported in 2017. (AHA 2020a, 2019a, 2017, 2015).
- In FY 2018, 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 (-2.3 percent for deemed DSH hospitals versus 0.6 percent for all hospitals). Total margins (which include government appropriations and revenue not directly related to patient care) were similar between deemed DSH hospitals (5.9 percent) and all hospitals (6.5 percent). Aggregate operating and total margins for deemed DSH hospitals would have been 3 to 4 percentage points lower without DSH payments.

In this report, we also project FY 2024 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; most recently, the Consolidated Appropriations Act, 2021 (P.L. 116-260) delayed implementation of reductions until FY 2024. The amount of reductions will be $8 billion a year between FY 2024 and FY 2027 (amounting to 57.8 percent of FY 2024 unreduced allotments).

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH program (Box 5-1). Most recently, the Commission recommended changes to the treatment of third-party payments in the DSH definition of Medicaid shortfall, which Congress enacted in the Consolidated Appropriations Act, 2021.[1] In March 2019, the Commission also made a package of three recommendations for how pending DSH allotment reductions should be structured, which have not been implemented. Although DSH allotment reductions have since been delayed, the Commission remains concerned about the issues we previously noted, such as the abrupt reductions under current law and the lack of meaningful relationship between DSH allotments and measures of need for DSH funds.

BOX 5-1. 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 (the Secretary) 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.
  - P.L. 116-260 requires the U.S. Department of Health and Human Services to establish a system for states to submit non-DSH supplemental payment data in a standard format, beginning October 1, 2021. However, this system does not include managed care payments or information on the sources of non-federal share necessary to determine net Medicaid payments at the provider level.

BOX 5-1. (continued)

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.
  - P.L. 116-260 enacted this recommendation for most DSH hospitals, effective October 1, 2021.

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 available.[2] In February 2016, the Commission recommended that the Secretary of the U.S. Department of Health and Human Services (HHS) collect and report complete information on Medicaid payments to hospitals to help inform analyses about the targeting of DSH payments.

The Consolidated Appropriations Act, 2021, requires HHS to collect and report data on non-DSH supplemental payments beginning October 1, 2021, which may help inform additional analyses about the targeting of DSH payments. However, HHS is not required to collect and report data on the sources of non-federal share necessary to determine net payments at the provider level.

The COVID-19 pandemic is having substantial effects on hospital finances, but the full effects of the pandemic are still not clear. In addition to reporting increased costs of treating patients with COVID-19 and costs associated with reducing the risk of COVID-19 infection among patients and staff, hospitals reported decreased revenue in April 2020 as a result of delays in elective procedures and other routine services (AHA 2020c).

Safety-net providers that serve a high share of Medicaid and uninsured patients are particularly vulnerable to financial pressures caused by the pandemic because prior to the pandemic they often had low operating margins. In addition, Medicaid-enrolled patients, the majority of whom identify as Black, Hispanic, Native American, or other non-white race or ethnicity, have been disproportionately affected by COVID-19 (MACPAC 2020a).

In March and April of 2020, to help address these financial challenges, Congress provided additional funding to hospitals through a variety of mechanisms, including a $175 billion federal provider relief fund (available to all provider types, not just hospitals). In December 2020, the Consolidated Appropriations Act, 2021, added an additional $3 billion to the provider relief fund. Some state Medicaid programs are also making additional payments to hospitals to supplement federal relief efforts (Gifford et al. 2020).

In April 2020, the Commission sent two letters to HHS expressing concerns that initial distributions of federal provider relief funding were not appropriately targeted to safety-net providers (MACPAC 2020b, 2020c). Since then, HHS has made additional targeted distributions of relief funding to safety-net hospitals. However, it is unclear whether this additional funding has been sufficient to cover the financial losses experienced by safety-net providers. Moreover, as of January 11, 2021, approximately $58 billion in federal provider relief funds had not been spent (HHS 2021a). The Commission plans to continue monitoring the effects of the pandemic on safety-net hospitals and the distribution of state and federal relief funding as more data become available.

This chapter begins with a background of the Medicaid DSH program and then reviews the most recently available data on the number of uninsured individuals, the amounts and sources of hospital uncompensated care, and the number of hospitals with high levels of uncompensated care that also provide essential community services. We also summarize the limited information available about the early effects of the COVID-19 pandemic on safety-net hospitals. The chapter concludes with an analysis of DSH allotment reductions under current law and how they relate to the factors that Congress asked us to consider.

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 uncoupled from Medicare payment levels.[3] 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).[4]

BOX 5-2. 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 regular 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).

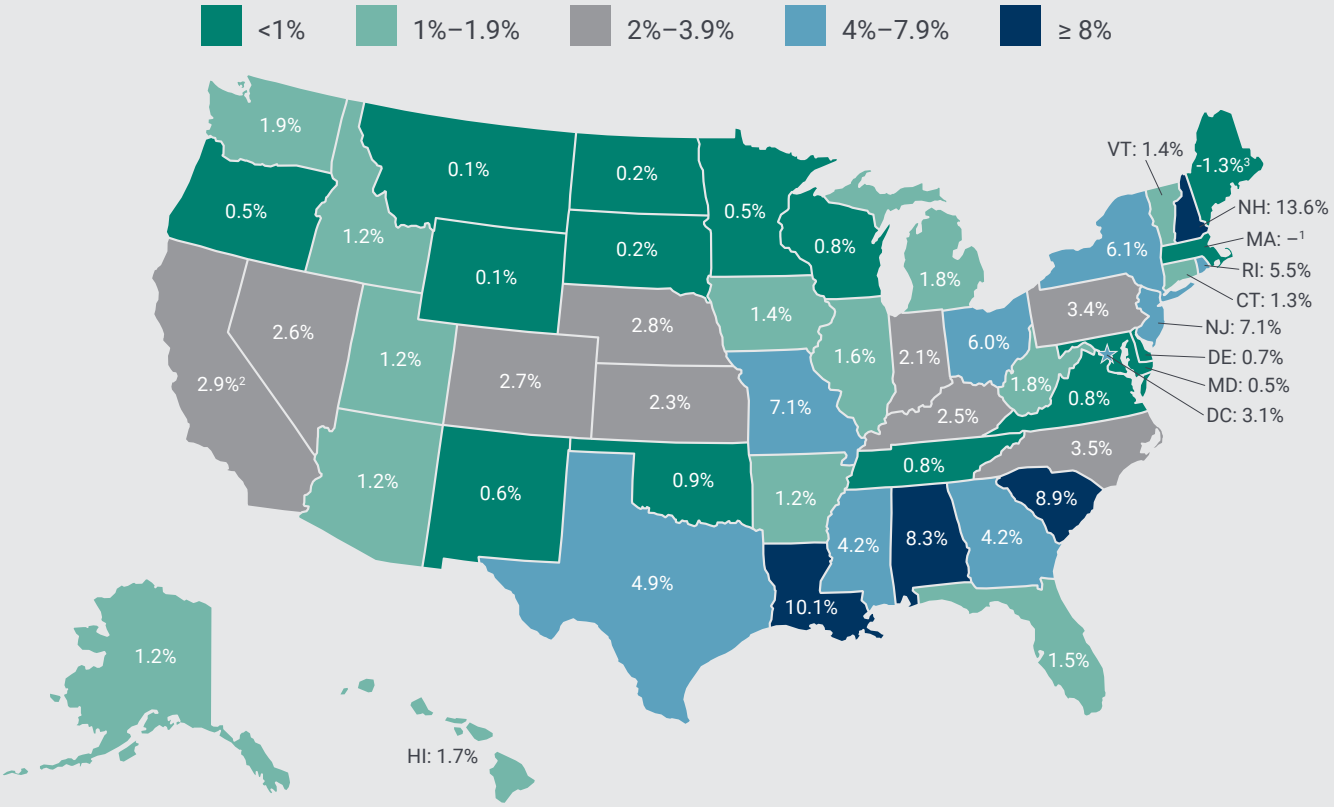
Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

In 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 5-2). Allotments were initially established for FY 1993 and were generally based on each state's 1992 DSH spending. Although Congress has made several incremental adjustments to these allotments, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 still have the smallest allotments.[5]

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 $19.7 billion in FY 2019 and accounted for 3.3 percent of total Medicaid benefit spending.[6] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 15 states to 13.6 percent in New Hampshire (Figure 5-1).

FIGURE 5-1. DSH Spending as a Share of Total Medicaid Benefit Spending, by State, FY 2019



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

— Dash indicates zero.

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

[3] Maine reported negative DSH spending in FY 2019. A state may report negative spending in a fiscal year due to a prior period adjustment.

Source: MACPAC, 2021, analysis of CMS-64 financial management report net expenditure data as of October 1, 2020.

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[7] As of the end of FY 2020, $1.3 billion in federal DSH allotments for FY 2018 went unspent.[8] There are two primary reasons states do not spend their full DSH allotment: (1) they lack state funds to provide the non-federal share; and (2) the DSH allotment exceeds the total amount of hospital uncompensated care in the state. As noted above, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care. In FY 2018, half of unspent DSH allotments were attributable to four states (Connecticut, Louisiana, Maine, and New Jersey). Three of these states (Connecticut, Louisiana, and New Jersey) had FY 2018 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated

care in the state reported on 2018 Medicare cost reports, which suggests that these states may not be able to spend their full DSH allotments even if they had sufficient state funds to provide the non-federal share. Though it should be noted that uncompensated care is calculated differently on DSH audits and Medicare cost reports.[9]

In state plan rate year (SPRY) 2016, 44 percent of U.S. hospitals received DSH payments (Table 5-1).[10] 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. 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 2016, Maine made DSH payments exclusively to IMDs, and DSH payments to IMDs amounted to more than half of DSH spending in four additional states (Alaska, Connecticut, North Dakota, and South Dakota). The amount of a state's federal DSH funds available for IMDs is limited. Each state's IMD limit is the lesser amount of either the DSH allotment the state paid to IMDs and other mental health facilities in FY 1995 or 33 percent of the state's FY 1995 DSH allotment.[12]

TABLE 5-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2016

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,648**	**6,021**	**44%**	**$16,598**
Hospital type				
Short-term acute care hospitals	1,859	3,292	56	13,012
Critical access hospitals	554	1,355	41	370
Psychiatric hospitals	147	593	25	2,886
Long-term hospitals	15	399	4	39
Rehabilitation hospitals	26	287	9	7
Children's hospitals	47	95	49	284
Urban or rural				
Urban	1,428	3,567	40	14,695
Rural	1,220	2,454	50	1,903
Hospital ownership				
For-profit	411	1,803	23	928
Non-profit	1,564	2,974	53	5,796
Public	673	1,244	54	9,874

TABLE 5-1. (continued)

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,648**	**6,021**	**44%**	**$16,598**
Teaching status				
Non-teaching	1,822	4,769	38	4,829
Low-teaching	522	836	62	3,269
High-teaching	304	416	73	8,500
Deemed DSH status				
Deemed	744	744	100	10,278
Not deemed	1,904	5,277	35	6,321

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 61 DSH hospitals that did not submit a fiscal year 2018 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. Analyses of deemed DSH hospitals is limited to hospitals that received DSH payments and excludes hospitals in California and Massachusetts that received funding from safety-net care pools that are financed with DSH funding in demonstrations authorized under waiver expenditure authority of Section 1115 of the Social Security Act.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

The proportion of hospitals receiving DSH payments varies widely by state. In SPRY 2016, four states made DSH payments to fewer than 10 percent of the hospitals in their state (Arkansas, Illinois, Iowa, and North Dakota) and two states made DSH payments to more than 90 percent of hospitals in their state (New York and Rhode Island).[13]

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 2016, about 12 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just over one-quarter (28 percent) of DSH hospitals but accounted for nearly two-thirds (62 percent) of all DSH payments, receiving $10.3 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 four states (Alabama, Arkansas, Hawaii, and Utah) to 100 percent in four states (Delaware, Illinois, Iowa, and Maine) and the District of Columbia.

State DSH targeting policies are difficult to categorize. States that concentrate DSH payments among a small number of hospitals do not necessarily make the largest share of payments to deemed DSH hospitals (e.g., Connecticut); 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 5-2). 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.[14]

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

FIGURE 5-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2016

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 and California, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools. 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 SPRY 2016.

Source: MACPAC, 2021, analysis of 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

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 2016 also received DSH payments in SPRY 2015. However, the amount that these hospitals receive can change significantly in subsequent reporting years. For example, our data shows that 25 percent of hospitals that received DSH payments in SPRY 2015 and SPRY 2016 reported that the amount of DSH payments they received in SPRY 2016 differed from the amount that they received in SPRY 2015 by more than 50 percent (including both increases and decreases).

Changes in the Number of Uninsured Individuals

According to the ACS, 29.6 million people were uninsured in 2019 (9.2 percent of the U.S. population), a statistically significant increase from the number and share in 2018 (28.6 million or 8.9 percent) (Table 5-2).[15] This statistic includes individuals who were uninsured at the time of the interview only, and therefore does not include individuals who may have been uninsured for other parts of the year.[16] Statistically significant increases were observed for most ages, races and ethnicities, and income levels (Keisler-Starkey and Bunch 2020). This is the second year in a row in which the overall uninsured rate increased significantly (Berchick et al. 2019).

TABLE 5-2. Uninsured Rates by Selected Characteristics, United States, 2018 and 2019

Characteristic	2018	2019	Percentage point change
All uninsured	**8.9%**	**9.2%**	**0.3%***
Age group			
Under age 19	5.2	5.7	0.5*
Age 19–64	12.5	12.9	0.4*
Over age 64	0.8	0.8	0.0
Race and ethnicity			
White, non-Hispanic	6.0	6.3	0.3*
Black, non-Hispanic	10.1	10.1	0
Asian, non-Hispanic	6.3	6.6	0.3*
Hispanic (any race)	17.9	18.7	0.7*
Income-to-poverty ratio			
Below 100 percent	15.5	16.0	0.5*
100–199 percent	14.6	15.2	0.6*
200–299 percent	11.3	12.3	0.8*
300–399 percent	7.9	8.6	0.7*
At or above 400 percent	3.6	3.9	0.2*

TABLE 5-2. (continued)

Characteristic	2018	2019	Percentage point change
All uninsured	**8.9%**	**9.2%**	**0.3%***
Medicaid expansion status in state of residence			
Non-expansion	12.2	13.1	0.6
Expansion	6.5	7.0	0.4

Notes: Uninsured rates by Medicaid expansion status are based on the American Community Survey. Medicaid expansion status reflects state expansion decisions as of January 10, 2019. In past years, we reported national data on uninsured individuals using the Current Population Survey (CPS) Annual Social and Economic Supplement. However, due to complications related to data collection for CPS 2019 estimates during March–June of 2020 due to COVID-19, we are reporting ACS numbers to align with how Census Bureau are reporting 2018–2019 trends. Numbers do not sum due to rounding. For a discussion on the differences between each survey's uninsured rates, please refer to Appendix 5B.

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

Source: MACPAC, 2021, analysis of Keisler-Starkey and Bunch 2020.

The uninsured rate in states that did not expand Medicaid 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. Virginia and Maine expanded Medicaid at the beginning of 2019. Of the two states, Virginia saw a statistically significant decline in its uninsured rate of 0.9 percentage points, while Maine's uninsured rate did not change significantly, possibly due to low uptake of coverage caused by delays in implementing the state's Medicaid expansion.[17] Idaho, Utah, Nebraska, Oklahoma, and Missouri all recently passed ballot initiatives authorizing the expansion of Medicaid, but these expansions are not reflected in the 2019 uninsured rates (KFF 2020a).

The net 1.3 million increase in the number of uninsured individuals between 2018 and 2019 includes a 1.6 million decline in individuals reporting enrollment in Medicaid and the State Children's Health Insurance Program (CHIP) in 2019 on the ACS. The number of individuals enrolled in Medicaid and CHIP also declined between 2017 and 2018, which was the first national decline in Medicaid and CHIP enrollment since the implementation of the ACA coverage expansions (Keisler-Starkey and Bunch 2020).[18]

The share of Asian and Hispanic individuals who reported being uninsured increased significantly between 2018 and 2019. This may be due, in part, to the so-called chilling effect of a proposed October 2018 rule by the U.S. Department of Homeland Security to change the definition of public charge for the purposes of immigration status to include receipt of public benefits, such as Medicaid.[19] The rule, along with other immigration policies, may have had chilling effects on participation in Medicaid and CHIP among immigrant families and their children, even before its finalization.[20] The Kaiser Family Foundation has estimated that between 2.0 and 4.7 million eligible Medicaid and CHIP enrollees with at least one non-citizen in their family may disenroll as a result of this policy (Artiga et al. 2019).[21]

Looking ahead, the number of uninsured individuals is expected to increase due to the job losses associated with the COVID-19 pandemic. The Congressional Budget Office (CBO) projects a 1 million increase in the number of uninsured individuals from prepandemic levels and estimate that this will increase by another million in 2021, totaling 32 million uninsured individuals in 2021. Likewise, CBO expects the total number of people enrolled in Medicaid to increase from 70 million to 76 million by the end of 2021 (CBO 2020a).

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 increased between 2014–2017, Medicaid shortfall increased as well.

Definitions of uncompensated care vary among data sources, complicating comparisons and our ability to fully understand effects at the hospital level (Box 5-3). 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 made publicly available by CMS until about five years after DSH payments are made.[22]

BOX 5-3. Definitions and Data Sources 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 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.

BOX 5-3. (continued)

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-eligible 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).

- The Consolidated Appropriations Act, 2021 (P.L. 116-260) changes the DSH definition of Medicaid shortfall for most hospitals beginning October 1, 2021, to exclude costs and payments for patients for whom Medicaid is not the primary payer.

Below, we review the most recent uncompensated care data available for all hospitals in 2018 as well as additional information about Medicaid shortfall from the 2018 AHA annual survey.

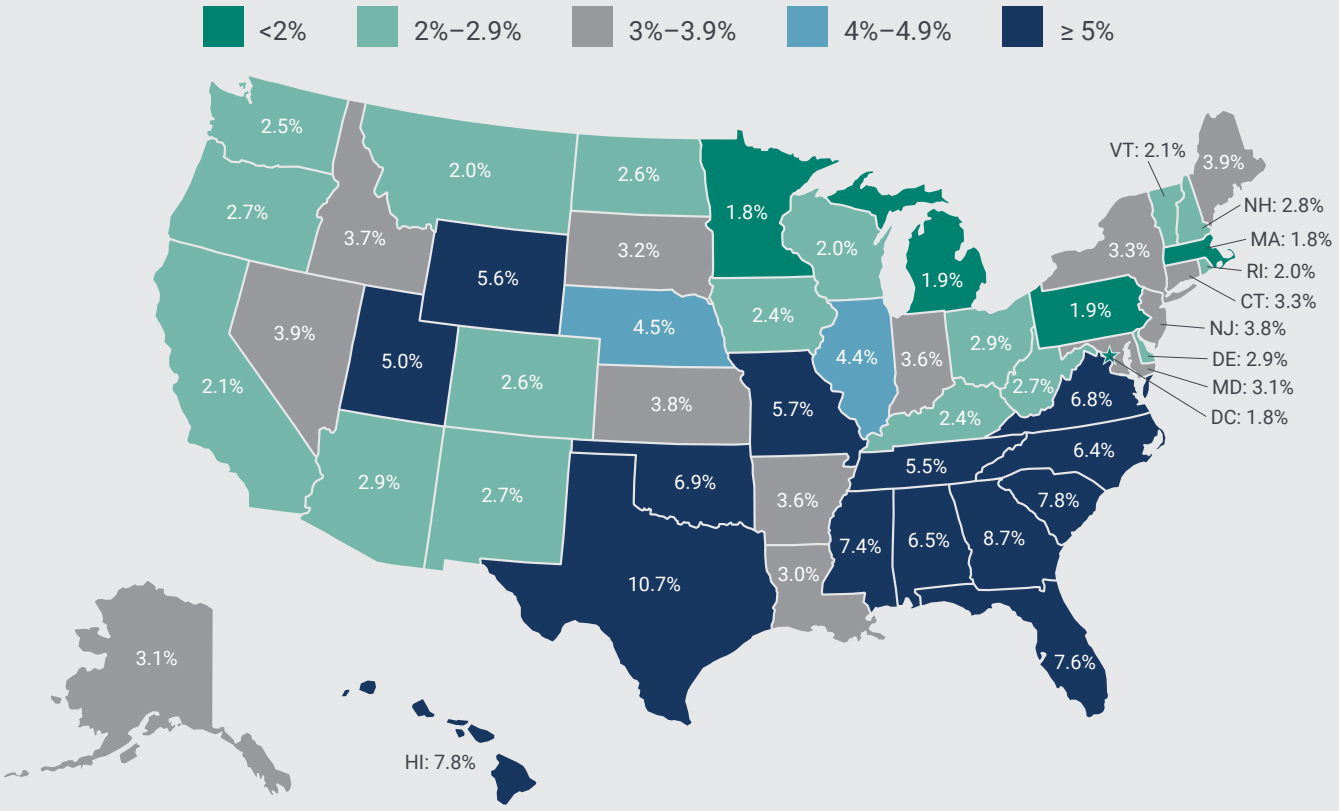
Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $40.7 billion in charity care and bad debt in FY 2018, comprising 4.2 percent of hospital operating expenses. This is a $2.8 billion (7.1 percent) increase from FY 2017, and a 0.1 percentage point increase as a share of hospital operating expenses, which is similar to the increase between FY 2016 and FY 2017.

Due to changes in Medicare cost report instructions, uncompensated care reported on FY 2018 Medicare cost reports cannot be compared to data from prior to the implementation of the ACA. The changes to the cost report instructions went into effect in FY 2017, and may have had a particularly marked effect on uncompensated care costs reported that year.[23] Moreover, we are no longer observing the large declines in uncompensated care that we observed immediately after the implementation of the ACA coverage expansions in 2014. 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).[24]

As a share of hospital operating expenses, charity care and bad debt varied widely by state in FY 2018 (Figure 5-3). In the aggregate, hospitals in states that expanded Medicaid before September 30, 2018, 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 7.0 percent in states that did not expand Medicaid).

FIGURE 5-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2018



Note: FY is fiscal year.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports.

Uncompensated care reported on Medicare cost reports includes the costs of care provided to both uninsured individuals and insured patients who cannot pay deductibles, co-payments, or coinsurance. In FY 2018, about 49 percent of uncompensated care reported was for charity care for uninsured individuals ($20.0 billion), 15 percent was for charity care for insured individuals ($6.3 billion), and 36 percent was for bad debt expenses for both insured and uninsured individuals ($14.6 billion).[25] 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, coinsurance, and other forms of cost sharing. When patients cannot pay the amounts associated with cost sharing, these costs might be forgiven as charity care or might become bad debt expenses for hospitals. Within the employer-sponsored insurance market, the share of covered workers with high-deductible health plans has increased from 4 percent in 2006 to 31 percent in 2020, while savings rates among those with health savings accounts remain low (KFF 2020b, Kullgren et al. 2020).

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.[26] According to the AHA annual survey, Medicaid shortfall in 2018 for all U.S. hospitals totaled $19.7 billion, a decrease of $3.2 billion from 2017. The aggregate Medicaid payment-to-cost ratio reported on the AHA survey was 89 percent in 2018, a modest increase from the 87 percent payment-to-cost ratio reported in 2017 (AHA 2020a, 2019a).

Previously MACPAC found wide variation in the amount of Medicaid shortfall for DSH hospitals reported on DSH audits.[27] 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 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.[28] At issue in these lawsuits is how Medicaid shortfall should be counted for Medicaid-eligible patients with third-party coverage.

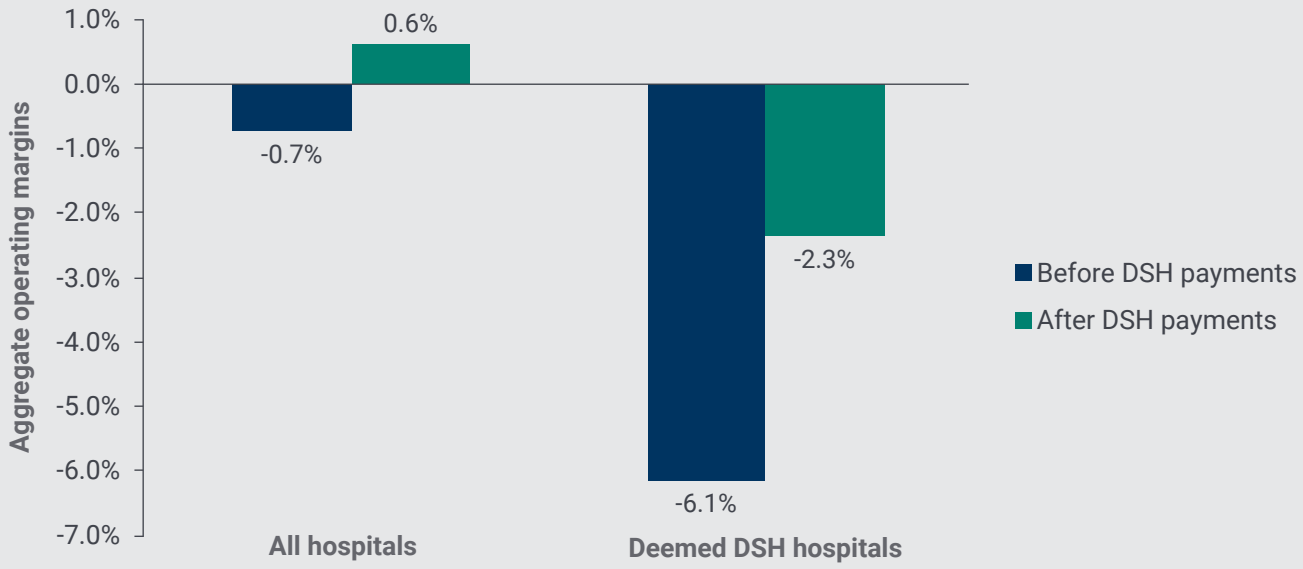
In August 2019, the U.S. Court of Appeals for the District of Columbia ruled that CMS can require states to count third-party payments in the calculation of Medicaid shortfall, and so CMS will be requiring states to calculate Medicaid shortfall according to this method for services furnished on or after June 2, 2017 (CMS 2020).[29] In December 2020, the Consolidated Appropriations Act , 2021, revised the DSH definition of Medicaid shortfall to exclude costs and payments for patients for whom Medicaid is not the primary payer, which will be effective October 1, 2021.

Hospital margins

Changes in hospital uncompensated care costs may affect hospital margins. For example, deemed DSH hospitals report higher uncompensated care costs and lower operating and total margins on average.[30] However, margins are an imperfect measure of a hospital's financial health and can be affected by factors other than uncompensated care.

In FY 2018, aggregate operating margins were positive across all hospitals after including DSH payments (0.6 percent) and were 0.4 percentage points higher than in FY 2017. By contrast, deemed DSH hospitals reported negative aggregate operating margins both before and after counting DSH payments (-6.1 percent and -2.3 percent, respectively) (Figure 5-4).[31]

FIGURE 5-4. Aggregate Hospital Operating Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2018

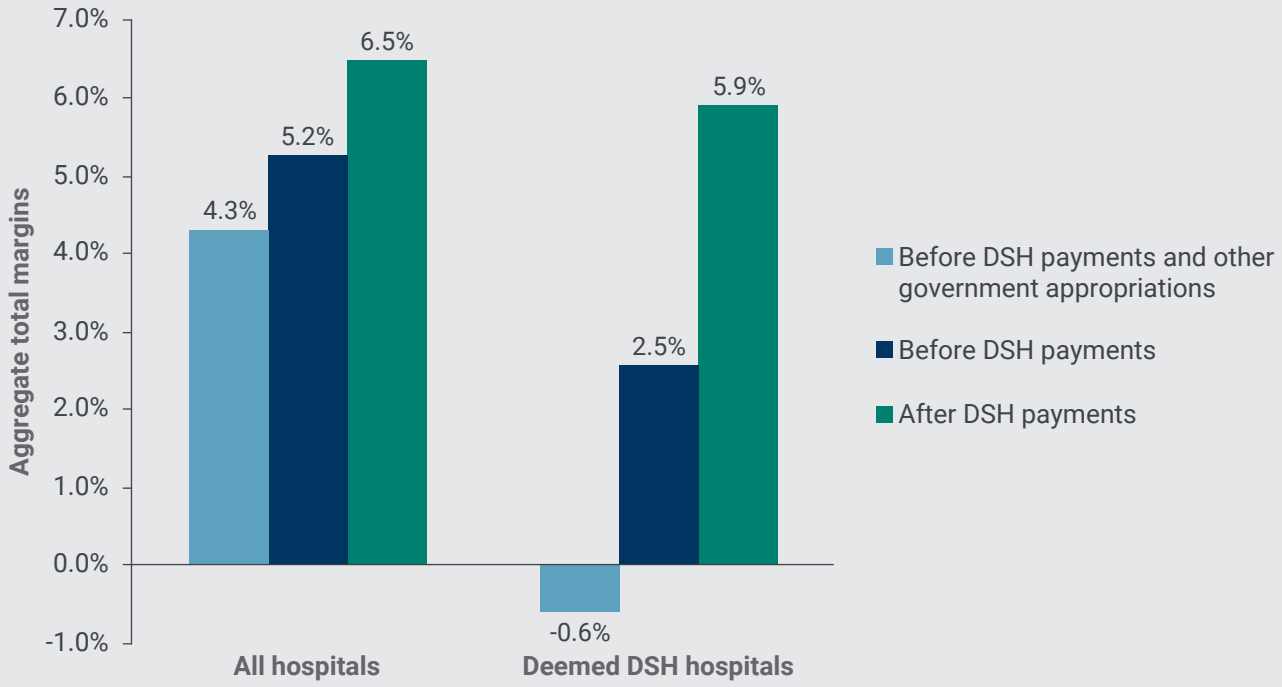


Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure income from patient care divided by net patient revenue. Operating margins before DSH payments in FY 2018 were estimated using state plan rate year (SPRY) 2016 DSH audit data. Analysis excluded outlier hospitals 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. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. For further discussion of this methodology and limitations, see Appendix 5B.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

Total margins include revenue not directly related to patient care (Appendix 5B). The aggregate total margins for all hospitals after DSH payments was 6.5 percent in FY 2018, which is 0.3 percentage points lower than in FY 2017. Before counting DSH payments and other government appropriations, deemed DSH hospitals reported an aggregate total margin of -0.6 percent in FY 2018. However, after counting these payments and appropriations, deemed DSH hospitals reported positive aggregate total margins of 5.9 percent, comparable to the aggregate total margins reported for all hospitals (Figure 5-5).

FIGURE 5-5. Aggregate Hospital Total Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2018



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 2018 were estimated using state plan rate year (SPRY) 2016 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. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. For further discussion of this methodology and limitations, see Appendix 5B.

Source: MACPAC, 2021, analysis of FY 2018 Medicare cost reports and SPRY 2016 as-filed Medicaid DSH audits.

Changes in hospital total margins may be affected by multiple factors, 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 may cut unprofitable services, which would increase their margins in the short term; hospitals that are doing well financially may make additional investments, which could decrease their margins in the short term.

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 5-4).[32]

BOX 5-4. 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 5B for further discussion of our methodology and its limitations.

Using data from 2018 Medicare cost reports and the 2018 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2016, 92 percent provided at least one of the services included in MACPAC's definition of essential community services, 74 percent provided two of these services, and 59 percent provided three or more of these services. By contrast, among non-deemed DSH hospitals, 39 percent provided three or more of these services.

In reviewing the services that hospitals provide, we included services provided outside of the hospital setting whose costs associated are not included in the calculation of uncompensated care for DSH purposes. Many of these services are considered essential for the community but not provided directly through the hospital. For example, MACPAC found that of the 2,472 hospitals that reported providing primary care services in the 2018 AHA annual survey, one-quarter provided access to primary care outside of the hospital setting, either through clinics owned by the larger system or by contracting directly with the hospital. In recent years, the share of hospitals and physicians affiliated with larger health systems has increased. In 2018, for example, 68 percent of all deemed DSH hospitals were part of larger health systems, representing a slight increase from 66 percent in 2016 (AHRQ 2019).[33] In addition, from 2016 to 2018, the share of physicians affiliated with health systems increased from 40 percent to 51 percent (Furukawa et al. 2020).

Hospital capacity

The COVID-19 pandemic has highlighted the importance of hospitals' ability to aggressively respond to surges in hospital utilization as a result of an infectious disease outbreak. During the pandemic, hospitals have reported lacking the staff, equipment, and space to withstand a large surge in patients (OIG 2020). Many facilities converted beds typically used for elective procedures into intensive care unit (ICU) beds and transferred ICU beds into mobile units (Abir et al. 2020). Meanwhile, some state governments responded by expediting medical license approvals for out-of-state practitioners to strengthen the system's workforce capacity (Tsai et al. 2020).

To examine the role of DSH hospitals in providing surge capacity, we examined prepandemic data on the share of hospital beds in deemed DSH hospitals in different hospital referral regions (HRRs).[34] In FY 2018, our data showed that deemed DSH hospitals accounted for 12 percent of hospitals but 20 percent of ICU beds nationwide. In 34 HRRs, deemed DSH hospitals accounted for the majority of ICU beds. We will continue to monitor how DSH hospitals have responded to the pandemic as more data become available.

Early Effects of the COVID-19 Pandemic

The COVID-19 pandemic is having substantial effects on hospital finances, but its ultimate effects on hospital uncompensated care are still unclear at this time. On one hand, hospitals are reporting increased costs related to treating patients with COVID-19 and implementing new infection control practices to protect patients and staff, which may increase hospital uncompensated care costs to the extent that these are not paid for by other sources. On the other hand, hospitals have been experiencing declines in utilization as a result of a deferred care and postponed non-emergent and elective surgeries, which may reduce the amount of uncompensated care relative to prior years. Although non-COVID 19 admissions rebounded to prepandemic levels over the summer of 2020, the winter surge in COVID-19 hospitalizations is expected to further disrupt usual patterns of hospital care in 2020 and 2021 (Birkmeyer et al. 2020, Mehrota et al. 2020a).

To help address these financial challenges, Congress provided additional funding for hospitals through a variety of mechanisms. Most notably, the Coronavirus Aid, Relief, and Economic Security Act

(CARES Act, P.L. 116-136), the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), and the Consolidated Appropriations Act, 2021, allocated a total of $178 billion in provider relief funding to offset lost revenue or expenses during the pandemic; a portion of this funding is also being used to pay for hospital care for uninsured individuals with COVID-19. The CARES Act also temporarily increased Medicare payments to hospitals for COVID-19 hospitalizations and established the Paycheck Protection Program for businesses with less than 500 employees.[35]

AHA estimates that approximately $70 billion of the $178 billion in provider relief funding had been disbursed to hospitals by October 2020 (AHA 2020b). In April 2020, HHS made a general distribution of provider relief funding to all Medicare-enrolled providers (which includes virtually all hospitals) equal to 2 percent of provider's patient care revenue.[36] In June 2020, HHS made additional, targeted, funding available to safety-net hospitals, defined as those with total margins below 3 percent, uncompensated care costs greater than $25,000 per bed, and a high Medicare DSH patient percentage, which is a measure of the share of patients enrolled in Medicaid and Supplemental Security Income (SSI). HHS has also made additional provider relief funding available to hospitals with a high number of COVID-19 admissions, rural hospitals, children's hospitals, and tribal hospitals. In October 2020, HHS announced another general distribution of relief funding to cover providers' losses during the first half of 2020 (HHS 2021b). In December 2020, the Consolidated Appropriations Act, 2021, required HHS to distribute 85 percent of unspent provider relief funding through a new general distribution that accounts for providers' losses during the second half of 2020 and the first quarter of 2021. As of the week of January 11, 2021, approximately $58 billion in provider relief funds remained unspent (HHS 2021a).

When FY 2020 Medicaid DSH audits are completed, it is not clear how federal relief funds will be accounted for. This is because provider relief funding is not specifically classified as payments for services to Medicaid or uninsured individuals, and DSH payments and provider relief payments are not supposed to pay for the same costs that hospitals incurred during the pandemic. As of the writing of this report, CMS has not issued guidance on how hospitals should report federal provider relief funding and DSH payments. If federal relief funds are counted against hospital uncompensated care costs on Medicaid DSH audits, it could reduce the amount of Medicaid DSH funding that hospitals receive, which may result in an increase in unspent DSH allotments.

Furthermore, during the COVID-19 pandemic, many states have used Medicaid payment policy to help supplement federal provider relief efforts. For example, New Mexico made accelerated DSH payments to providers to help offset the immediate financial disruption caused by the pandemic, and several other states have taken actions to support hospitals by increasing non-DSH payments, such as base payment rates, non-DSH supplemental payments, and directed payments in managed care (NMHSD 2020). Historically, economic downturns have resulted in Medicaid rate cuts for providers, but according to the Kaiser Family Foundation annual state Medicaid budget survey, more states increased payment rates for hospitals than decreased them in FY 2020 (Gifford et al. 2020).

The Families First and Coronavirus Response Act (FFCRA, P.L. 116-127) increased the federal matching assistance percentage (FMAP) by 6.2 percentage points for all Medicaid expenditures incurred during the public health emergency. Although this provision was intended to reduce financial strain on state budgets, it will also indirectly affect the amount of DSH payments a state can make. Given that federal DSH funding is capped for each state, an increased FMAP reduces the total amount of DSH funding available to providers. For example, a state with a $100 million federal allotment would be able to spend a total of $200 million in DSH payments at a 50 percent FMAP

($100 million state and $100 million federal funds) but would make a smaller amount ($178 million) of DSH payments at a 56.2 percent FMAP ($78 million state and $100 million federal funds).

DSH Allotment Reductions

In December 2020, Congress delayed the implementation of FY 2021 DSH reductions until FY 2024 and extended DSH allotment reductions until FY 2027. As such, DSH allotments are scheduled to be reduced by the following annual amounts:

- $8.0 billion in FY 2024;
- $8.0 billion in FY 2025;
- $8.0 billion in FY 2026; and
- $8.0 billion in FY 2027.

DSH allotment reductions are applied against unreduced DSH allotments, that is, the amounts that states would have received without DSH allotment reductions. In FY 2024, DSH allotment reductions will amount to 57.8 percent of states' unreduced DSH allotment amounts and, because unreduced DSH allotments continue to increase each year based on inflation, FY 2027 DSH allotment reductions will be a slightly smaller share of states' unreduced allotments (54.3 percent).[37] In FY 2028 and beyond, there are no DSH allotments reductions scheduled. Thus, under current law, state DSH allotments will return to their higher, unreduced DSH allotment amounts in FY 2028.

DSH allotment reductions will be applied using the DSH Health Reform Reduction Methodology (DHRM). This methodology uses specific statutorily defined 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 5-5).

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

The Disproportionate Share Hospital (DSH) Health Reform Reduction Methodology (DHRM), finalized in September 2019, is used by CMS to calculate how DSH allotment reductions will be distributed across states. As required by statute, the 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 expenditures 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.

BOX 5-5. (continued)

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.

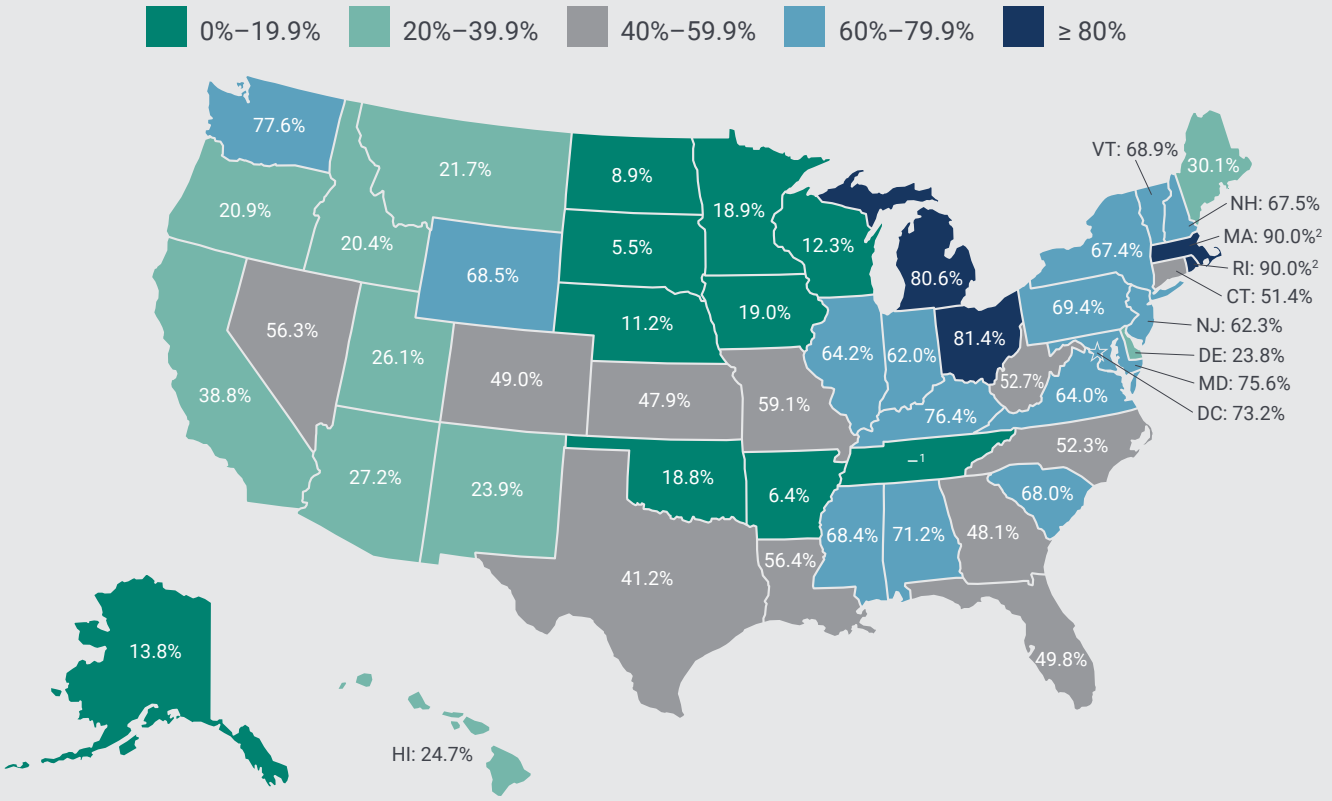
Budget neutrality factor. An adjustment to the high Medicaid and high uncompensated care factors that accounts for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under waivers under Section 1115 of the Social Security Act as of July 2009. Specifically, 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. Any DSH allotment amounts included in budget neutrality calculations for all 1115 waivers approved after July 2009 remain subject to DSH allotment reductions.

Reduced DSH allotments compared to unreduced DSH allotments

To determine the effects of DSH allotment reductions on state finances and DSH funding, we compared states' reduced DSH allotments to their unreduced amounts. For FY 2024, we used the DSH allotment reduction factors that CMS estimated for each state, and projected the DSH allotments in FY 2024. In each of FYs 2024 through 2027, DSH allotments will be reduced by $8 billion. The distribution of DSH allotment reductions among states is expected to be largely the same, assuming states do not change their DSH targeting policies and there are no changes in uninsured rates across states.

Reductions will affect states differently, with estimated reductions ranging from 5.5 percent to 90.0 percent of unreduced allotment amounts (Figure 5-6). Smaller reductions are applied to states with historically low DSH allotments (low-DSH states). Because of the low-DSH factor, the projected percentage reduction in DSH allotments for the 17 low-DSH states (16.4 percent in the aggregate) is about one-quarter that of the other states (59.8 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 10, 2019 (62.6 percent in the aggregate) than for states that did not expand Medicaid (52.9 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors are included in Appendix 5A.)

FIGURE 5-6. Decrease in State DSH Allotments as a Percentage of Unreduced Allotments, by State, FY 2024



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

[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).

[2] DSH allotment reductions are capped at 90 percent of unreduced allotments with the remaining allotment reductions being distributed to other states. This cap only affects the DSH allotment reductions in Massachusetts and Rhode Island in FY 2024.

Source: MACPAC, 2021, analysis of preliminary unreduced and reduced allotment amounts using data provided by CMS as of October 15, 2020, and projected for FY 2024.

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 13 states are projected to have FY 2024 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2018. This means that these states could make DSH payments from their reduced FY 2024 allotment equal to the payments that they made from their FY 2018 allotment.[38]

We do not know how states will respond to these reductions. As noted above, some states distribute DSH funding proportionally among all eligible hospitals while other states target payments to a small number of hospitals. States may also take different approaches to reductions, with some states applying them to all DSH hospitals and others reducing DSH payments only at specific hospitals. Because the 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.[39] However, the DSH audit data used to calculate the DSH targeting factors in the DHRM have a substantial data lag of 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. Each type of Medicaid payment is subject to its own unique rules and limitations. For example, aggregate fee-for-service 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.[40]

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 2021 DSH allotments range from less than $100 per uninsured individual in five states to more than $1,000 per uninsured individual in eight states and the District of Columbia. Nationally, the average FY 2021 DSH allotment per uninsured individual is $432.
- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2018 Medicare cost reports, unreduced FY 2021 federal DSH allotments range from less than 10 percent in nine states to more than 80 percent in five 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 2021 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in nine states and the District of Columbia. Because DSH payments to hospitals may not exceed total uncompensated care costs for Medicaid and uninsured patients, some states with DSH allotments larger than the amount of charity care and bad debt in their state may not be able to spend their full DSH allotment.[41]
- **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.

Endnotes

[1] The changes to the DSH definition of Medicaid shortfall made by the Consolidated Appropriations Act, 2021 are effective beginning October 1, 2021. The law exempts certain hospitals that treat a high number of patients who are eligible for Medicare and receive Supplemental Security Income (SSI) from this change.

[2] 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 2020d).

[3] Medicare also makes DSH payments. Hospitals are eligible for Medicare DSH payments based on their Medicaid and SSI patient utilization rate. 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.

[4] Medicaid fee-for-service 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.

[5] 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).

[6] DSH spending in FY 2019 includes spending funded from prior year allotments. Total DSH spending includes an estimate of the portion of California's spending under their demonstration waiver authorized under Section 1115 of the Act, which is based on the state's DSH allotment.

[7] 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).

[8] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts (also $1.3 billion total) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[9] Uncompensated care is calculated differently on DSH audits and Medicare cost reports. 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.

[10] 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.

[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] Additional information about Medicaid policies affecting IMDs can be found in MACPAC's December 2019 *Report to Congress on Oversight of Institutions for Mental Diseases* (MACPAC 2019b).

[13] California also made DSH payments to fewer than 10 percent of hospitals as reported on the Medicaid DSH audits for state fiscal year 2016. However, this analysis omits California and Massachusetts, because both states have hospitals that receive funding from safety-net care pools authorized under Section 1115 demonstrations that are financed with DSH funding.

[14] 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).

[15] Due to data collection issues affecting the Current Population Survey (CPS) Annual Social and Economic Supplement during the pandemic, we used American Community Survey (ACS) measures for year-to-year trends in the number of uninsured individuals instead of the CPS as in prior years. (Keisler-Starkey and Bunch 2020).

[16] There are a variety of ways to count the number of uninsured individuals. Estimates in this chapter are based on the ACS and reflect the number of people without health insurance at the time of interview during calendar years 2018 and 2019.

[17] Maine implemented its expansion on January 10, 2019. Although the state formally adopted the expansion through a ballot initiative in 2017, Governor LePage delayed its implementation. On January 3, 2019, Governor Mills signed

an executive order directing the state to begin expansion and make coverage to those eligible retroactive to July 2018. The Maine Department of Health and Human Services projected that 70,000 Mainers would be eligible for MaineCare under the Medicaid expansion. However only 42,000 people signed up in 2019 (KFF 2020a, Andrews 2019, Manatt 2018).

[18] 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 2019c).

[19] Federal law states that the applications of individuals seeking admission to the United States or seeking to change their status to lawful permanent residents must be denied if, at any time, these individuals are likely to become public charges (Artiga et al. 2019). Public charge has historically been defined as when an individual is primarily dependent on the government for subsistence.

[20] The 2018 proposed rule on Public Charge Ground of Inadmissibility was finalized in 2019, though implementation of the rule has been suspended by several legal challenges (USCIS 2020).

[21] CHIP benefits are not classified as public benefits for the purposes of the public charge rule, but the chilling effect of the rule may also apply to CHIP enrollees.

[22] 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).

[23] 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).

[24] 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 2019d).

[25] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2018 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).

[26] Most of costs of care for Medicaid-eligible patients with third-party coverage are paid by other payers because Medicaid is a payer of last resort. Medicaid shortfall is defined in Section 1923g of the Act, and refers to Medicaid eligible patients, in this chapter we discuss Medicaid enrolled because that is often how this provision is operationalized by states.

[27] 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).

[28] On April 30, 2019, states were informed that CMS would accept revised audits for SPRY 2011–2015. States have two years from April 30, 2019, to submit revised audits with the approval of a good-cause waiver of timely filing requirements by CMS (CMS 2021).

[29] In April 2020, the U.S. Court of Appeals for the Fifth Circuit issued a similar ruling against eight hospitals in Mississippi, contending that CMS acted within its authority in compelling DSH hospitals to count payments from Medicare and private insurers when calculating Medicaid shortfall. The Children's Hospital Association of Texas asked the Supreme Court to review the appeals court decision, a request that was declined (*Baptist Memorial Hospital-Golden Triangle, Inc. v. Azar*).

[30] It should be noted that there is no standard definition for operating versus non-operating margins, and therefore operating margins might be an imperfect measure of a hospital's financial health. This disclaimer does not apply to total margins, because hospitals are supposed to submit financial statements prepared by certified public accountants that match the data in the Medicare cost report schedule G.

[31] Reliability of financial reporting in Medicare cost reports improved substantially after 2010 compared to internal hospital audits; prior to 2010, cost report data was considered to be an imperfect method for determining hospital margins (Dranove et al. 2016, MedPAC 2015).

[32] 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).

[33] The Agency for Healthcare Research and Quality defines a health system as a system with at least one hospital and one group of physicians providing comprehensive care that are affiliated with each other through some form of common ownership or joint management (AHRQ 2019). A hospital in this instance is defined as a non-federal acute care hospital.

[34] HRRs are geographic regions developed by the Dartmouth Atlas Project. The Dartmouth Institute defines an HRR as a regional market where people seek highly specialized medical care, and it defines the set of hospitals a patient might be referred to for complications related to COVID (Dartmouth 1999).

[35] In addition, the Families First Coronavirus Response Act (P.L. 116-127) provided an option for states to provide Medicaid coverage for diagnostic testing to uninsured individuals with COVID-19.

[36] In June 2020, HHS made provider relief funds available to Medicaid-enrolled providers who are not enrolled in Medicare (HHS 2021b).

[37] 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.

[38] 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.

[39] 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).

[40] 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 2020d).

[41] 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 that states can pay for with Medicaid DSH funds.

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APPENDIX 5A: State-Level Data

TABLE 5A-1. State DSH Allotments, FYs 2021 and 2022 (millions)

State	FY 2021 without FFCRA Adjustment[1]		FY 2021 with FFCRA Adjustment[2]		FY 2022	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$20,500.2**	**$13,007.8**	**$23,184.1**	**$13,247.7**
Alabama	**502.4**	364.6	**462.8**	364.6	**511.7**	371.4
Alaska	**48.3**	24.2	**43.0**	24.2	**49.2**	24.6
Arizona	**171.5**	120.1	**157.5**	120.1	**174.7**	122.3
Arkansas	**71.8**	51.2	**66.1**	51.2	**73.1**	52.1
California	**2,599.8**	1,299.9	**2,313.0**	1,299.9	**2,647.9**	1,324.0
Colorado	**219.4**	109.7	**195.2**	109.7	**223.4**	111.7
Connecticut	**474.3**	237.2	**422.0**	237.2	**483.1**	241.5
Delaware	**18.6**	10.7	**16.8**	10.7	**18.9**	10.9
District of Columbia	**103.8**	72.6	**95.3**	72.6	**105.7**	74.0
Florida	**382.8**	237.2	**347.9**	237.2	**389.8**	241.5
Georgia	**475.4**	318.7	**435.2**	318.7	**484.2**	324.6
Hawaii	**21.8**	11.6	**19.5**	11.6	**22.2**	11.8
Idaho	**27.7**	19.5	**25.4**	19.5	**28.2**	19.9
Illinois	**500.3**	254.9	**446.0**	254.9	**509.5**	259.7
Indiana	**385.0**	253.5	**351.9**	253.5	**392.1**	258.2
Iowa	**75.6**	46.7	**68.7**	46.7	**77.0**	47.6
Kansas	**82.0**	48.9	**74.2**	48.9	**83.5**	49.8
Kentucky	**238.6**	171.9	**219.7**	171.9	**243.1**	175.1
Louisiana	**1,205.9**	813.0	**1,104.4**	813.0	**1,228.3**	828.1
Maine	**195.5**	124.5	**178.1**	124.5	**199.1**	126.8
Maryland	**180.8**	90.4	**160.9**	90.4	**184.2**	92.1
Massachusetts	**723.3**	361.7	**643.5**	361.7	**736.7**	368.4
Michigan	**490.4**	314.2	**447.1**	314.2	**499.5**	320.0
Minnesota	**177.1**	88.6	**157.6**	88.6	**180.4**	90.2
Mississippi	**232.5**	180.8	**215.4**	180.8	**236.9**	184.2
Missouri	**864.8**	561.8	**789.4**	561.8	**880.8**	572.2
Montana	**20.5**	13.5	**18.7**	13.5	**20.9**	13.7
Nebraska	**59.4**	33.6	**53.5**	33.6	**60.5**	34.2

TABLE 5A-1. (continued)

State	FY 2021 without FFCRA Adjustment[1]		FY 2021 with FFCRA Adjustment[2]		FY 2022	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$22,764.0**	**$13,007.8**	**$20,500.2**	**$13,007.8**	**$23,184.1**	**$13,247.7**
Nevada	**86.6**	54.8	**78.9**	54.8	**88.2**	55.9
New Hampshire	**379.7**	189.8	**337.8**	189.8	**386.7**	193.4
New Jersey	**1,526.7**	763.3	**1,358.3**	763.3	**1,555.0**	777.5
New Mexico	**32.9**	24.2	**30.3**	24.2	**33.5**	24.6
New York	**3,809.3**	1,904.6	**3,389.0**	1,904.6	**3,879.8**	1,939.9
North Carolina	**519.0**	349.8	**475.3**	349.8	**528.6**	356.3
North Dakota	**21.6**	11.3	**19.3**	11.3	**22.0**	11.5
Ohio	**757.1**	481.7	**689.8**	481.7	**771.1**	490.6
Oklahoma	**63.2**	42.9	**57.9**	42.9	**64.3**	43.7
Oregon	**88.2**	53.7	**80.1**	53.7	**89.9**	54.7
Pennsylvania	**1,274.9**	665.5	**1,139.6**	665.5	**1,298.5**	677.8
Rhode Island	**142.5**	77.1	**127.8**	77.1	**145.1**	78.5
South Carolina	**549.8**	388.3	**505.5**	388.3	**560.0**	395.5
South Dakota	**22.5**	13.1	**20.3**	13.1	**22.9**	13.3
Tennessee[3]	**80.3**	53.1	**73.4**	53.1	**80.3**	53.1
Texas	**1,834.5**	1,133.9	**1,667.2**	1,133.9	**1,868.5**	1,154.9
Utah	**34.5**	23.3	**31.6**	23.3	**35.1**	23.7
Vermont	**48.9**	26.7	**43.9**	26.7	**49.8**	27.2
Virginia	**207.8**	103.9	**184.8**	103.9	**211.6**	105.8
Washington	**438.7**	219.4	**390.3**	219.4	**446.9**	223.4
West Virginia	**106.7**	80.0	**98.6**	80.0	**108.7**	81.5
Wisconsin	**188.8**	112.1	**171.0**	112.1	**192.3**	114.2
Wyoming	**0.3**	0.0	**0.3**	0.2	**0.2**	0.1

Notes: DSH is disproportionate share hospital. FY is fiscal year. FFCRA is the Families First and Coronavirus Response Act (P.L. 116–127) which provided an enhanced federal medical assistance percentage (FMAP) to states during the COVID-19 public health emergency. This table assumes no FFCRA enhanced FMAP for FY 2022.

[1] Totals reflect an FMAP with no FFCRA adjustment for FY 2021.

[2] Totals reflect an FMAP with a FFCRA adjustment for FY 2021.

[3] 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, 2021, analysis of CBO 2020 and preliminary unreduced and reduced DSH allotment amounts as of October 15, 2020, provided by CMS.

TABLE 5A-2. FY 2024 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	**$24,212.7**	**$13,835.2**	**$14,054.4**	**$8,000.0**	**57.8%**
Alabama	**534.5**	387.9	**380.3**	276.0	71.2
Alaska	**51.4**	25.7	**7.1**	3.6	13.8
Arizona	**182.4**	127.7	**49.7**	34.8	27.2
Arkansas	**76.4**	54.4	**4.9**	3.5	6.4
California	**2,765.8**	1,382.9	**1,074.3**	537.1	38.8
Colorado	**233.4**	116.7	**114.3**	57.1	49.0
Connecticut	**504.6**	252.3	**259.3**	129.7	51.4
Delaware	**19.8**	11.4	**4.7**	2.7	23.8
District of Columbia	**110.4**	77.3	**80.8**	56.6	73.2
Florida	**407.2**	252.3	**202.7**	125.6	49.8
Georgia	**505.8**	339.0	**243.1**	162.9	48.1
Hawaii	**23.2**	12.3	**5.7**	3.0	24.7
Idaho	**29.5**	20.7	**6.0**	4.2	20.4
Illinois	**532.2**	271.2	**341.8**	174.2	64.2
Indiana	**409.6**	269.6	**253.8**	167.1	62.0
Iowa	**80.5**	49.7	**15.3**	9.4	19.0
Kansas	**87.2**	52.0	**41.8**	24.9	47.9
Kentucky	**253.9**	182.9	**194.0**	139.8	76.4
Louisiana	**1,283.0**	865.0	**723.8**	488.0	56.4
Maine	**208.0**	132.5	**62.6**	39.8	30.1
Maryland	**192.4**	96.2	**145.5**	72.7	75.6
Massachusetts	**769.5**	384.8	**692.6**	346.3	90.0
Michigan	**521.7**	334.3	**420.4**	269.4	80.6
Minnesota	**188.4**	94.2	**35.7**	17.8	18.9
Mississippi	**247.4**	192.4	**169.3**	131.6	68.4
Missouri	**920.0**	597.6	**543.6**	353.1	59.1
Montana	**21.8**	14.3	**4.7**	3.1	21.7
Nebraska	**63.2**	35.7	**7.1**	4.0	11.2
Nevada	**92.2**	58.3	**51.9**	32.9	56.3
New Hampshire	**403.9**	202.0	**272.5**	136.2	67.5

TABLE 5A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in federal DSH allotments
Total	**$24,212.7**	**$13,835.2**	**$14,054.4**	**$8,000.0**	**57.8%**
New Jersey	**1,624.2**	812.1	**1,011.9**	505.9	62.3
New Mexico	**35.0**	25.7	**8.4**	6.2	23.9
New York	**4,052.6**	2,026.3	**2,731.1**	1,365.5	67.4
North Carolina	**552.1**	372.1	**288.7**	194.6	52.3
North Dakota	**23.0**	12.0	**2.1**	1.1	8.9
Ohio	**805.4**	512.5	**655.9**	417.4	81.4
Oklahoma	**67.2**	45.7	**12.7**	8.6	18.8
Oregon	**93.9**	57.1	**19.6**	11.9	20.9
Pennsylvania	**1,356.4**	708.0	**941.4**	491.4	69.4
Rhode Island	**151.6**	82.0	**136.4**	73.8	90.0
South Carolina	**584.9**	413.1	**397.5**	280.8	68.0
South Dakota	**23.9**	13.9	**1.3**	0.8	5.5
Tennessee[1]	**80.3**	53.1	**–**	–	–
Texas	**1,951.6**	1,206.3	**804.6**	497.3	41.2
Utah	**36.7**	24.7	**9.6**	6.5	26.1
Vermont	**52.0**	28.4	**35.8**	19.6	68.9
Virginia	**221.0**	110.5	**141.4**	70.7	64.0
Washington	**466.8**	233.4	**362.1**	181.0	77.6
West Virginia	**113.6**	85.2	**59.8**	44.9	52.7
Wisconsin	**200.9**	119.3	**24.8**	14.7	12.3
Wyoming	**0.6**	0.3	**0.4**	0.2	68.5

Notes: FY is fiscal year. DSH is disproportionate share hospital. Under current law, federal DSH allotments will be reduced by $8 billion in FY 2024. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

— 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, 2021, analysis of the preliminary unreduced and reduced DSH allotment amounts as of October 15, 2020, provided by CMS.

TABLE 5A-3. Number of Uninsured Individuals and Uninsured Rate, by State, 2018–2019

State	2018		2019		Difference in uninsured (2019–2018)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**29,000**	**8.9%**	**30,141**	**9.2%**	**1,141**	**0.3%**
Alabama	489	10.0	476	9.7	-13	-0.3
Alaska	93	12.6	89	12.2	-4	-0.4
Arizona	760	10.6	822	11.3	62	0.7
Arkansas	247	8.2	275	9.1	27	0.9
California	2,848	7.2	3042	7.7	194	0.5
Colorado	427	7.5	461	8.0	34	0.5
Connecticut	189	5.3	210	5.9	21	0.6
Delaware	55	5.7	64	6.6	9	0.9
District of Columbia	22	3.2	25	3.5	2	0.3
Florida	2,769	13.0	2835	13.2	66	0.2
Georgia	1,441	13.7	1423	13.4	-18	-0.3
Hawaii	58	4.1	59	4.2	1	0.1
Idaho	195	11.1	193	10.8	-2	-0.3
Illinois	892	7.0	938	7.4	46	0.4
Indiana	555	8.3	586	8.7	30	0.4
Iowa	148	4.7	158	5.0	9	0.3
Kansas	256	8.8	268	9.2	12	0.4
Kentucky	250	5.6	286	6.4	36	0.8
Louisiana	373	8.0	414	8.9	41	0.9
Maine	107	8.0	108	8.0	0	0.0
Maryland	363	6.0	363	6.0	0	0.0
Massachusetts	193	2.8	207	3.0	14	0.2
Michigan	540	5.4	579	5.8	39	0.4
Minnesota	247	4.4	276	4.9	29	0.5
Mississippi	361	12.1	387	13.0	26	0.9
Missouri	576	9.4	614	10.0	38	0.6
Montana	87	8.2	89	8.3	2	0.1
Nebraska	160	8.3	161	8.3	0	0.0

TABLE 5A-3. (continued)

State	2018		2019		Difference in uninsured (2019–2018)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**29,000**	**8.9%**	**30,141**	**9.2%**	**1,141**	**0.3%**
Nevada	340	11.2	351	11.4	11	0.2
New Hampshire	77	5.7	86	6.3	8	0.6
New Jersey	659	7.4	702	7.9	42	0.5
New Mexico	199	9.5	210	10.0	11	0.5
New York	1,055	5.4	1012	5.2	-44	-0.2
North Carolina	1,111	10.7	1185	11.3	74	0.6
North Dakota	55	7.3	53	6.9	-3	-0.4
Ohio	760	6.5	771	6.6	12	0.1
Oklahoma	560	14.2	566	14.3	6	0.1
Oregon	298	7.1	304	7.2	6	0.1
Pennsylvania	704	5.5	743	5.8	38	0.3
Rhode Island	43	4.1	43	4.1	0	0.0
South Carolina	534	10.5	556	10.8	22	0.3
South Dakota	86	9.8	90	10.2	4	0.4
Tennessee	684	10.1	690	10.1	6	0.0
Texas	5,080	17.7	5335	18.4	255	0.7
Utah	297	9.4	311	9.7	14	0.3
Vermont	25	4.0	28	4.5	3	0.5
Virginia	750	8.8	674	7.9	-75	-0.9
Washington	482	6.4	503	6.6	20	0.2
West Virginia	116	6.4	120	6.7	5	0.3
Wisconsin	320	5.5	332	5.7	12	0.2
Wyoming	61	10.5	71	12.3	11	1.8

Note: 0.0 indicates an amount between -5,000 and 5,000 that rounds to zero; 0.0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero.

Source: MACPAC, 2021, analysis of Keisler-Starkey and Bunch 2020 and Census 2020.

TABLE 5A-4. State Levels of Uncompensated Care, FYs 2017–2018

State	Total hospital uncompensated care costs, 2017		Total hospital uncompensated care costs, 2018		Difference in total hospital uncompensated care costs	
	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	**$37,858**	**4.1%**	**$40,659**	**4.2%**	**$2,801**	**0.1%**
Alabama	**686**	6.5	**716**	6.5	**29**	0.0
Alaska	**60**	3.2	**58**	3.1	**-2**	-0.1
Arizona	**373**	2.5	**453**	2.9	**80**	0.4
Arkansas	**217**	3.3	**244**	3.6	**27**	0.3
California	**2,252**	2.0	**2,499**	2.1	**246**	0.1
Colorado	**354**	2.5	**386**	2.6	**32**	0.1
Connecticut	**210**	1.9	**396**	3.3	**185**	1.4
Delaware	**76**	2.6	**91**	2.9	**15**	0.4
District of Columbia	**73**	2.1	**64**	1.8	**-10**	-0.3
Florida	**3,432**	7.2	**3,785**	7.6	**353**	0.4
Georgia	**2,093**	8.5	**2,249**	8.7	**156**	0.1
Hawaii	**279**	8.1	**272**	7.8	**-7**	-0.3
Idaho	**181**	3.7	**196**	3.7	**15**	0.0
Illinois	**1,446**	3.8	**1,744**	4.4	**298**	0.6
Indiana	**828**	3.7	**851**	3.6	**23**	-0.1
Iowa	**223**	2.4	**227**	2.4	**4**	0.0
Kansas	**334**	3.8	**344**	3.8	**9**	0.0
Kentucky	**325**	2.3	**335**	2.4	**9**	0.0
Louisiana	**493**	3.7	**413**	3.0	**-80**	-0.7
Maine	**216**	3.8	**226**	3.9	**10**	0.1
Maryland	**512**	3.3	**487**	3.1	**-25**	-0.2
Massachusetts	**477**	1.8	**490**	1.8	**13**	0.0
Michigan	**545**	1.7	**612**	1.9	**68**	0.2
Minnesota	**319**	1.7	**349**	1.8	**30**	0.1
Mississippi	**606**	7.6	**592**	7.4	**-15**	-0.2
Missouri	**1,150**	5.7	**1,192**	5.7	**42**	0.0
Montana	**99**	2.5	**83**	2.0	**-15**	-0.5
Nebraska	**269**	4.3	**289**	4.5	**20**	0.2

TABLE 5A-4. (continued)

State	Total hospital uncompensated care costs, 2017		Total hospital uncompensated care costs, 2018		Difference in total hospital uncompensated care costs	
	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	**$37,858**	**4.1%**	**$40,659**	**4.2%**	**$2,801**	**0.1%**
Nevada	**228**	3.8	**243**	3.9	**16**	0.1
New Hampshire	**131**	2.8	**141**	2.8	**10**	0.1
New Jersey	**956**	4.1	**925**	3.8	**-31**	-0.2
New Mexico	**147**	2.7	**151**	2.7	**5**	0.0
New York	**2,497**	3.5	**2,556**	3.3	**59**	-0.1
North Carolina	**1,636**	6.0	**1,789**	6.4	**154**	0.4
North Dakota	**94**	2.4	**106**	2.6	**13**	0.2
Ohio	**1,091**	2.9	**1,139**	2.9	**48**	0.0
Oklahoma	**669**	6.6	**728**	6.9	**59**	0.3
Oregon	**286**	2.4	**334**	2.7	**48**	0.3
Pennsylvania	**784**	1.9	**811**	1.9	**26**	0.0
Rhode Island	**69**	1.9	**75**	2.0	**6**	0.1
South Carolina	**922**	7.1	**1,007**	7.8	**86**	0.6
South Dakota	**112**	2.8	**135**	3.2	**24**	0.4
Tennessee	**939**	5.3	**1,074**	5.5	**135**	0.2
Texas	**6,311**	10.3	**6,727**	10.7	**416**	0.4
Utah	**358**	5.1	**369**	5.0	**10**	-0.1
Vermont	**48**	1.9	**56**	2.1	**8**	0.2
Virginia	**1,276**	6.5	**1,409**	6.8	**133**	0.3
Washington	**466**	2.3	**532**	2.5	**66**	0.2
West Virginia	**171**	2.6	**185**	2.7	**14**	0.1
Wisconsin	**439**	2.1	**427**	2.0	**-11**	-0.1
Wyoming	**101**	6.1	**97**	5.6	**-4**	-0.6

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.

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

Source: MACPAC, 2021, analysis of Medicare cost reports for FYs 2017 and 2018.

TABLE 5A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria, by State, FY 2016

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	**6,021**	**2,648**	**44%**	**744**	**12%**	**681**	**11%**
Alabama	115	78	68	8	7	7	6
Alaska	25	4	16	1	4	1	4
Arizona	113	40	35	38	34	31	27
Arkansas	103	7	7	3	3	3	3
California[1]	408	29	7	15	4	10	2
Colorado	103	27	26	6	6	6	6
Connecticut	41	10	24	3	7	2	5
Delaware	13	2	15	2	15	2	15
District of Columbia	13	9	69	6	46	5	38
Florida	256	76	30	31	12	29	11
Georgia	166	125	75	23	14	16	10
Hawaii[2]	26	11	42	–	–	–	–
Idaho	51	25	49	8	16	7	14
Illinois	206	19	9	18	9	17	8
Indiana	168	54	32	11	7	11	7
Iowa	121	8	7	7	6	7	6
Kansas	151	63	42	9	6	8	5
Kentucky	115	99	86	40	35	34	30
Louisiana	209	63	30	33	16	30	14
Maine	36	5	14	3	8	3	8
Maryland	60	23	38	15	25	14	23
Massachusetts[3]	97	—	—	—	—	—	—

TABLE 5A-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
Total	**6,021**	**2,648**	**44%**	**744**	**12%**	**681**	**11%**
Michigan	164	124	76	23	14	22	13
Minnesota	142	34	24	13	9	13	9
Mississippi	109	61	56	15	14	14	13
Missouri	142	102	72	24	17	22	15
Montana	65	33	51	3	5	3	5
Nebraska	97	27	28	12	12	12	12
Nevada	56	22	39	4	7	4	7
New Hampshire	30	25	83	6	20	6	20
New Jersey	97	76	78	22	23	22	23
New Mexico	53	14	26	10	19	8	15
New York	203	190	94	46	23	46	23
North Carolina	129	80	62	18	14	18	14
North Dakota	49	2	4	1	2	1	2
Ohio	235	155	66	16	7	15	6
Oklahoma	153	49	32	16	10	14	9
Oregon	63	46	73	15	24	15	24
Pennsylvania	232	191	82	39	17	35	15
Rhode Island	15	14	93	3	20	2	13
South Carolina	83	61	73	15	18	14	17
South Dakota	61	21	34	12	20	12	20
Tennessee	145	75	52	19	13	14	10
Texas	579	174	30	71	12	69	12

TABLE 5A-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
Total	**6,021**	**2,648**	**44%**	**744**	**12%**	**681**	**11%**
Utah	60	41	68	6	10	5	8
Vermont	16	13	81	1	6	1	6
Virginia	107	36	34	5	5	5	5
Washington	103	53	51	14	14	12	12
West Virginia	60	46	77	14	23	13	22
Wisconsin	146	95	65	19	13	19	13
Wyoming	31	11	35	2	6	2	6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 61 DSH hospitals that did not submit a FY 2018 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] Analysis excludes 12 hospitals that received funding under the state's Global Payment Program as authorized under Section 1115 of the Social Security Act, which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[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 2016.

[3] 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. However, at least 10 hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Source: MACPAC, 2021, analysis of state plan rate year 2016 as-filed Medicaid DSH audits, Medicare cost reports for FYs 2016–2018, and the 2018 American Hospital Association annual survey.

TABLE 5A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals, by State, FY 2016

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	**848,379**	**489,764**	**58%**	**154,550**	**18%**	**42,991**	**28,534**	**66%**	**13,100**	**30%**
Alabama	14,787	12,849	87	1,066	7	687	609	89	107	16
Alaska	1,367	622	45	80	6	95	52	55	4	4
Arizona	15,050	7,456	50	7,005	47	990	652	66	622	63
Arkansas	9,255	1,018	11	227	2	331	32	10	5	1
California[1]	82,990	4,701	6	2,172	3	5,331	475	9	214	4
Colorado	10,321	4,155	40	1,498	15	630	322	51	157	25
Connecticut	7,136	2,000	28	657	9	525	228	44	81	15
Delaware	2,614	415	16	415	16	152	33	22	33	22
District of Columbia	3,037	2,587	85	1,178	39	268	250	93	128	48
Florida	91,920	24,741	27	12,385	13	2,760	1,733	63	1,183	43
Georgia	21,577	18,034	84	4,733	22	1,163	1,054	91	378	32
Hawaii	2,419	1,726	71	–	–	180	110	61	–	–
Idaho	3,172	2,476	78	1,203	38	136	121	89	65	48
Illinois	30,910	4,938	16	4,320	14	1,815	427	24	373	21
Indiana	17,282	7,052	41	3,833	22	891	464	52	347	39
Iowa	7,532	2,150	29	2,101	28	354	189	53	188	53
Kansas	8,161	4,505	55	1,912	23	240	170	71	103	43
Kentucky	14,154	13,277	94	5,929	42	853	818	96	487	57
Louisiana	16,505	8,395	51	3,516	21	766	480	63	282	37
Maine	2,989	1,158	39	802	27	137	70	51	46	34

TABLE 5A-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
Total	**848,379**	**489,764**	**58%**	**154,550**	**18%**	**42,991**	**28,534**	**66%**	**13,100**	**30%**
Maryland	12,708	4,528	36	3,643	29	812	299	37	238	29
Massachusetts[2]	18,674	—	—	—	—	1,370	—	—	—	—
Michigan	23,751	21,750	92	6,779	29	1,294	1,258	97	602	47
Minnesota	11,036	6,505	59	2,548	23	595	468	79	256	43
Mississippi	10,756	6,679	62	2,553	24	447	281	63	153	34
Missouri	18,376	13,218	72	2,221	12	932	522	56	119	13
Montana	2,855	2,104	74	214	7	96	88	92	12	13
Nebraska	5,456	3,751	69	1,794	33	170	162	95	104	61
Nevada	6,799	4,323	64	1,491	22	479	395	83	206	43
New Hampshire	2,641	2,415	91	1,178	45	108	104	96	78	72
New Jersey[3]	34,914	33,294	95	5,865	17	1,104	1,049	95	417	38
New Mexico	4,409	1,968	45	1,151	26	325	199	61	130	40
New York	45,962	45,045	98	10,249	22	3,697	3,621	98	1,159	31
North Carolina	21,917	18,629	85	5,838	27	1,177	1,085	92	423	36
North Dakota	2,548	125	5	25	1	86	0	0	0	0
Ohio	31,758	25,575	81	5,316	17	1,716	1,340	78	498	29
Oklahoma	11,338	6,681	59	1,807	16	477	310	65	102	21
Oregon	6,723	5,797	86	1,950	29	431	418	97	199	46
Pennsylvania	36,975	34,566	93	7,720	21	1,823	1,779	98	649	36
Rhode Island	2,935	2,853	97	885	30	156	156	100	61	39
South Carolina	12,316	11,069	90	4,032	33	583	566	97	327	56
South Dakota	2,783	1,837	66	1,132	41	94	87	93	63	68

TABLE 5A-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
Total	**848,379**	**489,764**	**58%**	**154,550**	**18%**	**42,991**	**28,534**	**66%**	**13,100**	**30%**
Tennessee	18,848	14,461	77	4,332	23	941	812	86	362	38
Texas	68,256	37,208	55	15,724	23	3,023	2,171	72	1,276	42
Utah	5,618	4,641	83	963	17	231	222	96	75	33
Vermont	1,118	952	85	410	37	53	50	95	29	55
Virginia	16,519	9,442	57	1,699	10	724	499	69	149	21
Washington	25,567	22,719	89	2,571	10	852	704	83	217	26
West Virginia	6,145	5,388	88	1,573	26	305	293	96	132	43
Wisconsin	14,153	11,704	83	3,690	26	561	513	91	257	46
Wyoming	1,345	737	55	165	12	24	15	61	2	10

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 61 DSH hospitals that did not submit a FY 2018 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 5B.

— 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] Analysis excludes 12 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[2] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least 10 hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

[3] One hospital in New Jersey misreported its hospital beds, so 2018 data were used to populate this hospital's bed information.

Source: MACPAC, 2021, analysis of Medicare cost reports for FYs 2015–2018 and state plan rate year 2015–2016 as-filed Medicaid DSH audits.

TABLE 5A-7. FY 2021 Unreduced DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual, by State

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per uninsured individual		FY 2021 unreduced DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$22,764.0**	**$13,007.8**	**$755.3**	**$431.6**	**$271.4**	**$155.1**
Alabama	**502.4**	364.6	**1,056.3**	766.6	**336.2**	244.0
Alaska	**48.3**	24.2	**541.3**	270.6	**293.3**	146.6
Arizona	**171.5**	120.1	**208.5**	146.0	**83.5**	58.4
Arkansas	**71.8**	51.2	**261.5**	186.3	**72.5**	51.6
California	**2,599.8**	1,299.9	**854.5**	427.3	**249.0**	124.5
Colorado	**219.4**	109.7	**476.2**	238.1	**179.7**	89.9
Connecticut	**474.3**	237.2	**2,254.8**	1,127.4	**717.3**	358.7
Delaware	**18.6**	10.7	**289.3**	167.0	**89.3**	51.6
District of Columbia	**103.8**	72.6	**4,200.4**	2,940.3	**636.0**	445.2
Florida	**382.8**	237.2	**135.0**	83.7	**66.5**	41.2
Georgia	**475.4**	318.7	**334.2**	224.0	**155.8**	104.4
Hawaii	**21.8**	11.6	**366.5**	194.3	**86.9**	46.1
Idaho	**27.7**	19.5	**143.4**	101.0	**54.8**	38.6
Illinois	**500.3**	254.9	**533.5**	271.9	**164.3**	83.7
Indiana	**385.0**	253.5	**657.4**	432.7	**217.7**	143.3
Iowa	**75.6**	46.7	**479.4**	296.0	**104.4**	64.4
Kansas	**82.0**	48.9	**305.8**	182.5	**112.2**	67.0
Kentucky	**238.6**	171.9	**834.6**	601.3	**176.3**	127.0
Louisiana	**1,205.9**	813.0	**2,914.7**	1,965.1	**792.4**	534.2
Maine	**195.5**	124.5	**1,817.9**	1,157.8	**647.1**	412.1
Maryland	**180.8**	90.4	**498.5**	249.3	**166.8**	83.4
Massachusetts	**723.3**	361.7	**3,498.1**	1,749.0	**599.4**	299.7
Michigan	**490.4**	314.2	**846.6**	542.5	**184.5**	118.2
Minnesota	**177.1**	88.6	**641.0**	320.5	**162.1**	81.1
Mississippi	**232.5**	180.8	**601.1**	467.4	**221.0**	171.8
Missouri	**864.8**	561.8	**1,409.0**	915.3	**533.4**	346.5

TABLE 5A-7. (continued)

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per uninsured individual		FY 2021 unreduced DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$22,764.0**	**$13,007.8**	**$755.3**	**$431.6**	**$271.4**	**$155.1**
Montana	**20.5**	13.5	**231.3**	151.7	**73.5**	48.2
Nebraska	**59.4**	33.6	**370.1**	209.0	**130.7**	73.8
Nevada	**86.6**	54.8	**246.7**	156.2	**105.4**	66.7
New Hampshire	**379.7**	189.8	**4,432.3**	2,216.2	**1,840.4**	920.2
New Jersey	**1,526.7**	763.3	**2,175.7**	1,087.9	**912.7**	456.4
New Mexico	**32.9**	24.2	**156.8**	115.2	**45.6**	33.5
New York	**3,809.3**	1,904.6	**3,765.7**	1,882.8	**798.9**	399.4
North Carolina	**519.0**	349.8	**437.9**	295.2	**176.8**	119.1
North Dakota	**21.6**	11.3	**411.1**	215.4	**138.2**	72.4
Ohio	**757.1**	481.7	**981.3**	624.4	**250.5**	159.4
Oklahoma	**63.2**	42.9	**111.6**	75.9	**51.9**	35.3
Oregon	**88.2**	53.7	**290.5**	176.8	**82.9**	50.4
Pennsylvania	**1,274.9**	665.5	**1,717.0**	896.3	**441.3**	230.4
Rhode Island	**142.5**	77.1	**3,280.7**	1,774.5	**632.4**	342.1
South Carolina	**549.8**	388.3	**988.8**	698.4	**376.6**	266.0
South Dakota	**22.5**	13.1	**249.0**	145.1	**102.8**	59.9
Tennessee	**80.3**	53.1	**116.5**	77.0	**41.0**	27.1
Texas	**1,834.5**	1,133.9	**343.8**	212.5	**216.4**	133.8
Utah	**34.5**	23.3	**110.8**	74.8	**46.2**	31.2
Vermont	**48.9**	26.7	**1,741.2**	950.2	**370.4**	202.1
Virginia	**207.8**	103.9	**308.1**	154.1	**119.3**	59.7
Washington	**438.7**	219.4	**873.0**	436.5	**272.4**	136.2
West Virginia	**106.7**	80.0	**888.9**	666.6	**190.8**	143.1
Wisconsin	**188.8**	112.1	**568.9**	337.8	**146.2**	86.8
Wyoming	**0.5**	0.3	**7.5**	3.8	**4.1**	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. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

Sources: MACPAC, 2021, analysis of state plan rate year 2016 as-filed Medicaid DSH audits and the CMS Medicaid Budget Expenditure System. Keisler-Starkey and Bunch 2020, and Census 2020.

TABLE 5A-8. FY 2021 Unreduced DSH Allotments as a Percentage of Hospital Uncompensated Care, by State, FY 2018

State	FY 2021 unreduced federal DSH allotment (millions)	FY 2021 unreduced federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018	FY 2021 unreduced DSH allotment (state and federal, millions)	FY 2021 total unreduced DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018
Total	**$13,007.8**	**32.0%**	**$22,764.0**	**56.0%**
Alabama	364.6	50.9	502.4	70.2
Alaska	24.2	41.4	48.3	82.9
Arizona	120.1	26.5	171.5	37.9
Arkansas	51.2	21.0	71.8	29.4
California	1,299.9	52.0	2,599.8	104.1
Colorado	109.7	28.4	219.4	56.8
Connecticut	237.2	60.0	474.3	119.9
Delaware	10.7	11.9	18.6	20.5
District of Columbia	72.6	114.0	103.8	162.8
Florida	237.2	6.3	382.8	10.1
Georgia	318.7	14.2	475.4	21.1
Hawaii	11.6	4.2	21.8	8.0
Idaho	19.5	10.0	27.7	14.2
Illinois	254.9	14.6	500.3	28.7
Indiana	253.5	29.8	385.0	45.2
Iowa	46.7	20.6	75.6	33.3
Kansas	48.9	14.2	82.0	23.8
Kentucky	171.9	51.4	238.6	71.3
Louisiana	813.0	196.6	1,205.9	291.6
Maine	124.5	55.1	195.5	86.5
Maryland	90.4	18.6	180.8	37.1
Massachusetts	361.7	73.7	723.3	147.5
Michigan	314.2	51.3	490.4	80.1
Minnesota	88.6	25.4	177.1	50.8
Mississippi	180.8	30.6	232.5	39.3
Missouri	561.8	47.1	864.8	72.6
Montana	13.5	16.1	20.5	24.6
Nebraska	33.6	11.6	59.4	20.6

TABLE 5A-8. (continued)

State	FY 2021 unreduced federal DSH allotment (millions)	FY 2021 unreduced federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018	FY 2021 unreduced DSH allotment (state and federal, millions)	FY 2021 total unreduced DSH allotment as a percentage of hospital uncompensated care in the state, FY 2018
Total	**$13,007.8**	**32.0%**	**$22,764.0**	**56.0%**
Nevada	54.8	22.5	86.6	35.6
New Hampshire	189.8	134.3	379.7	268.7
New Jersey	763.3	82.5	1,526.7	165.0
New Mexico	24.2	15.9	32.9	21.7
New York	1,904.6	74.5	3,809.3	149.0
North Carolina	349.8	19.5	519.0	29.0
North Dakota	11.3	10.7	21.6	20.4
Ohio	481.7	42.3	757.1	66.5
Oklahoma	42.9	5.9	63.2	8.7
Oregon	53.7	16.1	88.2	26.4
Pennsylvania	665.5	82.1	1,274.9	157.3
Rhode Island	77.1	102.6	142.5	189.8
South Carolina	388.3	38.5	549.8	54.6
South Dakota	13.1	9.7	22.5	16.6
Tennessee	53.1	4.9	80.3	7.5
Texas	1,133.9	16.9	1,834.5	27.3
Utah	23.3	6.3	34.5	9.3
Vermont	26.7	47.8	48.9	87.6
Virginia	103.9	7.4	207.8	14.7
Washington	219.4	41.2	438.7	82.5
West Virginia	80.0	43.4	106.7	57.8
Wisconsin	112.1	26.2	188.8	44.2
Wyoming	0.3	0.3	0.5	0.6

Notes: FY is fiscal year. DSH is disproportionate share hospital. Excludes 61 DSH hospitals that did not submit a FY 2018 Medicare cost report. Uncompensated care is calculated using 2018 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. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

Source: MACPAC, 2021, analysis of state plan rate year 2016 as-filed Medicaid DSH audits, the CMS Medicaid Budget Expenditure System, FY 2018 Medicare cost reports, and AHA 2020.

TABLE 5A-9. FY 2021 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service, by State

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2021 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	**$22,764.0**	**$13,007.8**	**$29.7**	**$17.0**	**$32.4**	**$18.5**
Alabama	502.4	364.6	62.8	45.6	71.8	52.1
Alaska	48.3	24.2	48.3	24.2	48.3	24.2
Arizona	171.5	120.1	4.5	3.2	5.5	3.9
Arkansas	71.8	51.2	23.9	17.1	23.9	17.1
California[1]	2,599.8	1,299.9	173.3	86.7	260.0	130.0
Colorado	219.4	109.7	36.6	18.3	36.6	18.3
Connecticut	474.3	237.2	158.1	79.1	237.2	118.6
Delaware	18.6	10.7	9.3	5.4	9.3	5.4
District of Columbia	103.8	72.6	17.3	12.1	20.8	14.5
Florida	382.8	237.2	12.3	7.7	13.2	8.2
Georgia	475.4	318.7	20.7	13.9	29.7	19.9
Hawaii[2]	21.8	11.6	–	–	–	–
Idaho	27.7	19.5	3.5	2.4	4.0	2.8
Illinois	500.3	254.9	27.8	14.2	29.4	15.0
Indiana	385.0	253.5	35.0	23.0	35.0	23.0
Iowa	75.6	46.7	10.8	6.7	10.8	6.7
Kansas	82.0	48.9	9.1	5.4	10.2	6.1
Kentucky	238.6	171.9	6.0	4.3	7.0	5.1
Louisiana	1,205.9	813.0	36.5	24.6	40.2	27.1
Maine	195.5	124.5	65.2	41.5	65.2	41.5
Maryland	180.8	90.4	12.1	6.0	12.9	6.5
Massachusetts[3]	723.3	361.7	–	–	–	–
Michigan	490.4	314.2	21.3	13.7	22.3	14.3
Minnesota	177.1	88.6	13.6	6.8	13.6	6.8

TABLE 5A-9. (continued)

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2021 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	**$22,764.0**	**$13,007.8**	**$29.7**	**$17.0**	**$32.4**	**$18.5**
Mississippi	232.5	180.8	15.5	12.1	16.6	12.9
Missouri	864.8	561.8	36.0	23.4	39.3	25.5
Montana	20.5	13.5	6.8	4.5	6.8	4.5
Nebraska	59.4	33.6	5.0	2.8	5.0	2.8
Nevada	86.6	54.8	21.7	13.7	21.7	13.7
New Hampshire	379.7	189.8	63.3	31.6	63.3	31.6
New Jersey	1,526.7	763.3	69.4	34.7	69.4	34.7
New Mexico	32.9	24.2	3.3	2.4	4.1	3.0
New York	3,809.3	1,904.6	82.8	41.4	82.8	41.4
North Carolina	519.0	349.8	28.8	19.4	28.8	19.4
North Dakota	21.6	11.3	21.6	11.3	21.6	11.3
Ohio	757.1	481.7	47.3	30.1	50.5	32.1
Oklahoma	63.2	42.9	3.9	2.7	4.5	3.1
Oregon	88.2	53.7	5.9	3.6	5.9	3.6
Pennsylvania	1,274.9	665.5	32.7	17.1	36.4	19.0
Rhode Island	142.5	77.1	47.5	25.7	71.2	38.5
South Carolina	549.8	388.3	36.7	25.9	39.3	27.7
South Dakota	22.5	13.1	1.9	1.1	1.9	1.1
Tennessee	80.3	53.1	4.2	2.8	5.7	3.8
Texas	1,834.5	1,133.9	25.8	16.0	26.6	16.4
Utah	34.5	23.3	5.7	3.9	6.9	4.7
Vermont	48.9	26.7	48.9	26.7	48.9	26.7
Virginia	207.8	103.9	41.6	20.8	41.6	20.8
Washington	438.7	219.4	31.3	15.7	36.6	18.3

TABLE 5A-9. (continued)

State	FY 2021 unreduced DSH allotment (millions)		FY 2021 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2021 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	**$22,764.0**	**$13,007.8**	**$29.7**	**$17.0**	**$32.4**	**$18.5**
West Virginia	106.7	80.0	7.6	5.7	8.2	6.2
Wisconsin	188.8	112.1	9.9	5.9	9.9	5.9
Wyoming	0.5	0.3	0.3	0.1	0.3	0.1

Notes: FY is fiscal year. DSH is disproportionate share hospital. Excludes 61 DSH hospitals that did not submit a FY 2018 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 5B. Totals reflect a federal medical assistance percentage (FMAP) with no Families First Coronavirus Response Act (P.L. 116-127) adjustment for FY 2021.

– Dash indicates that the category is not applicable.

[1] Analysis excludes 12 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[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 2016.

[3] 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.

Source: MACPAC, 2021, analysis of the CMS Medicaid Budget Expenditure System, state plan rate year 2016 as-filed Medicaid DSH audits, Medicare cost reports for FYs 2016–2018, and AHA 2020.

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APPENDIX 5B: 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 2016 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, 2,648 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. (Sixty 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. (Ninety hospitals were excluded under these criteria.) These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. Hospitals were matched based on their CMS certification number. A total of 2,648 DSH hospitals were included in these analyses. We excluded 61 DSH hospitals without matching 2018 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. Two hospitals were 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. (Under this criterion, 465 hospitals were excluded from our analysis of FY 2018 margins.) 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 such 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 2016.

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 17 percent 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.

Both California and Massachusetts distribute DSH funding through waivers authorized under Section 1115 of the Social Security Act. Consequently, Massachusetts does not have any hospital that submits Medicaid DSH audits, while California has some public hospitals which do not submit Medicaid DSH audits. For these two states, MACPAC used Medicare cost report data to estimate deemed DSH status for the purposes of calculating margins for deemed DSH hospitals. Twenty-three additional hospitals were included from California and Massachusetts using this methodology.

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 2018 Medicare cost reports and the 2018 American Hospital Association (AHA) annual survey (Table 5B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the AHA annual survey.

TABLE 5B-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. For deemed DSH hospitals, 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 2024 were calculated using projections provided by CMS based on its DSH allotment reduction methodology, which was finalized in September 2019. DSH allotments for FY 2024 were calculated by increasing prior year allotments based on the Consumer Price Index for All Urban Consumers and applying an $8 billion reduction, 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 in FY 2024, and their excess reduction amounts are proportionately allocated among the remaining states that do not exceed the reduction cap.

Uninsured Rate

Each year the Census Bureau releases its annual report on health insurance coverage in the United States. The report presents statistics on coverage based on information collected in the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) and the American Community Survey (ACS). The two surveys differ in the timing of data collection, the reference period, the time frame of the resulting health insurance coverage estimates, and the uses of the data.

The 2019 CPS collected data in February through April in 2020; the survey asks whether respondents had health insurance coverage at any time during the previous year. The CPS 2019 insurance questions measure whether a person was insured on any day in 2019. In contrast, the 2019 ACS provides a rolling sample of households, with data collected throughout 2019; the survey asks whether a person is currently covered at the time of the interview. Therefore, the ACS presents a point-in-time profile of the population's health insurance coverage status.

TABLE 5B-2. Differences in the Uninsured Rate for American Community Survey and Current Population Survey, 2018–2019

Characteristic	American Community Survey			Current Population Survey		
	2018	2019	Percentage point change (2018–2019)	2018	2019	Percentage point change (2018–2019)
All uninsured	**8.9%**	**9.2%**	**0.3%***	**8.5%**	**8.0%**	**-0.5%***
Age group						
Under age 19	5.2	5.7	0.5*	5.5	5.2	-0.3
Age 19–64	12.5	12.9	0.4*	11.7	11.1	-0.6*
Over age 64	0.8	0.8	0.0	0.9	1.1	0.2*
Race and ethnicity						
White, non-Hispanic	6.0	6.3	0.3*	5.4	5.2	-0.2
Black, non-Hispanic	10.1	10.1	0.0	9.7	9.6	-0.1
Asian, non-Hispanic	6.3	6.6	0.3*	6.8	6.2	-0.6
Hispanic (any race)	17.9	18.7	0.8*	17.8	16.7	-1.1*
Income-to-poverty ratio						
Below 100 percent	15.5	16.0	0.5*	16.3	15.9	-0.4
100–199 percent	14.6	15.2	0.6*	13.6	14.1	0.5
200–299 percent	11.3	12.2	0.9*	10.8	11.0	0.2
300–399 percent	7.9	8.6	0.7*	8.1	8.3	0.2
At or above 400 percent	3.6	3.9	0.3*	3.4	3.0	-0.4*

Notes: Uninsured rates by Medicaid expansion status are based on the American Community Survey. Medicaid expansion status reflects state expansion decisions as of January 10, 2019. In past years, we reported national data on uninsured individuals using the Current Population Survey (CPS) Annual Social and Economic Supplement. However, due to complications related to data collection for CPS 2019 estimates during March–June of 2020 due to COVID, we are reporting ACS numbers to align with how the Census Bureau reports 2018–2019 trends. Numbers do not sum due to rounding.

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

Sources: MACPAC, 2021, analysis of Keisler-Starkey and Bunch 2020.

We show the results of two different surveys meaning the 2018–2019 uninsured rates because each survey tells a different story (Table 5B-2). With the ACS, the total uninsured rate increased significantly from 8.9 percent to 9.2 percent. With the CPS ASEC, the total uninsured rate declined significantly from 8.5 percent to 8.0 percent. Comparing the surveys by age group, in the ACS, both groups in the under-65 category saw a significant increase in the uninsured rate. By contrast, CPS estimates found a significant decrease in the uninsured rate for individuals age 19–64 and a significant increase in the uninsured rate for individuals over the age of 64. The ACS found a significant increase in the uninsured rate for all race and ethnicity groups except individuals who are Black, non-Hispanic. The CPS ASEC found that the uninsured rate went down significantly for

Hispanics of any race. The ACS found a significant increase in the uninsured rate for all income-to-poverty ratios, while the CPS found a decrease in the uninsured rate for households that earn above 400 percent of the federal poverty level.

The COVID-19 pandemic affected survey collection for the 2019 CPS ASEC. Although the Census Bureau went to great lengths to complete interviews by telephone, the response rate for the CPS basic household survey was 10 percentage points lower in March 2020 compared to the same period in 2019. For the CPS ASEC specifically, the Census Bureau estimates that the unweighted combined supplement response was 61.1 percent in 2020, down from 67.6 percent in 2019. Furthermore, Census found that high-income families were more likely than low-income families to respond to the 2019 CPS ASEC (Rothbaum 2020, Rothbaum and Bee 2020, DOC 2019). As a consequence, Census used the ACS to measure most insurance trends between 2018 and 2019 in their annual report on health insurance coverage because ACS represents a more consistent data collection methodology for 2018–2019 than the CPS. MACPAC has followed suit.

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