Chapter 3:

Annual Analysis of Disproportionate Share Hospital Allotments to States

Annual Analysis of Disproportionate Share Hospital Allotments to States

Key Points

- MACPAC continues to find no meaningful relationship between 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.
- In 2020, 28 million people, or 8.6 percent of the U.S. population, were uninsured, which indicates no statistical change from the number or share of the uninsured population in 2018 (27.5 million or 8.5 percent).
- The uninsured rate increased in spring 2020, which coincided with the early stages of the COVID-19 pandemic. Starting in August 2020 until July 2021, the Census reported declines in the monthly uninsured rate and increases in Medicaid enrollment.
  - The decline in the uninsured rate and increase in Medicaid enrollment are partially attributable to the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), which required states to provide continuous coverage to Medicaid enrollees until the end of the public health emergency to receive FFCRA's increased federal medical assistance percentage (FMAP).
- Medicaid shortfall, the difference between the Medicaid base payments a hospital receives and its costs of providing services to Medicaid-enrolled patients, decreased 700 million (4 percent) between 2018 and 2019, according to the American Hospital Association (AHA) annual survey. In 2019, total Medicaid shortfall for all U.S. hospitals was $19 billion.
- To help address financial challenges related to the pandemic, Congress authorized relief funding to support providers. But provider relief funds mostly targeted hospitals with high patient revenue, and there was no relationship between total hospital relief funding and the number of uninsured individuals in the area.
- The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increased DSH allotments for the remainder of the public health emergency by applying an enhanced FMAP to the total DSH funds available to states. We estimate that ARPA increased federal allotments by $1.5 billion for fiscal year 2022.
- The Consolidated Appropriations Act, 2021 (P.L. 116-260) partially implemented a prior MACPAC recommendation requiring the Secretary of the U.S. Department of Health and Human Services (HHS) to report Medicaid supplemental payments. Beginning in October 2021, HHS started collecting hospital-level data on non-DSH supplemental payments. These data will be useful in analyzing Medicaid shortfall for DSH and non-DSH hospitals.

CHAPTER 3: Annual Analysis of Disproportionate Share Hospital Allotments to States

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. The total amount of such payments is limited by annual federal DSH allotments, which vary widely by state. States can distribute DSH payments to virtually any hospital in their state, but total DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides. DSH payments help 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 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)).[1]

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:

- Twenty-eight million people, or 8.6 percent of the U.S. population, were uninsured in 2020.[2]
- Hospitals reported $42 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2019. This represented a $2.3 billion (5.5 percent) increase in uncompensated care costs from FY 2018. While uncompensated care as a share of hospital operating expense dropped substantially after coverage provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) went into effect, it has largely remained unchanged since 2016.
- Hospitals reported $19 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey for 2019, a 4 percent decline from 2018 (AHA 2021a, 2020, 2019, 2017, 2015).
- In FY 2019, deemed DSH hospitals continued to report lower aggregate operating margins than other hospitals (-3.3 percent for deemed DSH hospitals vs. 0.2 percent for all hospitals). Total margins (which include government appropriations and revenue not directly related to patient care) were also lower for deemed DSH hospitals (5.7 percent) compared with all

hospitals (6.9 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 DSH allotments before and after implementation of federal DSH allotment reductions, which are currently scheduled to begin in FY 2024. 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 is scheduled to be $8 billion a year between FY 2024 and FY 2027 (amounting to 56.9 percent of FY 2024 unreduced allotments).

MACPAC has made several recommendations for statutory changes to improve Medicaid DSH policy (Box 3-1). 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.[3] In March 2019, the Commission also made recommendations for how pending DSH allotment reductions should be structured; these have not been implemented, and no reductions have been made. The Commission remains concerned about the issues it previously noted, such as the abrupt reductions anticipated under current law and the lack of meaningful relationship between DSH allotments and measures of need for DSH funds.

Congress also made some changes to how DSH allotments are calculated in response to the COVID-19 pandemic. The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) increased the Medicaid federal medical assistance percentage (FMAP) during the COVID-19 public health emergency, which decreased the total amount of DSH funding available for states during the public health emergency. Subsequently, Congress increased DSH funding under the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) so that the combined amount of state and federal DSH funding remained the same as it would have been before the FMAP increase.[4] For FY 2022, we estimate that ARPA led to an increase of approximately $1.5 billion in federal DSH allotments.

BOX 3-1. 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-disproportionate share hospital (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 3-1. (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, while exempting hospitals that treat a large percentage and number of patients who are eligible for Medicare and receive Supplemental Security Income (SSI).

The Commission has also 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. 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.[5] In February 2016, the Commission recommended that the Secretary of the U.S. Department of Health and Human Services (the Secretary) 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 the U.S. Department of Health and Human Services (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.[6] This data will be collected through the Medicaid Budget and Expenditure System, but the Centers for Medicare & Medicaid Services (CMS) is still working with states to develop the format for data submissions (CMS 2021b). This means any challenges setting up this new system may further delay reporting of supplemental payment data.

The COVID-19 pandemic is having substantial effects on hospital finances, but the full effects of the pandemic on safety-net and DSH hospitals will likely not be clear until after the public health emergency has ended. Hospitals have reported increased costs of treating patients with COVID-19 and costs associated with reducing the risk of COVID-19 infection among patients and staff, as well as declines in revenue as a result of delays in elective procedures and other routine services (AHA 2021b).

To respond to these challenges, Congress has authorized several relief funds to support providers. Some state Medicaid programs are also making additional payments to hospitals to supplement federal relief efforts (Gifford et al. 2020). However, as noted by the Commission and others, the actual distribution of funds suggests that relief funding has not been well targeted based on community needs (Buxbaum and Rak 2021, Coughlin et al. 2021, MACPAC 2020b and 2020c). The Commission will continue to monitor the pandemic's effects on safety-net providers as more data become available.

This chapter begins with a background on Medicaid DSH policy 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 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 payment methods and amounts were uncoupled from Medicare payment standards.[7] 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. Total state and federal 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 hospital upper payment limitations (Matherlee 2002, Holahan et al. 1998, Klem 2000).[8] Most of this growth was driven by large DSH spending increases in a small number of states, while the majority of states made relatively level year-over-year DSH payments.

In 1991, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments, referred to as allotments (Box 3-2). 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.[9] States are not required to spend their entire allotment and do not receive federal funding for DSH payments that exceed the allotment.

BOX 3-2. 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 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).

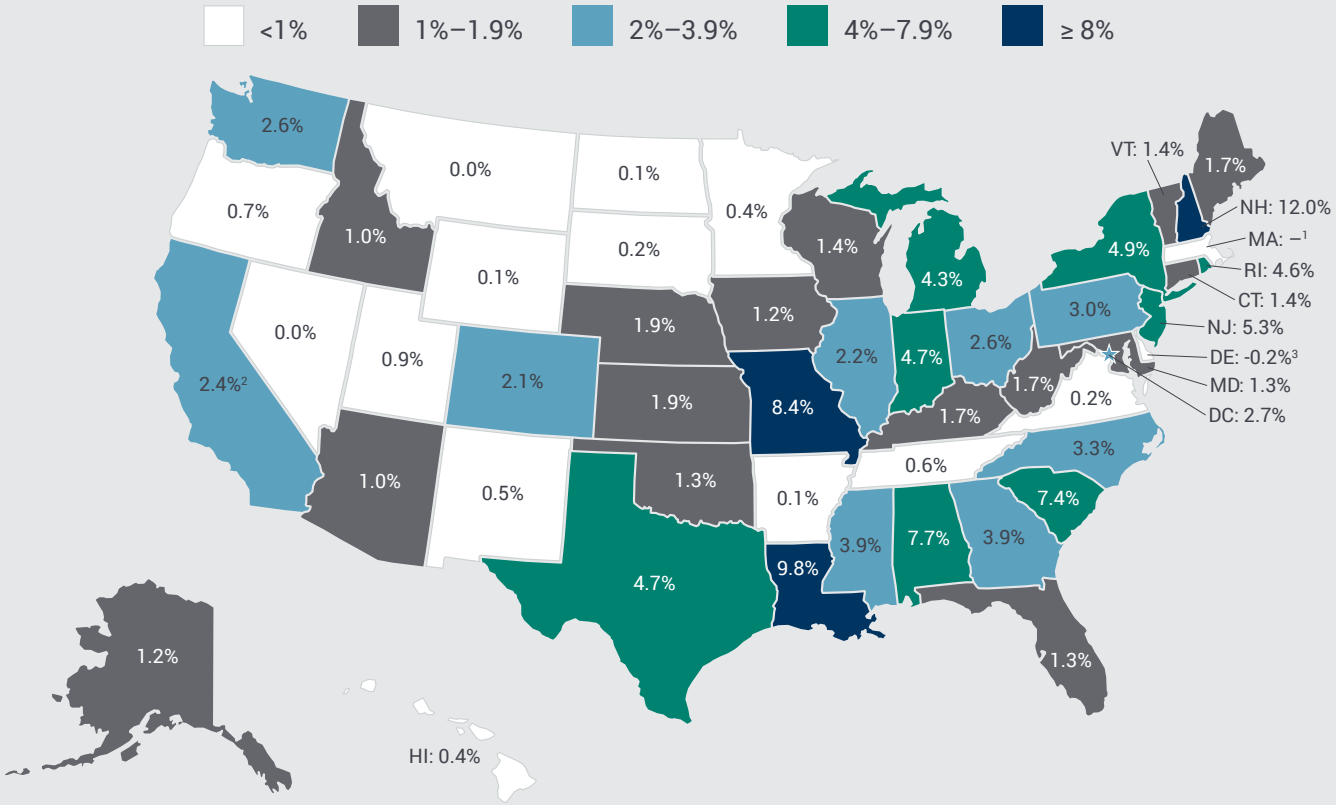
Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

In FY 2020, federal allotments to states for DSH payments totaled $14.2 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 $19.5 billion in FY 2020 and accounted for 3 percent of total Medicaid benefit spending.[10] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 15 states to 12 percent in New Hampshire (Figure 3-1).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[11] As of the end of FY 2021, $1.4 billion in federal DSH allotments for FY 2019 were unspent.[12] 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 previously, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care. In FY 2019, half of unspent DSH allotments were attributable to four states (Connecticut, Maine, New Jersey, and Pennsylvania). All of these states, excluding Maine, had FY 2019 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on 2019 Medicare cost reports, which suggests that these states may not be able to spend their full DSH allotments even if they have sufficient state funds to provide the non-federal share.[13]

FIGURE 3-1. DSH Spending as a Share of Total Medicaid Benefit Spending, by State, FY 2020



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

— Dash indicates zero; 0.0 percent indicates an amount between 0 and 0.05 percent that rounds to zero.

[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act (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] Delaware reported negative DSH spending in FY 2020. A state may report negative spending in a fiscal year due to a prior period adjustment.

Source: MACPAC, 2022, analysis of CMS-64 financial management report net expenditure data as of June 28, 2021.

In state plan rate year (SPRY) 2017, 43 percent of U.S. hospitals received DSH payments (Table 3-1).[14] 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 (50 percent) also received DSH payments, including many critical access hospitals (42 percent), which receive a special payment designation from Medicare because they are small and often the only provider in their geographic area.

The proportion of hospitals receiving DSH payments varies widely by state. In SPRY 2017, five states made DSH payments to fewer than 10 percent of the hospitals in their state (Arkansas,

TABLE 3-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2017

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,598**	**5,994**	**43%**	**$16,516**
Hospital type				
Short-term acute care hospitals	1,800	3,249	55	12,877
Critical access hospitals	574	1,360	42	385
Psychiatric hospitals	140	612	23	2,873
Long-term hospitals	10	377	3	23
Rehabilitation hospitals	21	300	7	6
Children's hospitals	53	96	55	352
Urban or rural				
Urban	1,370	3,554	39	14,581
Rural	1,228	2,439	50	1,935
Hospital ownership				
For-profit	380	1,778	21	876
Non-profit	1,568	2,980	53	5,644
Public	650	1,236	53	9,996
Teaching status				
Non-teaching	1,788	4,734	38	4,772
Low-teaching	509	834	61	3,225
High-teaching	301	426	71	8,518
Deemed DSH status				
Deemed	733	733	100	10,577
Not deemed	1,865	5,261	35	5,939

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 55 DSH hospitals that did not submit a fiscal year 2019 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 are limited to hospitals that received DSH payments and exclude 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, 2022, analysis of FY 2019 Medicare cost reports and SPRY 2017 as-filed Medicaid DSH audits.

Illinois, Iowa, and North Dakota), and only New York made DSH payments to more than 90 percent of hospitals in the state (93 percent).[15]

As noted previously, 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 2017, 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 (64 percent) of all DSH payments, receiving $10 billion in DSH

FIGURE 3-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2017

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.

Source: MACPAC, 2022, analysis of FY 2019 Medicare cost reports and SPRY 2017 as-filed Medicaid DSH audits.

payments. States vary in how they distribute DSH payments to deemed DSH hospitals, from less than 10 percent of DSH payments to deemed DSH hospitals in five states (Alabama, Arkansas, Connecticut, Hawaii, and Utah) to 100 percent in three states (Delaware, Illinois, 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., Arkansas and 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, North Carolina, and Oregon) (Figure 3-2). 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. For example, states that finance DSH payments with greater levels of intergovernmental transfers or certified public expenditures tend to have a greater share of DSH payments to public hospitals (MACPAC 2017). More information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

State DSH policies change frequently, often as a function of state budgets. The amounts paid to hospitals are more likely to change than the types of hospitals receiving payments. Over 90 percent of the hospitals that received DSH payments in SPRY 2017 also received DSH payments in SPRY 2016. However, the amount that hospitals receive can change considerably in subsequent reporting years. For example, 21 percent of hospitals that received DSH payments in SPRY 2016 and SPRY 2017 reported that the amount of DSH payments they received in SPRY 2017 increased or decreased by more than 50 percent, compared with SPRY 2016.

Changes in the Number of Uninsured Individuals

In 2020, 28 million people were uninsured (8.6 percent of the U.S. population), which is not statistically different from the number or share in 2018 (27.5 million or 8.5 percent) (Table 3-2) (Keisler-Starkey and Bunch 2021).[16] This statistic from the Current Population Survey (CPS) includes only individuals who did not have coverage at any point during the year and therefore does not include individuals who had coverage in early 2020 but lost it after the start of the COVID-19 public health emergency.

Similar to prior years, the CPS uninsured rate in 2020 was highest for adults below age 65, individuals of Hispanic origin, and individuals with incomes below the federal poverty level (FPL) (Table 3-2). Between 2018 and 2020, the uninsured rate increased significantly for individuals living between 200 and 400 percent FPL. In addition, there was a significant decrease in the uninsured rate for non-Hispanic Asian individuals (Keisler-Starkey and Bunch 2021).

In 2020, the uninsured rate in states that did not expand Medicaid under the ACA to adults under age 65 with incomes at or below 138 percent FPL was nearly twice as high as the uninsured rate in states that expanded Medicaid (12.6 and 6.4 percent, respectively).[17] Between 2019 and 2021, Idaho, Missouri, Nebraska, Oklahoma, and Utah expanded Medicaid, but state-level data on the effects of Medicaid expansion in these states is not yet available (KFF 2021a).[18]

To better understand the effects of the COVID-19 pandemic on the number of uninsured individuals, MACPAC examined findings from the U.S. Census Bureau's Household Pulse Survey (HPS), a biweekly survey intended to collect a range of information about household experiences during the pandemic.[19] During the first phase of HPS data collection (April through July 2020), the

uninsured rate in the sample increased significantly by 0.9 percentage points.[20] Furthermore, by the third quarter of 2020, 69.5 percent of uninsured respondents to the HPS reported that they or a family member had experienced a loss of employment income, and 41.5 percent of uninsured respondents reported a household income below 100 percent FPL, indicating that COVID-19 had a large effect on household finances.

Between August 2020 and July 2021, the uninsured rate in the sample declined significantly by 1.1 percentage points and the Medicaid coverage rate increased significantly by 1.0 percentage

TABLE 3-2. Uninsured Rates by Selected Characteristics, United States, 2018 and 2020

Characteristic	2018	2020	Percentage point change
All uninsured	**8.5%**	**8.6%**	**0.1%**
Age group			
Under age 19	5.5	5.6	0.1
Age 19–64	11.7	11.9	0.2
Over age 64	0.9	1.0	0.1
Race and ethnicity			
White, non-Hispanic	5.4	5.4	0.0
Black, non-Hispanic	9.7	10.4	0.7
Asian, non-Hispanic	6.8	5.9	-0.9*
Hispanic (any race)	17.8	18.3	0.5
Income-to-poverty ratio			
Below 100 percent	16.3	17.2	0.9
100–199 percent	13.6	13.3	-0.3
200–299 percent	10.8	11.9	1.1*
300–399 percent	8.1	8.9	0.8*
At or above 400 percent	3.4	3.4	0.0
Medicaid expansion status in state of residence[1]			
Non-expansion	12.0	12.6	0.6*
Expansion	6.2	6.4	0.2

Notes: Uninsured rates by Medicaid expansion status are based on the Current Population Survey Annual Social and Economic Supplement (CPS). Medicaid expansion status reflects state expansion decisions as of January 1, 2020. In past years, we reported national data on uninsured individuals using the American Community Survey (ACS). However, due to complications related to data collection during COIVD-19 for CPS 2019 and ACS 2020 estimates, we are reporting CPS 2018 and 2020 numbers to align with pre-pandemic trends. Numbers do not sum due to rounding. For a discussion on the differences between each survey's uninsured rates, please refer to Appendix 3B.

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

[1] MACPAC calculated significance using technical documentation from Keisler-Starkey and Bunch 2021.

Sources: MACPAC, 2022, analysis of Keisler-Starkey and Bunch 2021.

point.[21] Similar trends were observed in states that expanded Medicaid and those that did not.

Because Medicaid is a countercyclical program, Medicaid enrollment often increases during economic recessions (MACPAC 2021b). The continuous coverage provisions of the FFCRA that prohibit states from disenrolling Medicaid beneficiaries during the COVID-19 public health emergency are also likely contributing to the increases in Medicaid enrollment and decreases in the uninsured rate. When the COVID-19 public health emergency ends and states resume Medicaid eligibility redeterminations, Medicaid enrollment is expected to decline substantially, and the uninsured rate will likely increase. One analysis estimated that approximately 15 million Medicaid beneficiaries (including 8.7 million adults and 5.9 million children) will no longer be eligible for coverage when the public health emergency ends (Buettgens and Green 2021).[22] The Commission is particularly concerned about eligible Medicaid beneficiaries who may lose coverage during this time because of difficulties navigating the renewal process and plans to closely monitor how restarting Medicaid redeterminations affects Medicaid enrollment and the number of uninsured individuals (MACPAC 2020b).

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 expansion 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 and 2017, Medicaid shortfall increased as well.

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

Data sources

American Hospital Association 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 audit. A statutorily required audit of a disproportionate share hospital's (DSH) 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 public data are available.

BOX 3-3. (continued)

Definitions

Medicare cost report components of uncompensated care

Charity care. Health care services for which a hospital determines the patient does not have the capacity to pay and, based on its charity care policy, either does not charge the patient at all for the services or charges the patient a discounted rate below the hospital's cost of delivering the care. Charity care costs cannot exceed a hospital's cost of delivering the care. Medicare cost reports include costs of care provided to both uninsured individuals and patients with insurance who cannot pay deductibles, co-payments, or coinsurance.

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

Medicaid DSH audit components of uncompensated care

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

Medicaid shortfall. The difference between a hospital's costs of providing services to Medicaid-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.

State decisions about whether to expand Medicaid coverage can affect hospital uncompensated care, especially among safety-net providers. Medicaid expansion tended to decrease unpaid costs of care for the uninsured while also increasing Medicaid revenue between 2011 and 2017. Researchers estimated that expansion led to a decline in unpaid costs of care for the uninsured among safety-net hospitals of $9.5 million (2.5 percentage point decline as a share of total expenses) and $5.8 million for non-safety-net hospitals (2.6 percentage point decline as a share of total expenses) over a six-year period, though some of these declines in unpaid costs of care could have been offset by states paying below costs for Medicaid services (Blavin and Ramos 2021) (Box 3-3). This trend could be seen nationally but was also pronounced at the state level. For example, after Louisiana expanded Medicaid in 2016, there was a 33 percent reduction in the share of total operating expenses attributable to unpaid costs of care for the uninsured within acute care and surgical hospitals. Furthermore, these effects were more pronounced for Louisiana's rural and public hospitals (Callison et al. 2021). It should be noted that these studies looked only at unpaid costs of

care for the uninsured and Medicaid revenue. They did not examine Medicaid shortfall (discussed in more detail in the following sections). MACPAC previously found that Medicaid shortfall increased by 23 percent ($3 billion) due to enrollment gains after the ACA (MACPAC 2018a).

Definitions of uncompensated care vary among data sources, complicating comparisons at the hospital level and our ability to fully understand the effects of uncompensated care on hospital finances (Box 3-3). 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 audits are due to CMS approximately three years after DSH payments are made and are not published until CMS reviews the data for completeness (42 CFR 455.304). Furthermore, DSH audits are available only for those hospitals that receive Medicaid DSH payments. As of the publication of this report, the last publicly available DSH audit is for SPRY 2015, indicating a data lag of almost six years.

In the following sections, we review the most recent uncompensated care data available for all hospitals in 2019 as well as additional information about Medicaid shortfall reported for DSH hospitals in SPRY 2017.

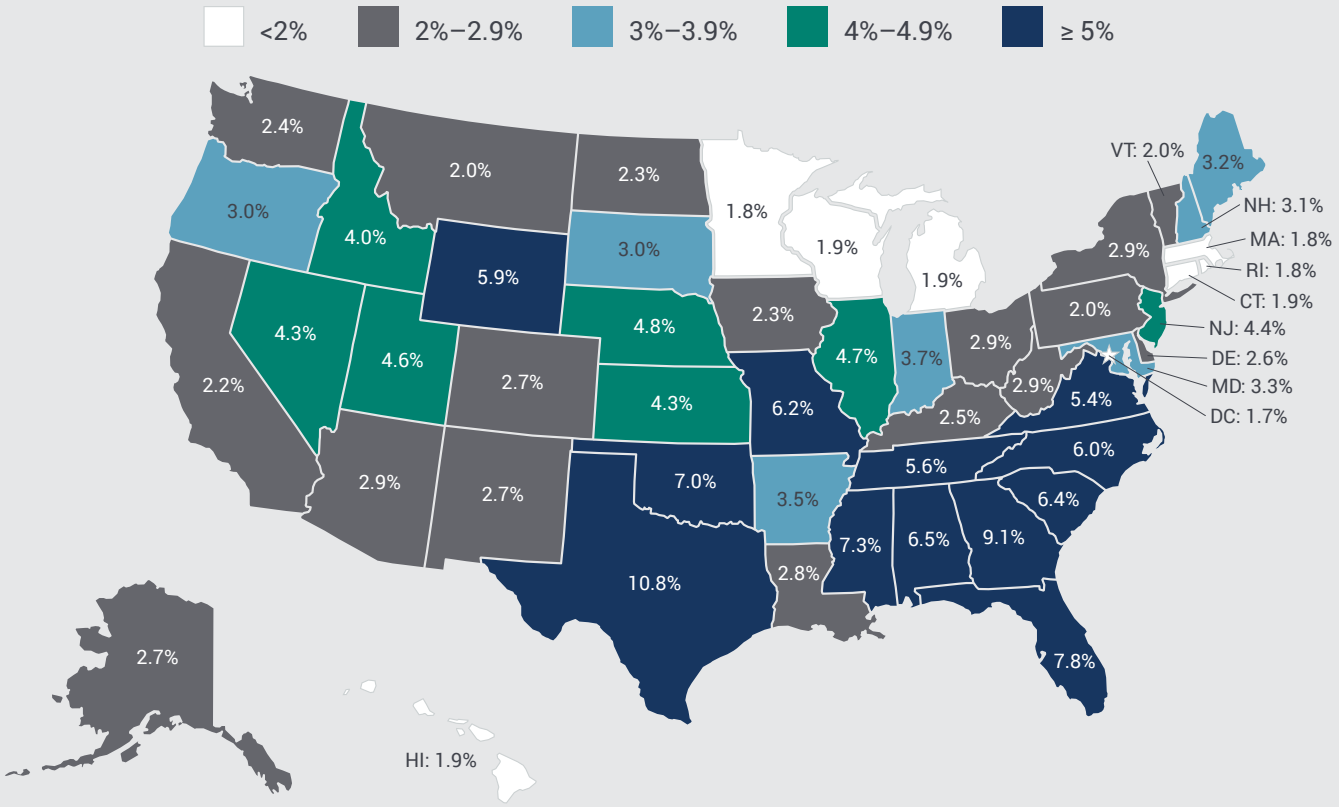
Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $42 billion in charity care and bad debt in FY 2019, comprising 4.2 percent of hospital operating expenses. This is a $2.3 billion increase from FY 2018 and a 0.03 percentage point increase as a share of hospital operating expenses. Uncompensated care as a percentage of hospital operating expenses has remained largely unchanged since FY 2017 (4.3 percent), and uncompensated care no longer appears to be declining year-over-year as it did in the first few years after the ACA coverage expansions took effect.[23, 24]

As a share of hospital operating expenses, charity care and bad debt varied widely by state in FY 2019 (Figure 3-3). In the aggregate, hospitals in states that expanded Medicaid before September 30, 2019, reported less than half the uncompensated care that was reported in non-expansion states (2.8 percent of hospital operating expenses in Medicaid expansion states vs. 7.1 percent in states that did not expand Medicaid).

Uncompensated care reported on Medicare cost reports includes the costs of care provided to both uninsured individuals and insured patients who cannot pay deductibles, co-payments, or coinsurance. In FY 2019, about 51 percent of reported uncompensated care was for charity care for uninsured individuals ($21.6 billion), 16 percent was for charity care for insured individuals ($6.7 billion), and 34 percent was for bad debt expenses for both insured and uninsured individuals ($14.1 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 (Kullgren 2020). These costs are increasing; within the employer-sponsored insurance market, the average deductible for single workers was $1,434 in 2021, almost double the average deductible in 2011 ($747) (KFF 2019a, 2019b, 2021b). However, when patients cannot pay cost sharing, these costs might be forgiven as charity care or might become bad debt expenses for hospitals. This type of uncompensated care for insured patients cannot be covered by Medicaid DSH.

FIGURE 3-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2019



Notes: FY is fiscal year.

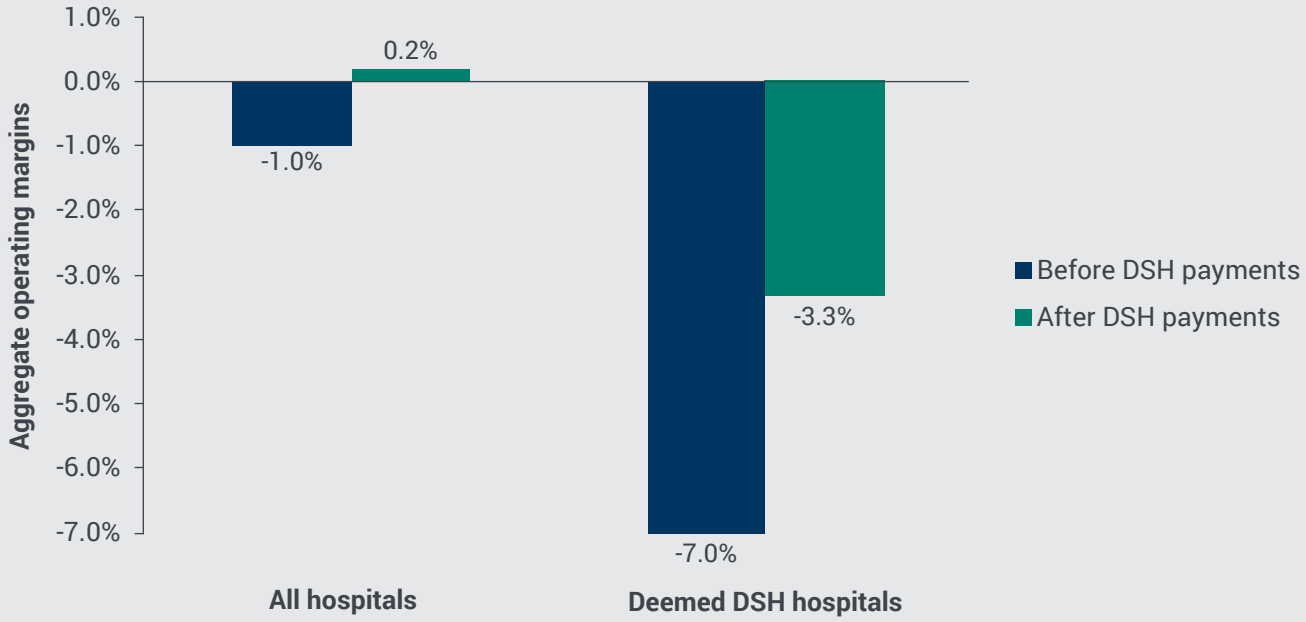
Source: MACPAC, 2022, analysis of FY 2019 Medicare cost reports.

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 2019 for all U.S. hospitals totaled $19 billion, a decrease of $700 million from 2018. In the same survey, the aggregate Medicaid payment-to-cost ratio was 90 percent in 2019, which means national shortfall as a percentage of costs has mostly remained unchanged since 2013 (AHA 2021a, 2020a, 2019a, 2015).

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.[28] 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.[29] At issue in these lawsuits is how Medicaid shortfall should be counted for Medicaid-eligible patients with third-party coverage.

FIGURE 3-4. Aggregate Hospital Operating Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2019



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 2019 were estimated using state plan rate year (SPRY) 2017 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 3B.

Source: MACPAC, 2022, analysis of FY 2019 Medicare cost reports and SPRY 2017 as-filed Medicaid DSH audits.

In 2019, the U.S. Court of Appeals for the District of Columbia ruled that CMS can require states to count third-party payments associated with Medicaid-eligible individuals in calculating Medicaid shortfall for payments after June 2, 2017 (CMS 2020).[30] States implemented this guidance in SPRY 2017, though many did so only for payments for a portion of the fiscal year.

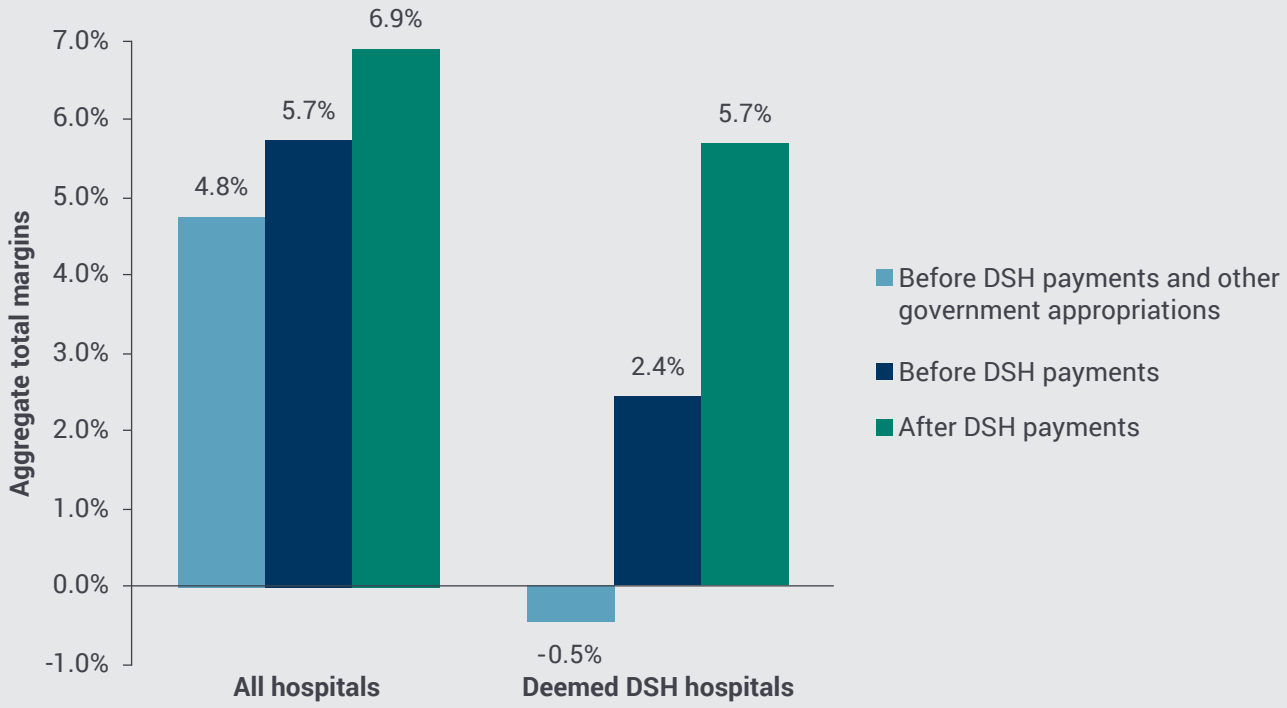
Congress further revised the DSH definition of Medicaid shortfall to exclude costs and payments for patients for whom Medicaid is not the primary payer starting with the SPRY 2022 reporting year (Consolidated Appropriations Act, 2021, P.L. 116-260). The revised shortfall definition is expected to increase the amount of uncompensated care reported for hospitals that serve a large number of Medicaid-enrolled patients with private insurance, such as children's hospitals, and decrease the amount of uncompensated care reported for hospitals that serve a large number of patients dually eligible for Medicare and Medicaid, for whom Medicare is the primary payer (MACPAC 2019a).[31] In the Consolidated Appropriations Act, 2021, Congress added an exception to this change that allows hospitals with a high share of Medicaid patients who are dually eligible to calculate Medicaid shortfall using CMS's prior definition,

which may increase the amount of uncompensated care that these hospitals report.[32] CMS is developing a database that will support states in determining which hospitals are eligible for this exception but noted that since this provision went into effect in October 2021, states need to amend their DSH payment policies to be consistent with the new shortfall definition (CMS 2021b).

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 than other hospital types on average.[33] MACPAC estimates both total and operating margins using a

FIGURE 3-5. Aggregate Hospital Total Margins Before and After DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2019



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 2019 were estimated using state plan rate year (SPRY) 2017 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 3B.

Source: MACPAC, 2022, analysis of FY 2019 Medicare cost reports and SPRY 2017 as-filed Medicaid DSH audits.

combination of Medicaid DSH audit and Medicare cost report data. Operating margins primarily include only revenues and costs related to patient care, while total margins can include the hospital's investment income, parking receipts, or state and local subsidies. MACPAC analyzes both types of margins to have a fuller understanding of the financial health of safety-net hospitals.

In FY 2019, aggregate operating margins were positive across all hospitals after including DSH payments (0.2 percent), although they were 0.4 percentage points lower than in FY 2018. By contrast, deemed DSH hospitals reported negative aggregate operating margins both before and after counting DSH payments (-7 percent and -3.3 percent, respectively) (Figure 3-4).[34]

Total margins include revenue not directly related to patient care (Appendix 3B). The aggregate total margins for all hospitals after DSH payments was 6.9 percent in FY 2019, which is 0.5 percentage points higher than in FY 2018. Before counting DSH payments and other government appropriations, deemed DSH hospitals reported an aggregate total margin of -0.5 percent in FY 2019. However, after counting these payments and appropriations, deemed DSH hospitals reported positive aggregate total margins of 5.7 percent, comparable to the aggregate total margins reported for all hospitals (Figure 3-5).

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, Tollen and Keating 2020). 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. Struggling hospitals that are unable to improve their financial outlook and face payment cuts from Medicare or Medicaid are more likely to close or consolidate with a larger health system (Chernew et al. 2021).

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 3-4).[35]

Using data from 2019 Medicare cost reports and the 2019 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2017, almost all (91 percent) provided at least one of the services included in MACPAC's definition of essential community services, 70 percent provided two of these services, and 56 percent provided three or more of these services. By contrast, among non-deemed DSH hospitals, 34 percent provided three or more of these services.

The COVID-19 Pandemic and Hospital Finances

The COVID-19 pandemic is affecting hospital finances in a variety of ways, but its ultimate effect on hospital costs and revenue and uncompensated care are still unclear at this time. For example, hospitals have had higher expenses largely due to the costs of treating patients with COVID-19, and they implemented new infection control practices to protect patients and staff, which may have increased hospital uncompensated care costs to the extent that these are not paid for by other sources (AHA 2021b). However, hospitals are experiencing declines in care unrelated to COVID-19 as a result of postponed non-emergent and elective

surgeries, which may reduce the amount of overall care (including reduced uncompensated care but also reduced revenue) relative to prior years (AHA 2021b; Gallagher et al. 2021; Birkmeyer et al. 2020; Mehrotra et al. 2020a, 2020b, 2020c). Furthermore, it should be noted that the pandemic led to significant workforce shortages, which may be contributing to increased labor costs, further straining hospital finances (KaufmanHall 2021, Russell 2021). In early 2022, hospitalization rates surged once again due to the omicron variant of COVID-19 (CDC 2022).

Provider relief funding

To help address pandemic-related financial challenges, Congress provided dedicated relief funding for hospitals through a variety of mechanisms. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136),

BOX 3-4. 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 3B for further discussion of our methodology and its limitations.

the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), and the Consolidated Appropriations Act, 2021, made available $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 fewer than 500 employees.[36]

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 each provider's FY 2019 patient care revenue.[37] In June 2020, HHS made additional, targeted funding available to specific 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, a measure of the share of patients enrolled in Medicaid and Supplemental Security Income (HHS 2021a). 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 (GAO 2021, HRSA 2021).

At the time of the initial distribution of funds, MACPAC expressed concern that provider relief funding was not appropriately targeting safety-net providers (MACPAC 2020b). Since disbursements were based on Medicare revenue, it was unclear whether the funding would be disbursed to hospitals that serve a large percentage of the Medicaid population. For example, deemed DSH hospitals account for about 17 percent of Medicare fee-for-service revenue and 19 percent of patient care revenue. However, deemed DSH hospitals accounted for nearly one-third (31 percent) of hospital uncompensated care costs in FY 2017 (MACPAC 2020c).

A more recent review of funds distributed through February 2021 found that relief funding was mostly distributed to hospitals with high patient revenue. The research team found no association between total hospital relief funding and the number of uninsured residents in a region (Buxbaum and Rak 2021).

In January 2022, CMS issued guidance on how federal relief funds should be accounted for in the SPRY 2020–2021 Medicaid DSH audits. In general, provider relief payments should not be used to offset the costs of Medicaid patients but can be used to pay for COVID-19 testing and treatment for uninsured individuals (CMS 2022). Since federal relief funds can be counted as a payment for unpaid costs of care for the uninsured, those funds will reduce the amount of Medicaid DSH funding that a hospital could receive, which may result in an increase in unspent DSH allotments. The Commission will continue to monitor the effect of the pandemic on safety-net providers as more data become available.

Federal changes to DSH allotments

ARPA temporarily adjusted the DSH allotment calculations to account for the effect of the enhanced FMAP available to states due to the COVID-19 pandemic. As noted previously, the increase in federal share decreased the amount of required state contribution by 6.2 percentage points. This effectively reduced total (state and federal) DSH spending as federal spending remained the same under the cap, but state contributions were reduced. ARPA changed how state and federal DSH allotments are calculated for the duration of the public health emergency by combining the state and federal DSH allotment and then applying the FFCRA-enhanced FMAP to the total amount, so that the total DSH allotment for each state increases in proportion to the FMAP increase. We estimate that this led to an increase of $1.5 billion in federal DSH allotments for FY 2022.

DSH Allotment Reductions

In December 2020, Congress delayed implementing 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 billion in FY 2024;
- $8 billion in FY 2025;
- $8 billion in FY 2026; and
- $8 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 56.9 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 (52.9 percent).[38] In FY 2028 and beyond, there are no DSH allotment reductions scheduled. Thus, under current law, state DSH allotments will return to their higher, unreduced DSH allotment amounts in FY 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 3-5).

Reduced versus 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 estimated DSH allotment reduction factors using the most reliable and latest available data. We used data from the 2019 American Community Survey and SPRY 2017 Medicaid DSH audits to estimate the reduction factors for each state and projected the DSH allotments in FY 2024 (Dobson and DaVanzo 2016). In each of FYs 2024–2027, 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 6.4 percent to 90 percent of unreduced allotment amounts (Figure 3-6). 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 one-quarter that of the other states (58.8 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 1, 2021 (61.1 percent in the aggregate), than for states that did not expand Medicaid (58.8 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors are included in Appendix 3A.)

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 11 states are projected to have FY 2024 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2019. 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 2019 allotment.[39]

BOX 3-5. 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 the Centers for Medicare & Medicaid Services 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 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, including Hawaii, where eligibility is based on a special statutory exception (§§ 1923(f)(5) and 1923(f)(6) of the Social Security Act).

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

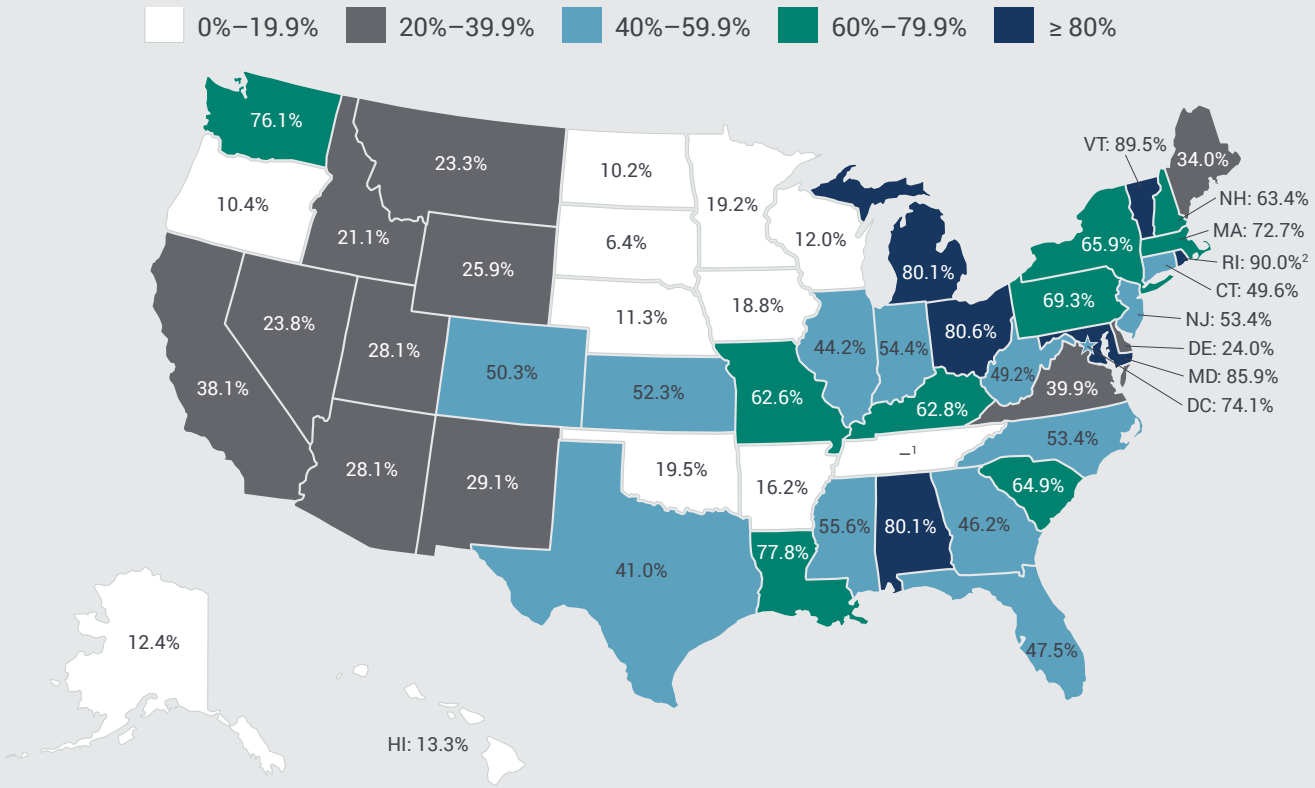
High volume of Medicaid inpatients factor. Imposes larger DSH allotment reductions on states that do not target DSH payments to hospitals with high Medicaid volume. The proportion of a state's DSH payments made to hospitals with Medicaid inpatient utilization that is one standard deviation above the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

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

Budget neutrality factor. An adjustment to the high Medicaid and high uncompensated care factors that accounts for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under waivers under Section 1115 of the Social Security Act as of July 2009. Specifically, DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments were targeted to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care.

We do not know how states will respond to these reductions. As noted previously, 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.[40] 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.[41]

FIGURE 3-6. 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 Rhode Island.

Source: MACPAC, 2022, analysis of preliminary unreduced and reduced allotment amounts using data provided by CMS as of October 15, 2021, and projected for FY 2024.

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.[42] In summary, we found the following:

- **Changes in number of uninsured individuals.** FY 2022 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 2022 DSH allotment per uninsured individual is $453.[43]
- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2019 Medicare cost reports, unreduced FY 2022 federal DSH allotments range from less than 10 percent in eight states to more than 80 percent in five states and the District of Columbia. Nationally, these allotments are equal to 31.9 percent of hospital charity care and bad debt costs. At the state level, total unreduced FY 2022 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, states with DSH allotments larger than the amount of charity care and bad debt in their state will not be able to spend their full DSH allotment.[44]
- **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] This chapter includes findings for fiscal year (FY) 2019, which includes the period from October 1, 2018, through September 30, 2019, and FY 2020, which covers October 1, 2019, through September 30, 2020. The first determination of a nationwide public health emergency due to the novel coronavirus (COVID-19) was on January 31, 2020, midway through FY 2020. Thus, any FY 2019 findings in this chapter are from the period before the public health emergency, while findings from FY 2020 include periods both before and during the public health emergency. We have noted any specific policy changes or data reporting differences related to the public health emergency as appropriate in the chapter.

[2] Due to the COVID-19 pandemic, the U.S. Census Bureau suspended in-person interviews and completed the 2019 Current Population Survey (CPS) Annual Social and Economic Supplement using telephone interviews. As a result, the response rate for the 2019 CPS was about 10 percentage points lower compared with the same period for the 2018 CPS. To make the most consistent comparisons, we are following the Census Bureau's decision to focus on health insurance coverage changes between 2018 and 2020.

[3] The changes to the DSH definition of Medicaid shortfall made by the Consolidated Appropriations Act, 2021(P.L. 116-260) were effective beginning October 1, 2021. The law exempts the top 3 percent of hospitals that treat a high number and share of patients who are eligible for Medicare and receive Supplemental Security Income (SSI) from this change.

[4] ARPA increases the combined state and federal DSH allotment with inflation and then applies an enhanced FMAP of 6.2 percentage points to the combined amount as a way of determining the total federal allotment.

[5] Hospitals may also receive upper payment limit payments and payments from Medicaid managed care plans. Furthermore, some hospitals may also partially finance the non-federal share of DSH through provider taxes and other contributions (GAO 2014). Assessing DSH payment within the context of these other financing and payment arrangements would assist the Commission in determining the extent to which DSH fulfills its statutory intent of funding hospitals that serve a high proportion of Medicaid beneficiaries and uninsured individuals. 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 2021c). Additional information on how provider taxes are used to finance the non-federal share within Medicaid is provided in MACPAC's issue brief, *Health Care-Related Taxes in Medicaid* (MACPAC 2021a).

[6] The Consolidated Appropriations Act, 2021 (P.L 116-260) does not require states to collect and report data on the sources of non-federal share necessary to determine net payments at the provider level, which was also a component of MACPAC's prior recommendation. Subsequent guidance has clarified that all supplemental payments under Section 1115 demonstration waiver authority, such as Delivery System Reform Incentive Payments and uncompensated care pool payments, will be included in the new reporting requirements. However, managed care payments to providers will not be included in this new supplemental payment database (CMS 2021b).

[7] 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.

[8] 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.

[9] The most recent marginal change to allotments was due to the federal government's response to the COVID-19 pandemic; the federal share of available DSH funding increased by 6.2 percent within each state starting in January 2020. This did not change the total amount of DSH funding available (state and federal) for the public health emergency and only changed the federal share of available funding. 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).

[10] DSH spending in FY 2020 includes spending funded from prior year allotments. Total DSH spending includes an estimate of the portion of California's spending under its demonstration waiver authorized under Section 1115 of the Act, which is based on the state's DSH allotment.

[11] 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).

[12] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts ($1.3 billion in FY 2019) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[13] 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.

[14] 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.

[15] California also made DSH payments to fewer than 10 percent of hospitals (4 percent) as reported on the as-filed Medicaid DSH audits for state FY 2017. However, this analysis omits California and Massachusetts, because both states have hospitals that receive funding from safety-net care pools authorized under Section 1115 demonstration waivers that are financed with DSH funds.

[16] As noted earlier, the COVID-19 pandemic affected survey collection for the 2019 CPS. The U.S. Census Bureau's telephone response rate was 10 percentage points lower in March 2020 compared with the same period in 2019, indicating a possibility that the sampled population differed in unobservable characteristics between the two periods.

[17] This statistic includes only states that expanded Medicaid before January 1, 2020. Therefore, it does not include Nebraska (expanded in October 2020), Oklahoma (expanded in July 2021), and Missouri (expanded in October 2021 with coverage retroactive to July 2021) (KFF 2021a).

[18] While the CPS Annual Social and Economic Supplement collects state-level data, those values are primarily used for creating national-level estimates. As a result, we rely on the American Community Survey (ACS) for state-level data. Due to data collection issues during the COVID-19 pandemic, the 2020 ACS collected only two-thirds of the responses it is normally able to collect. The U.S. Census Bureau reported higher non-response rates in people with lower income, educational attainment, and home ownership. Therefore, the Census Bureau provided experimental estimates developed from its 2020 ACS one-year data instead of the standard one-year estimates from the 2020 ACS. Given the experimental nature of these estimates, we have decided not to use 2020 ACS data for our analysis.

[19] The HPS is designed to collect and measure household experiences during the COVID-19 pandemic, including education, employment, insurance coverage, and physical and mental health. HPS is collected over several phases with multiple two-week collection periods. Data from each two-week collection period is disseminated in real time throughout the phase duration.

[20] Because of differences in methodology between the CPS and the HPS, the uninsured rate is not directly comparable between the two data sets. We are therefore displaying HPS data as percentage point changes in the uninsured rate. Our analysis of 2021 third-quarter data includes only July 2021.

[21] Because several variables were replaced following Phase 1 of the HPS, we treated this as a break in series and did not report time trends with these data. The last month of data used within HPS was July 2021.

[22] The authors made these estimates based on the assumption that all states will process redeterminations within six months of the expiration of the public health emergency. The redetermination process can disenroll eligible individuals who fail to submit the required paperwork. This estimate does not include these individuals and may undercount the number of Medicaid beneficiaries who potentially lose coverage (Buettgens and Green 2021).

[23] Due to changes in Medicare cost report instructions, uncompensated care reported on FY 2018 Medicare cost reports cannot be compared with data from before the implementation of the ACA. These changes went into effect in FY 2017 and may have had a particularly marked effect on uncompensated care costs reported that year. CMS modified the definition of charity care to include uninsured discounts and changed the way that cost-to-charge ratios were applied. 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 2017). 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 previously reported. 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 2019b).

[24] MACPAC compared FY 2017 Medicare cost reports with SPRY 2017 Medicaid DSH audits to compare reporting of uncompensated care costs for the uninsured. While there is a large degree of correlation, the two data sets provide different figures. For example, average reported uncompensated care costs on Medicaid DSH audits were 28 percent lower than reported charity care and bad debt on the Medicare cost reports.

[25] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2018 Medicare cost report data used 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 fall 2018 (CMS 2018).

[26] Most 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 1923(g) 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 for DSH hospitals reported on DSH audits because of differences in the set of hospitals included in each data source and 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] One reason many states may report no Medicaid shortfall for DSH hospitals is that when Medicaid base payments for hospital services are below costs, many states make large non-DSH supplemental payments that reduce or eliminate the amount of shortfall reported on DSH audits (MACPAC 2019a).

[29] 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 2021a).

[30] 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 denied (*Baptist Memorial Hospital-Golden Triangle, Inc. v. Azar*).

[31] Medicare shortfall for patients dually eligible for Medicare and Medicaid consists of the difference between Medicare payment rates and hospital costs and the amount of Medicare cost sharing that is not paid for by Medicaid. For example, in 2015 hospitals were paid, on average, $930 below costs for a Medicare inpatient stay, which would normally be covered by the patient's Medicare hospital deductible (MACPAC 2018b, MACPAC 2018c). For Medicaid beneficiaries, most states cover part or all of this cost sharing amount. In 2017, deemed DSH hospitals reported an aggregate Medicare payment-to-cost ratio of 92.8 percent, indicating that DSH hospitals that see a large number of beneficiaries eligible for Medicare and Medicaid could see declines in their DSH limit and therefore receive less in DSH payments (MedPAC 2019).

[32] The Consolidated Appropriations Act, 2021 (P.L. 116-260) exempts the top 3 percent of hospitals that treat a high number and share of patients who are eligible for Medicare and receive SSI.

[33] Note that no standard definition exists 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.

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

[35] 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).

[36] In addition, the FFCRA (P.L. 116-127) provided an option for states to provide Medicaid coverage for diagnostic testing to uninsured individuals with COVID-19.

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

[38] 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.

[39] For states to spend the same amount of DSH funding in FY 2024 as they spent in FY 2019, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[40] 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).

[41] 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 2021c).

[42] All estimates using FY 2022 DSH allotments assume totals with no ARPA-enhanced FMAP of 6.2 percentage points. To see our FY 2022 DSH allotment estimates with and without ARPA's enhanced FMAP, please refer to Appendix 3A.

[43] Due to complications related to collecting 2020 state-level uninsured data, we are using 2019 uninsured estimates from the ACS for this statistic.

[44] 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.

References

American Hospital Association (AHA). 2021a. *Underpayment by Medicare and Medicaid fact sheet, January 2021*. Washington, DC: AHA. https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid.

American Hospital Association (AHA). 2021b. *Financial effects of COVID-19: Hospital outlook for the remainder of 2021*. Washington, DC: AHA. https://www.aha.org/guidesreports/2021-09-21-financial-effects-covid-19-hospital-outlook-remainder-2021.

American Hospital Association (AHA). 2020. *Underpayment by Medicare and Medicaid fact sheet, January 2020*. Washington, DC: AHA. https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf.

American Hospital Association (AHA). 2019. *Underpayment by Medicare and Medicaid fact sheet, January 2019*. Washington, DC: AHA. https://www.aha.org/system/files/2019-01/underpayment-by-medicare-medicaid-fact-sheet-jan-2019.pdf.

American Hospital Association (AHA). 2017. *Underpayment by Medicare and Medicaid fact sheet, December 2017 update*. Washington, DC: AHA. https://www.aha.org/data-insights/2018-01-03-underpayment-medicare-and-medicaid-fact-sheet-december-2017-update.

American Hospital Association (AHA). 2015. *Underpayment by Medicare and Medicaid fact sheet, 2015*. Washington, DC: AHA. https://www.aha.org/system/files/2018-02/2015-medicaremedicaidunderpmt.pdf.

Bai, G., and G.F. Anderson. 2016. A more detailed understanding of factors associated with hospital profitability. *Health Affairs* 35, no. 5: 889–897. https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1193.

Birkmeyer, J., A. Barnato, N. Birkmeyer, et al. 2020. The impact of the COVID-19 pandemic on hospital admissions in the United States. *Health Affairs* 39, no. 11: 2010—2017. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00980.

Blavin, F., and C. Ramos. 2021. Medicaid expansion: Effects on hospital finances and implications for hospitals facing COVID-19 challenges. *Health Affairs* 40, no. 1: 82–90. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00502.

Buettgens, M., and A. Green. 2021. *What will happen to unprecedented high Medicaid enrollment after the public health emergency?* Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf.

Buxbaum, J.D., and S. Rak. 2021. Equity and the uneven distribution of federal COVID-19 relief funds to US hospitals. *Health Affairs* 40, no. 9: 1473-1482. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02018.

Callison, K., B. Walker, C. Stoecker, et al. 2021. Medicaid expansion reduced uncompensated care costs at Louisiana hospitals: May be a model for other states. *Health Affairs* 40, no. 3: 529-535. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.01677.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2022. COVID data tracker. Accessed on January 11, 2022. Atlanta, GA: CDC. https://covid.cdc.gov/covid-data-tracker/#hospitalizations.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. COVID-19 frequently asked questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies. Updated January 6, 2021. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. E-mail to MACPAC, January 4.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. State Medicaid Director Letter 21-006: New supplemental payment reporting and Medicaid Disproportionate Share Hospital Requirements under Consolidated Appropriations Act, 2021. December 10, 2021. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2019 rates; quality reporting requirements for specific providers; Medicare and Medicaid electronic health record (EHR) incentive programs (promoting interoperability programs) requirements for eligible hospitals, critical access hospitals, and eligible professionals; Medicare cost reporting requirements; and physician certification and recertification of claims. Final rule. *Federal Register* 83, no. 160 (August 17): 41144–41784. https://www.federalregister.gov/d/2018-16766.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. *Medicare provider reimbursement manual: Part 2, provider cost reporting forms and instructions.* Transmittal 11, September 29, 2017. Baltimore, MD: CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R11p240.pdf.

Chernew, M., H. He, H. Mintz, and N. Beaulieu. 2021. Public payment rates for hospitals and the potential for consolidation-induced cost shifting. *Health Affairs* 40, no. 8(2021):1277-1285. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00201.

Coughlin, T., C. Ramos, and H. Samuel-Jakubos. 2021. Safety net hospitals in the COVID-19 crisis: How five hospitals have fared financially. Washington, DC: Urban Institute. https://www.urban.org/research/publication/safety-net-hospitals-covid-19-crisis-how-five-hospitals-have-fared-financially.

Dobson, A., and J.E. DaVanzo. 2016. *DSH allotment reduction projections*. Washington, DC: Medicaid and CHIP Payment and Access Commission.

Dranove, D., C. Garthwite, and C. Ody. 2016. Uncompensated care decreased at hospitals in Medicaid expansion states but not at hospitals in nonexpansion states. *Health Affairs* 35, no. 9: 1471–1479. https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1344.

Gifford, K., A. Lashbrook, S. Barth, et al. 2020. State Medicaid programs respond to meet COVID-19 challenges: Results from a 50-state Medicaid budget survey for state fiscal years 2020 and 2021. Washington, DC: Kaiser Family Foundation. https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-provider-rates-and-taxes/.

Gallagher, K., J. Gerhart, K. Amin, et al. 2021. Early 2021 data show no rebound in health care utilization. Washington, DC: Kaiser Family Foundation. August 2021. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2021. Provider relief fund general information. Accessed on September 1, 2021. https://www.hrsa.gov/provider-relief/faq/general?field_faq_category_tid=All&combine=.

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

Kaiser Family Foundation (KFF). 2021a. Status of state Medicaid expansion decisions: Interactive map. September 8, 2021. Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

Kaiser Family Foundation (KFF). 2021b. *2021 Employer Health Benefits Survey.* November 2021. San Francisco, CA: KFF. https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.

Kaiser Family Foundation (KFF). 2019a. *Employer health benefits 2019 annual survey*. October 2019. San Francisco, CA: KFF. https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.

Kaiser Family Foundation (KFF). 2019b. *Kaiser Family Foundation/LA Times survey of adults with employer-sponsored insurance*. San Francisco, CA: KFF. https://www.kff.org/private-insurance/report/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance/.

KaufmanHall. 2021. *National hospital flash report summary: December 2021*. Chicago, IL: KaufmanHall. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-summary-december-2021.

Keisler-Starkey, K., and L.N. Bunch. 2021. *Health insurance coverage in the United States: 2020: Current population reports.* Washington, DC: U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf.

Klem, J.D. 2000. Medicaid spending: A brief history. *Health Care Financing Review* 22, no. 1. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg105.pdf.

Kullgren, J.T., E.Q. Cliff, C. Krenz, et al. 2020. Use of health savings accounts among US adults enrolled in high-deductible health plans. *JAMA Network Open* 3, no. 7: e2011014. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768350.

Matherlee, K. 2002. *The federal-state struggle over Medicaid matching funds: An update*. Washington, DC: National Health Policy Forum. https://hsrc.himmelfarb.gwu.edu/sphhs_centers_nhpf/99/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. *Health care-related taxes in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/health-care-related-taxes-in-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *An automatic countercyclical financing adjustment for Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/an-automatic-countercyclical-financing-adjustment-for-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. *Medicaid base and supplemental payments to hospitals*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

Medicaid and CHIP Payments and Access Commission (MACPAC). 2020b. Letter from Melanie Bella to Alex Azar regarding "The decision to extend the public health emergency." August 25, 2020. https://www.macpac.gov/wp-content/uploads/2020/08/Letter-to-the-HHS-Secretary-Regarding-Notice-to-States-on-Unwinding-the-COVID-19-Public-Health-Emergency.pdf.

Medicaid and CHIP Payments and Access Commission (MACPAC). 2020c. Letter from Melanie Bella to Seema Verma regarding "The decision to distribute the first wave of funding to health care providers under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) based on institutions' Medicare fee-for-service revenues." April 10, 2020. https://www.macpac.gov/wp-content/uploads/2020/04/Letter-to-the-CMS-Administrator-on-CARES-Act-Fund-Distribution.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. Chapter 2: Treatment of third-party payments in the definition of Medicaid shortfall. In *Report to Congress on Medicaid and CHIP*. June 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/treatment-of-third-party-payments-in-the-definition-of-medicaid-shortfall/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. Chapter 3: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/march-2019-analysis-of-disproportionate-share-hospital-allotments-to-states/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018a. Chapter 3: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2018. Washington, DC: MACPAC. https://www.macpac.gov/publication/annual-analysis-of-disproportionate-share-hospital-allotments-to-states/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018b. *State Medicaid payment policies for inpatient hospital services*. December 2018. Washington, DC: MACPAC. https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018c. *State Medicaid payment policies for Medicare cost-sharing*. September 2018. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/.

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

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *Report to Congress on Medicaid disproportionate share hospital payments*. February 2016. Washington, DC: MACPAC. https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/.

Medicare Payment Advisory Commission (MedPAC). 2019. Analysis for MACPAC of Medicare cost reports.

Medicare Payment Advisory Commission (MedPAC). 2018. Letter from Francis J. Crosson to Seema Verma regarding "CMS-1694-P Medicare program: Hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and proposed policy changes and fiscal year 2019 rates; proposed quality reporting requirements for specific providers; proposed Medicare and Medicaid electronic health record (EHR) incentive programs (promoting interoperability programs) requirements for eligible hospitals, critical access hospitals, and eligible professionals; Medicare cost reporting requirements; and physician certification and recertification of claims." June 22, 2018. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/publications/06222018_medpac_2019_ipps_comment_sec.pdf.

Medicare Payment Advisory Commission (MedPAC). 2015. Comment letter regarding "Medicare proposed rule: Hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system policy changes and fiscal year 2016 rates; revisions to quality reporting requirements for specific providers, including changes related to the electronic health record incentive program." June 9, 2015.

Mehrotra, A., M. Chernew, D. Linetsky, et al. 2020a. The impact of the COVID-19 pandemic on outpatient visits: Visits return to pre-pandemic levels, but not for all providers and patients. October 2020. New York, NY: Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels.

Mehrotra, A., M. Chernew, D. Linetsky, et al. 2020b. *The impact of the COVID-19 pandemic on outpatient visits: Changing patterns of care in the newest COVID-19 hot spots*. August 2020. New York, NY: Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/aug/impact-covid-19-pandemic-outpatient-visits-changing-patterns-care-newest.

Mehrotra, A., M. Chernew, D. Linetsky, et al. 2020c. *The impact of the COVID-19 pandemic on outpatient visits: A rebound emerges*. May 2020. New York, NY: Commonwealth Fund. https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits.

Nelb, R., J. Teisl, A. Dobson, et al. 2016. For disproportionate-share hospitals, taxes and fees curtail Medicaid payments. *Health Affairs* 35, no. 12: 2277–2281. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0602.

Russell, J. 2021. Hospitals spent millions in race to hire traveling nurses. *Indiana Business Journal*, October 2021. https://www.ibj.com/articles/hospitals-race-to-hire-traveling-nurses.

Tollen, L., and E. Keating. 2020. COVID-19, market consolidation, and price growth. *Health Affairs Blog*, August 2020. https://www.healthaffairs.org/do/10.1377/hblog20200728.592180/full/.

U.S. Department of Health and Human Services (HHS). 2021a. HHS announces provider relief fund reporting update. January 15, 2021, press release. Washington, DC: HHS. https://www.hhs.gov/about/news/2021/01/15/hhs-announces-provider-relief-fund-reporting-update.html.

U.S. Department of Health and Human Services (HHS). 2021b. *CARES Act provider relief fund: General information*. January 21, 2021. Washington, DC: HHS. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html.

U.S. Government Accountability Office (GAO). 2021. *COVID-19: Sustained federal action is crucial as pandemic enters its second year*. March 2021. Washington, DC: GAO. https://www.gao.gov/products/gao-21-387.

U.S. Government Accountability Office (GAO). 2014. Medicaid financing: States' increased reliance on funds from health care providers and local governments warrants improved CMS data collection. July 2014. Washington, DC: GAO. https://www.gao.gov/assets/670/665077.pdf.

APPENDIX 3A: State-Level Data

TABLE 3A-1. State DSH Allotments, FYs 2022 and 2023 (millions)

State	FY 2022 without ARPA Adjustment[1]		FY 2022 with ARPA Adjustment[2]		FY 2023	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$23,473.9**	**$13,435.5**	**$23,473.9**	**$14,890.9**	**$24,010.1**	**$13,742.3**
Alabama	**520.5**	376.7	**520.5**	408.9	**532.4**	385.3
Alaska	**49.9**	25.0	**49.9**	28.0	**51.0**	25.5
Arizona	**177.2**	124.0	**177.2**	135.0	**181.2**	126.9
Arkansas	**73.8**	52.8	**73.8**	57.4	**75.5**	54.1
California	**2,685.6**	1,342.8	**2,685.6**	1,509.3	**2,747.2**	1,373.6
Colorado	**226.6**	113.3	**226.6**	127.4	**231.8**	115.9
Connecticut	**490.0**	245.0	**490.0**	275.4	**501.2**	250.6
Delaware	**19.2**	11.1	**19.2**	12.3	**19.7**	11.3
District of Columbia	**107.2**	75.0	**107.2**	81.7	**109.6**	76.7
Florida	**401.4**	245.0	**401.4**	269.9	**410.6**	250.6
Georgia	**492.4**	329.2	**492.4**	359.7	**503.7**	336.7
Hawaii	**22.3**	11.9	**22.3**	13.3	**22.8**	12.2
Idaho	**28.7**	20.1	**28.7**	21.9	**29.3**	20.6
Illinois	**515.5**	263.4	**515.5**	295.3	**527.3**	269.4
Indiana	**394.9**	261.8	**394.9**	286.3	**404.0**	267.8
Iowa	**77.6**	48.2	**77.6**	53.1	**79.4**	49.3
Kansas	**84.0**	50.5	**84.0**	55.7	**85.9**	51.7
Kentucky	**244.1**	177.6	**244.1**	192.8	**249.7**	181.7
Louisiana	**1,234.8**	839.9	**1,234.8**	916.4	**1,263.1**	859.1
Maine	**201.0**	128.6	**201.0**	141.1	**205.6**	131.6
Maryland	**186.8**	93.4	**186.8**	105.0	**191.1**	95.5
Massachusetts	**747.2**	373.6	**747.2**	419.9	**764.3**	382.2
Michigan	**495.7**	324.6	**495.7**	355.3	**507.1**	332.0
Minnesota	**181.1**	91.5	**181.1**	102.7	**185.3**	93.6
Mississippi	**238.5**	186.8	**238.5**	201.6	**244.0**	191.1
Missouri	**874.5**	580.3	**874.5**	634.5	**894.5**	593.6
Montana	**21.4**	13.9	**21.4**	15.2	**21.9**	14.2
Nebraska	**60.0**	34.7	**60.0**	38.4	**61.3**	35.5

TABLE 3A-1. (continued)

State	FY 2022 without ARPA Adjustment[1]		FY 2022 with ARPA Adjustment[2]		FY 2023	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$23,473.9**	**$13,435.5**	**$23,473.9**	**$14,890.9**	**$24,010.1**	**$13,742.3**
Nevada	**90.5**	56.7	**90.5**	62.3	**92.6**	58.0
New Hampshire	**392.2**	196.1	**392.2**	220.4	**401.2**	200.6
New Jersey	**1,577.1**	788.5	**1,577.1**	886.3	**1,613.2**	806.6
New Mexico	**33.9**	25.0	**33.9**	27.0	**34.6**	25.5
New York	**3,935.1**	1,967.5	**3,935.1**	2,211.5	**4,025.2**	2,012.6
North Carolina	**534.1**	361.4	**534.1**	394.5	**546.4**	369.6
North Dakota	**21.8**	11.7	**21.8**	13.1	**22.3**	12.0
Ohio	**776.3**	497.6	**776.3**	545.8	**794.1**	509.0
Oklahoma	**64.9**	44.4	**64.9**	48.4	**66.4**	45.4
Oregon	**92.1**	55.4	**92.1**	61.2	**94.2**	56.7
Pennsylvania	**1,305.0**	687.5	**1,305.0**	768.4	**1,334.9**	703.2
Rhode Island	**145.1**	79.6	**145.1**	88.6	**148.4**	81.4
South Carolina	**567.0**	401.2	**567.0**	436.3	**580.0**	410.4
South Dakota	**23.1**	13.5	**23.1**	15.0	**23.6**	13.8
Tennessee[3]	**80.0**	53.1	**80.0**	58.1	**80.0**	53.1
Texas	**1,926.5**	1,171.3	**1,926.5**	1,290.8	**1,970.7**	1,198.2
Utah	**36.0**	24.0	**36.0**	26.3	**36.8**	24.6
Vermont	**48.8**	27.6	**48.8**	30.6	**49.9**	28.2
Virginia	**214.6**	107.3	**214.6**	120.6	**219.5**	109.8
Washington	**453.2**	226.6	**453.2**	254.7	**463.6**	231.8
West Virginia	**110.7**	82.7	**110.7**	89.5	**113.3**	84.6
Wisconsin	**193.4**	115.8	**193.4**	127.8	**197.8**	118.4
Wyoming	**0.6**	0.3	**0.6**	0.3	**0.6**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. ARPA is the American Rescue Plan Act (P.L. 117-2) which provided an enhanced FMAP to states during the COVID-19 public health emergency. This table assumes the non-ARPA adjusted FY 2022 FMAP for FY 2023. State and federal totals are different from data reported to the Medicaid Budget and Expenditure System (MBES) because MBES estimates apply a traditional FMAP to the ARPA enhanced federal allotment.

[1] Totals reflect a federal medical assistance percentage with no ARPA adjustment for FY 2022.

[2] Totals reflect a federal medical assistance percentage with an ARPA adjustment for FY 2022.

[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, 2022, analysis of CMS Medicaid Budget and Expenditure System and CBO 2021.

TABLE 3A-2. FY 2024 DSH Allotment Reductions, By State (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)
Total	**$24,570.7**	**$14,063.0**	**$13,919.1**	**$8,000.0**	**56.9%**
Alabama	**544.9**	394.3	**436.5**	315.9	80.1
Alaska	**52.2**	26.1	**6.5**	3.2	12.4
Arizona	**185.5**	129.8	**52.1**	36.5	28.1
Arkansas	**77.2**	55.3	**12.5**	8.9	16.2
California	**2,811.6**	1,405.8	**1,071.5**	535.8	38.1
Colorado	**237.2**	118.6	**119.3**	59.6	50.3
Connecticut	**512.9**	256.5	**254.5**	127.2	49.6
Delaware	**20.1**	11.6	**4.8**	2.8	24.0
District of Columbia	**112.2**	78.5	**83.1**	58.2	74.1
Florida	**420.2**	256.5	**199.8**	121.9	47.5
Georgia	**515.5**	344.6	**238.1**	159.1	46.2
Hawaii	**23.3**	12.5	**3.1**	1.7	13.3
Idaho	**30.0**	21.1	**6.3**	4.4	21.1
Illinois	**539.6**	275.7	**238.7**	122.0	44.2
Indiana	**413.4**	274.1	**225.0**	149.2	54.4
Iowa	**81.3**	50.5	**15.3**	9.5	18.8
Kansas	**87.9**	52.9	**46.0**	27.7	52.3
Kentucky	**255.6**	185.9	**160.4**	116.7	62.8
Louisiana	**1,292.7**	879.3	**1,006.1**	684.4	77.8
Maine	**210.4**	134.6	**71.6**	45.8	34.0
Maryland	**195.6**	97.8	**168.0**	84.0	85.9
Massachusetts	**782.2**	391.1	**568.7**	284.4	72.7
Michigan	**519.0**	339.8	**415.9**	272.3	80.1
Minnesota	**189.6**	95.8	**36.4**	18.4	19.2
Mississippi	**249.7**	195.6	**138.9**	108.8	55.6
Missouri	**915.5**	607.5	**573.3**	380.4	62.6
Montana	**22.4**	14.6	**5.2**	3.4	23.3
Nebraska	**62.8**	36.3	**7.1**	4.1	11.3
Nevada	**94.8**	59.3	**22.6**	14.1	23.8
New Hampshire	**410.6**	205.3	**260.4**	130.2	63.4

TABLE 3A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)
Total	**$24,570.7**	**$14,063.0**	**$13,919.1**	**$8,000.0**	**56.9%**
New Jersey	**1,651.0**	825.5	**881.6**	440.8	53.4
New Mexico	**35.4**	26.1	**10.3**	7.6	29.1
New York	**4,119.6**	2,059.8	**2,714.6**	1,357.3	65.9
North Carolina	**559.2**	378.3	**298.5**	202.0	53.4
North Dakota	**22.9**	12.2	**2.3**	1.3	10.2
Ohio	**812.7**	521.0	**655.1**	420.0	80.6
Oklahoma	**68.0**	46.4	**13.3**	9.1	19.5
Oregon	**96.4**	58.0	**10.1**	6.1	10.4
Pennsylvania	**1,366.2**	719.7	**947.2**	499.0	69.3
Rhode Island	**151.9**	83.4	**136.7**	75.0	90.0
South Carolina	**593.6**	420.0	**385.5**	272.7	64.9
South Dakota	**24.1**	14.2	**1.6**	0.9	6.4
Tennessee[1]	**80.0**	53.1	**—**	—	—
Texas	**2,016.9**	1,226.3	**826.2**	502.3	41.0
Utah	**37.6**	25.2	**10.6**	7.1	28.1
Vermont	**51.1**	28.9	**45.7**	25.8	89.5
Virginia	**224.7**	112.3	**89.7**	44.8	39.9
Washington	**474.5**	237.2	**361.2**	180.6	76.1
West Virginia	**115.9**	86.6	**57.0**	42.6	49.2
Wisconsin	**202.4**	121.2	**24.3**	14.5	12.0
Wyoming	**0.6**	0.3	**0.2**	0.1	25.9

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. DSH allotments were estimated using FY 2022 DSH allotments with no American Rescue Plan Act (P.L. 117-2) adjustment for FY 2022. For further discussion of methodology and limitations, see Appendix 3B.

[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, 2022, analysis of SPRY 2017 as-filed Medicaid DSH audits, 2019 American Community Survey, CBO 2021, and Dobson and DaVanzo 2016.

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

State	2018		2019		Difference in uninsured	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population
Total	**28,566**	**8.9%**	**29,639**	**9.2%**	**1,073**	**0.3%**
Alabama	481	10.0	469	9.7	-12	-0.3
Alaska	90	12.6	86	12.2	-4	-0.4
Arizona	750	10.6	809	11.3	59	0.7
Arkansas	244	8.2	271	9.1	27	0.9
California	2,826	7.2	3,002	7.7	176	0.5
Colorado	422	7.5	453	8.0	31	0.5
Connecticut	187	5.3	207	5.9	20	0.6
Delaware	54	5.7	63	6.6	9	0.9
District of Columbia	22	3.2	25	3.5	3	0.3
Florida	2,728	13.0	2,784	13.2	56	0.2
Georgia	1,411	13.7	1,398	13.4	-13	-0.3
Hawaii	56	4.1	56	4.2	0	0.1
Idaho	193	11.1	191	10.8	-2	-0.3
Illinois	875	7.0	923	7.4	48	0.4
Indiana	545	8.3	578	8.7	33	0.4
Iowa	147	4.7	156	5.0	9	0.3
Kansas	250	8.8	262	9.2	12	0.4
Kentucky	248	5.6	283	6.4	35	0.8
Louisiana	363	8.0	404	8.9	41	0.9
Maine	106	8.0	107	8.0	1	0.0
Maryland	357	6.0	357	6.0	0	0.0
Massachusetts	189	2.8	204	3.0	15	0.2
Michigan	535	5.4	571	5.8	36	0.4
Minnesota	244	4.4	273	4.9	29	0.5
Mississippi	354	12.1	377	13.0	23	0.9
Missouri	566	9.4	604	10.0	38	0.6
Montana	86	8.2	87	8.3	1	0.1
Nebraska	158	8.3	158	8.3	0	0.0
Nevada	336	11.2	348	11.4	12	0.2

TABLE 3A-3. (continued)

State	2018		2019		Difference in uninsured	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population
Total	**28,566**	**8.9%**	**29,639**	**9.2%**	**1,073**	**0.3%**
New Hampshire	77	5.7	84	6.3	7	0.6
New Jersey	655	7.4	692	7.9	37	0.5
New Mexico	196	9.5	205	10.0	9	0.5
New York	1,041	5.4	1,007	5.2	-34	-0.2
North Carolina	1,092	10.7	1,157	11.3	65	0.6
North Dakota	54	7.3	51	6.9	-3	-0.4
Ohio	744	6.5	758	6.6	14	0.1
Oklahoma	548	14.2	553	14.3	5	0.1
Oregon	293	7.1	299	7.2	6	0.1
Pennsylvania	699	5.5	726	5.8	27	0.3
Rhode Island	42	4.1	43	4.1	1	0.0
South Carolina	522	10.5	548	10.8	26	0.3
South Dakota	85	9.8	88	10.2	3	0.4
Tennessee	675	10.1	682	10.1	7	0.0
Texas	5,003	17.7	5,234	18.4	231	0.7
Utah	295	9.4	307	9.7	12	0.3
Vermont	25	4.0	28	4.5	3	0.5
Virginia	731	8.8	658	7.9	-73	-0.9
Washington	477	6.4	496	6.6	19	0.2
West Virginia	114	6.4	118	6.7	4	0.3
Wisconsin	313	5.5	329	5.7	16	0.2
Wyoming	59	10.5	70	12.3	11	1.8

Notes: 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, 2022, analysis of Keisler-Starkey and Bunch 2020 and Census 2020.

TABLE 3A-4. State Levels of Uncompensated Care, FYs 2018–2019

State	Total hospital uncompensated care costs, 2018		Total hospital uncompensated care costs, 2019		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	**$39,813**	**4.1%**	**$42,063**	**4.2%**	**$2,250**	**0.0%**
Alabama	**765**	7.0	**754**	6.5	**-11**	-0.4
Alaska	**54**	2.8	**53**	2.7	**-0**	-0.1
Arizona	**437**	2.8	**480**	2.9	**43**	0.1
Arkansas	**230**	3.4	**248**	3.5	**18**	0.1
California	**2,374**	2.0	**2,714**	2.2	**340**	0.2
Colorado	**390**	2.7	**434**	2.7	**44**	0.1
Connecticut	**229**	1.9	**243**	1.9	**14**	0.0
Delaware	**88**	2.9	**85**	2.6	**-4**	-0.3
District of Columbia	**62**	1.7	**65**	1.7	**3**	-0.1
Florida	**3,570**	7.2	**4,096**	7.8	**526**	0.6
Georgia	**2,231**	8.6	**2,480**	9.1	**249**	0.5
Hawaii	**108**	3.1	**69**	1.9	**-39**	-1.2
Idaho	**188**	3.6	**223**	4.0	**35**	0.4
Illinois	**1,695**	4.3	**1,916**	4.7	**222**	0.4
Indiana	**828**	3.5	**900**	3.7	**72**	0.2
Iowa	**208**	2.2	**226**	2.3	**17**	0.1
Kansas	**360**	3.9	**414**	4.3	**54**	0.3
Kentucky	**316**	2.2	**364**	2.5	**48**	0.2
Louisiana	**403**	2.9	**409**	2.8	**6**	-0.1
Maine	**223**	3.7	**195**	3.2	**-28**	-0.6
Maryland	**487**	3.1	**550**	3.3	**62**	0.2
Massachusetts	**451**	1.7	**505**	1.8	**55**	0.1
Michigan	**599**	1.8	**643**	1.9	**44**	0.0
Minnesota	**317**	1.6	**356**	1.8	**39**	0.1
Mississippi	**583**	7.3	**604**	7.3	**21**	0.1
Missouri	**1,181**	5.7	**1,328**	6.2	**146**	0.5
Montana	**86**	2.0	**89**	2.0	**3**	0.0
Nebraska	**278**	4.3	**325**	4.8	**47**	0.5

TABLE 3A-4. (continued)

State	Total hospital uncompensated care costs, 2018		Total hospital uncompensated care costs, 2019		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	**$39,813**	**4.1%**	**$42,063**	**4.2%**	**$2,250**	**0.0%**
Nevada	**244**	3.9	**273**	4.3	**29**	0.4
New Hampshire	**137**	2.7	**165**	3.1	**28**	0.3
New Jersey	**1,005**	4.1	**1,104**	4.4	**99**	0.2
New Mexico	**149**	2.7	**158**	2.7	**9**	0.0
New York	**2,482**	3.2	**2,380**	2.9	**-101**	-0.3
North Carolina	**1,775**	6.4	**1,793**	6.0	**18**	-0.4
North Dakota	**94**	2.3	**98**	2.3	**4**	0.0
Ohio	**1,088**	2.8	**1,173**	2.9	**84**	0.1
Oklahoma	**722**	6.8	**770**	7.0	**48**	0.2
Oregon	**831**	6.4	**410**	3.0	**-421**	-3.4
Pennsylvania	**782**	1.8	**875**	2.0	**93**	0.1
Rhode Island	**71**	1.9	**70**	1.8	**-1**	0.0
South Carolina	**983**	7.4	**895**	6.4	**-88**	-0.9
South Dakota	**134**	3.2	**136**	3.0	**2**	-0.2
Tennessee	**1,079**	5.5	**1,132**	5.6	**53**	0.1
Texas	**6,561**	10.5	**6,965**	10.8	**404**	0.3
Utah	**369**	5.0	**369**	4.6	**-0**	-0.4
Vermont	**51**	1.9	**56**	2.0	**5**	0.1
Virginia	**1,359**	6.6	**1,170**	5.4	**-189**	-1.2
Washington	**494**	2.3	**550**	2.4	**56**	0.0
West Virginia	**159**	2.3	**214**	2.9	**54**	0.6
Wisconsin	**404**	1.9	**433**	1.9	**29**	0.0
Wyoming	**97**	5.6	**106**	5.9	**9**	0.3

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

Source: MACPAC, 2022, analysis of Medicare cost reports for FYs 2018 and 2019.

TABLE 3A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria, by State, FY 2017

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	**5,994**	**2,598**	**43%**	**733**	**12%**	**668**	**11%**
Alabama	115	84	73	8	7	7	6
Alaska	25	4	16	2	8	2	8
Arizona	112	31	28	28	25	28	25
Arkansas	102	7	7	1	1	1	1
California[1]	407	15	4	13	3	8	2
Colorado	106	26	25	7	7	7	7
Connecticut	41	8	20	2	5	2	5
Delaware	15	3	20	3	20	3	20
District of Columbia	13	7	54	6	46	4	31
Florida	254	50	20	24	9	22	9
Georgia	162	124	77	25	15	22	14
Hawaii	26	13	50	2	8	2	8
Idaho	51	25	49	7	14	6	12
Illinois	206	13	6	12	6	11	5
Indiana	166	52	31	11	7	10	6
Iowa	121	11	9	9	7	9	7
Kansas	152	63	41	11	7	9	6
Kentucky	114	97	85	40	35	34	30
Louisiana	204	62	30	41	20	35	17
Maine	38	1	3	1	3	1	3
Maryland	59	19	32	10	17	8	14
Massachusetts[2]	98	—	—	—	—	—	—

TABLE 3A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,994**	**2,598**	**43%**	**733**	**12%**	**668**	**11%**
Michigan	161	125	78	17	11	16	10
Minnesota	142	37	26	12	8	12	8
Mississippi	109	55	50	15	14	13	12
Missouri	141	107	76	24	17	23	16
Montana	67	35	52	7	10	6	9
Nebraska	97	28	29	13	13	13	13
Nevada	57	21	37	3	5	3	5
New Hampshire	30	25	83	4	13	4	13
New Jersey	97	77	79	24	25	23	24
New Mexico	54	14	26	7	13	6	11
New York	200	185	93	46	23	45	23
North Carolina	131	82	63	22	17	21	16
North Dakota	49	4	8	2	4	2	4
Ohio	233	153	66	18	8	17	7
Oklahoma	148	59	40	14	9	12	8
Oregon	63	42	67	10	16	10	16
Pennsylvania	226	176	78	39	17	34	15
Rhode Island	14	10	71	1	7	1	7
South Carolina	84	62	74	14	17	11	13
South Dakota	60	22	37	13	22	12	20
Tennessee	142	74	52	17	12	11	8

TABLE 3A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,994**	**2,598**	**43%**	**733**	**12%**	**668**	**11%**
Texas	577	178	31	87	15	85	15
Utah	60	42	70	6	10	5	8
Vermont	16	13	81	1	6	1	6
Virginia	108	38	35	5	5	5	5
Washington	105	63	60	16	15	13	12
West Virginia	62	47	76	12	19	12	19
Wisconsin	144	98	68	18	13	18	13
Wyoming	30	11	37	3	10	3	10
Wyoming	30	11	37	3	10	3	10

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 55 DSH hospitals that did not submit a FY 2019 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 17 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]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 eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Source: MACPAC, 2022, analysis of SPRY 2017 as-filed Medicaid DSH audits, Medicare cost reports for FYs 2016–2019, and the AHA 2021.

TABLE 3A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals, by State, FY 2017

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	**808,332**	**449,383**	**56%**	**150,462**	**19%**	**43,037**	**26,954**	**63%**	**12,914**	**30%**
Alabama	14,869	13,369	90	1,038	7	693	634	92	107	15
Alaska	2,119	638	30	471	22	102	57	56	47	46
Arizona	15,170	5,962	39	5,291	35	996	529	53	497	50
Arkansas	9,348	907	10	57	1	352	32	9	2	1
California[1]	75,414	4,140	5	2,913	4	5,320	436	8	307	6
Colorado	10,421	3,925	38	1,485	14	643	325	51	176	27
Connecticut	8,042	2,450	30	330	4	519	163	32	34	7
Delaware	2,606	480	18	480	18	146	34	23	34	23
District of Columbia	3,018	1,848	61	1,142	38	256	180	70	119	47
Florida	55,081	15,158	28	8,710	16	2,738	1,144	42	876	32
Georgia	21,826	18,258	84	5,892	27	1,179	1,070	91	517	44
Hawaii	2,597	2,230	86	258	10	175	164	94	50	28
Idaho	3,136	2,474	79	1,066	34	136	121	89	61	45
Illinois	30,875	2,902	9	2,280	7	1,755	218	12	166	9
Indiana	17,190	6,904	40	3,833	22	912	466	51	359	39
Iowa	7,457	2,699	36	2,603	35	347	228	66	225	65
Kansas	8,243	4,373	53	2,750	33	247	175	71	153	62
Kentucky	14,167	12,962	91	5,629	40	869	787	91	452	52
Louisiana	16,454	8,262	50	3,673	22	814	488	60	268	33
Maine	3,011	51	2	51	2	134	0	0	0	0

TABLE 3A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**808,332**	**449,383**	**56%**	**150,462**	**19%**	**43,037**	**26,954**	**63%**	**12,914**	**30%**
Maryland	12,571	4,304	34	3,174	25	808	271	34	197	24
Massachusetts[2]	42,010	—	—	—	—	1,396	—	—	—	—
Michigan	23,844	21,996	92	4,919	21	1,320	1,256	95	480	36
Minnesota	11,139	6,834	61	1,476	13	607	492	81	153	25
Mississippi	10,375	5,713	55	2,289	22	426	257	60	145	34
Missouri	18,292	14,589	80	3,117	17	915	685	75	268	29
Montana	2,902	2,195	76	448	15	108	101	94	27	25
Nebraska	5,539	3,784	68	1,838	33	185	176	95	117	63
Nevada	7,018	4,113	59	1,190	17	515	370	72	168	33
New Hampshire	2,728	2,419	89	768	28	121	116	97	74	61
New Jersey	26,020	24,438	94	6,294	24	1,090	1,035	95	449	41
New Mexico	4,383	1,531	35	424	10	335	105	31	18	5
New York	45,567	44,557	98	10,287	23	3,647	3,565	98	1,134	31
North Carolina	21,931	18,824	86	6,558	30	1,179	1,098	93	453	38
North Dakota	2,566	357	14	230	9	86	13	15	11	13
Ohio	31,622	24,797	78	6,256	20	1,727	1,349	78	596	34
Oklahoma	11,187	6,974	62	1,461	13	472	316	67	76	16
Oregon	6,989	5,190	74	1,356	19	437	389	89	150	34
Pennsylvania	36,577	33,530	92	7,795	21	1,857	1,805	97	707	38
Rhode Island	2,855	2,135	75	247	9	161	141	87	41	26
South Carolina	12,461	11,200	90	3,479	28	588	571	97	284	48

TABLE 3A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**808,332**	**449,383**	**56%**	**150,462**	**19%**	**43,037**	**26,954**	**63%**	**12,914**	**30%**
South Dakota	2,750	1,927	70	1,543	56	90	87	96	81	89
Tennessee	18,707	14,373	77	4,124	22	931	808	87	365	39
Texas	68,832	38,929	57	19,699	29	2,934	2,306	79	1,514	52
Utah	5,638	4,634	82	962	17	233	219	94	76	33
Vermont	1,136	972	86	415	37	51	51	100	30	59
Virginia	16,472	9,795	59	2,172	13	723	549	76	201	28
Washington	11,750	9,581	82	1,844	16	843	736	87	200	24
West Virginia	6,199	5,568	90	2,466	40	314	305	97	199	64
Wisconsin	15,887	13,523	85	3,448	22	580	518	89	247	43
Wyoming	1,339	609	45	231	17	23	10	44	4	18

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 55 DSH hospitals that did not submit a FY 2019 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of the methodology and limitations, see Appendix 3B.

— Dash indicates zero; 0 indicates 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 17 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 8 hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Source: MACPAC, 2022, analysis of Medicare cost reports for FYs 2016–2019 and SPRY 2017 as-filed Medicaid DSH audits.

TABLE 3A-7. FY 2022 DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual, by State

State	FY 2022 DSH allotment (millions)		FY 2022 DSH allotment per uninsured individual (thousands)		FY 2022 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$23,473.9**	**$13,435.5**	**$792.0**	**$453.3**	**$279.8**	**$160.2**
Alabama	**520.5**	376.7	**1,109.7**	803.1	**348.3**	252.1
Alaska	**49.9**	25.0	**580.3**	290.1	**303.0**	151.5
Arizona	**177.2**	124.0	**219.0**	153.3	**86.2**	60.4
Arkansas	**73.8**	52.8	**272.2**	195.0	**74.5**	53.3
California	**2,685.6**	1,342.8	**894.6**	447.3	**257.3**	128.6
Colorado	**226.6**	113.3	**500.2**	250.1	**185.6**	92.8
Connecticut	**490.0**	245.0	**2,367.0**	1,183.5	**741.0**	370.5
Delaware	**19.2**	11.1	**305.0**	176.0	**92.3**	53.3
District of Columbia	**107.2**	75.0	**4,287.2**	3,001.1	**657.0**	459.9
Florida	**401.4**	245.0	**144.2**	88.0	**69.7**	42.6
Georgia	**492.4**	329.2	**352.2**	235.5	**161.4**	107.9
Hawaii	**22.3**	11.9	**397.4**	213.2	**88.7**	47.6
Idaho	**28.7**	20.1	**150.1**	105.4	**56.8**	39.9
Illinois	**515.5**	263.4	**558.5**	285.3	**169.2**	86.5
Indiana	**394.9**	261.8	**683.2**	453.0	**223.3**	148.0
Iowa	**77.6**	48.2	**497.6**	309.2	**107.1**	66.6
Kansas	**84.0**	50.5	**320.6**	192.9	**115.0**	69.2
Kentucky	**244.1**	177.6	**862.7**	627.6	**180.3**	131.2
Louisiana	**1,234.8**	839.9	**3,056.3**	2,078.9	**811.3**	551.9
Maine	**201.0**	128.6	**1,878.2**	1,202.0	**665.2**	425.7
Maryland	**186.8**	93.4	**523.3**	261.6	**172.3**	86.2
Massachusetts	**747.2**	373.6	**3,662.8**	1,831.4	**619.2**	309.6
Michigan	**495.7**	324.6	**868.2**	568.5	**186.5**	122.2
Minnesota	**181.1**	91.5	**663.5**	335.1	**165.8**	83.7
Mississippi	**238.5**	186.8	**632.7**	495.5	**226.7**	177.5
Missouri	**874.5**	580.3	**1,447.8**	960.8	**539.4**	358.0
Montana	**21.4**	13.9	**246.2**	159.8	**76.7**	49.8

TABLE 3A-7. (continued)

State	FY 2022 DSH allotment (millions)		FY 2022 DSH allotment per uninsured individual (thousands)		FY 2022 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$23,473.9**	**$13,435.5**	**$792.0**	**$453.3**	**$279.8**	**$160.2**
Nebraska	**60.0**	34.7	**379.6**	219.4	**131.9**	76.2
Nevada	**90.5**	56.7	**260.1**	162.8	**110.1**	68.9
New Hampshire	**392.2**	196.1	**4,669.2**	2,334.6	**1,901.2**	950.6
New Jersey	**1,577.1**	788.5	**2,279.0**	1,139.5	**942.9**	471.4
New Mexico	**33.9**	25.0	**165.1**	121.7	**47.0**	34.6
New York	**3,935.1**	1,967.5	**3,907.7**	1,953.9	**825.2**	412.6
North Carolina	**534.1**	361.4	**461.7**	312.3	**181.9**	123.1
North Dakota	**21.8**	11.7	**428.1**	229.4	**139.6**	74.8
Ohio	**776.3**	497.6	**1,024.2**	656.5	**256.8**	164.6
Oklahoma	**64.9**	44.4	**117.4**	80.2	**53.4**	36.5
Oregon	**92.1**	55.4	**307.9**	185.4	**86.5**	52.1
Pennsylvania	**1,305.0**	687.5	**1,797.6**	947.0	**451.7**	238.0
Rhode Island	**145.1**	79.6	**3,374.0**	1,851.6	**643.9**	353.4
South Carolina	**567.0**	401.2	**1,034.7**	732.0	**388.4**	274.8
South Dakota	**23.1**	13.5	**261.9**	153.7	**105.4**	61.9
Tennessee	**80.0**	53.1	**117.3**	77.9	**40.8**	27.1
Texas	**1,926.5**	1,171.3	**368.1**	223.8	**227.3**	138.2
Utah	**36.0**	24.0	**117.1**	78.3	**48.2**	32.2
Vermont	**48.8**	27.6	**1,743.1**	984.3	**369.8**	208.8
Virginia	**214.6**	107.3	**326.2**	163.1	**123.3**	61.6
Washington	**453.2**	226.6	**913.8**	456.9	**281.4**	140.7
West Virginia	**110.7**	82.7	**938.3**	700.7	**198.0**	147.8
Wisconsin	**193.4**	115.8	**587.8**	352.0	**149.7**	89.7
Wyoming	**0.6**	0.3	**7.9**	4.0	**4.2**	2.1

Notes: DSH is disproportionate share hospital. FY is fiscal year. Non-elderly low-income individuals are defined as individuals under age 65 with family incomes less than 200 percent of the federal poverty level. Totals reflect a federal medical assistance percentage (FMAP) without adjustments made in the American Rescue Plan Act (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 3B.

Source: MACPAC, 2022, analysis of the CMS Medicaid Budget Expenditure, Keisler-Starkey and Bunch 2020, and Census 2020.

TABLE 3A-8. FY 2022 DSH Allotments as a Percentage of Hospital Uncompensated Care, by State, FY 2019

State	FY 2022 federal DSH allotment (millions)	FY 2022 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2019	FY 2022 DSH allotment (state and federal, millions)	FY 2022 total DSH allotment as a percentage of hospital uncompensated care in the state, FY 2019
Total	**$13,435.5**	**31.9%**	**$23,473.9**	**55.8%**
Alabama	376.7	50.0	520.5	69.0
Alaska	25.0	46.7	49.9	93.4
Arizona	124.0	25.8	177.2	36.9
Arkansas	52.8	21.3	73.8	29.7
California	1,342.8	49.5	2,685.6	98.9
Colorado	113.3	26.1	226.6	52.2
Connecticut	245.0	100.9	490.0	201.9
Delaware	11.1	13.1	19.2	22.7
District of Columbia	75.0	115.0	107.2	164.3
Florida	245.0	6.0	401.4	9.8
Georgia	329.2	13.3	492.4	19.9
Hawaii	11.9	17.3	22.3	32.3
Idaho	20.1	9.0	28.7	12.9
Illinois	263.4	13.7	515.5	26.9
Indiana	261.8	29.1	394.9	43.9
Iowa	48.2	21.4	77.6	34.4
Kansas	50.5	12.2	84.0	20.3
Kentucky	177.6	48.8	244.1	67.1
Louisiana	839.9	205.2	1,234.8	301.7
Maine	128.6	66.1	201.0	103.2
Maryland	93.4	17.0	186.8	34.0
Massachusetts	373.6	73.9	747.2	147.9
Michigan	324.6	50.5	495.7	77.1
Minnesota	91.5	25.7	181.1	50.8
Mississippi	186.8	31.0	238.5	39.5
Missouri	580.3	43.7	874.5	65.9
Montana	13.9	15.6	21.4	24.1
Nebraska	34.7	10.7	60.0	18.4

TABLE 3A-8. (continued)

State	FY 2022 federal DSH allotment (millions)	FY 2022 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2019	FY 2022 DSH allotment (state and federal, millions)	FY 2022 total DSH allotment as a percentage of hospital uncompensated care in the state, FY 2019
Total	**$13,435.5**	**31.9%**	**$23,473.9**	**55.8%**
Nevada	56.7	20.7	90.5	33.1
New Hampshire	196.1	118.7	392.2	237.5
New Jersey	788.5	71.4	1,577.1	142.9
New Mexico	25.0	15.8	33.9	21.4
New York	1,967.5	82.7	3,935.1	165.3
North Carolina	361.4	20.1	534.1	29.8
North Dakota	11.7	12.0	21.8	22.4
Ohio	497.6	42.4	776.3	66.2
Oklahoma	44.4	5.8	64.9	8.4
Oregon	55.4	13.5	92.1	22.5
Pennsylvania	687.5	78.5	1,305.0	149.1
Rhode Island	79.6	113.7	145.1	207.1
South Carolina	401.2	44.8	567.0	63.3
South Dakota	13.5	10.0	23.1	17.0
Tennessee	53.1	4.7	80.0	7.1
Texas	1,171.3	16.8	1,926.5	27.7
Utah	24.0	6.5	36.0	9.8
Vermont	27.6	49.2	48.8	87.1
Virginia	107.3	9.2	214.6	18.3
Washington	226.6	41.2	453.2	82.4
West Virginia	82.7	38.7	110.7	51.8
Wisconsin	115.8	26.8	193.4	44.7
Wyoming	0.3	0.3	0.6	0.5

Notes: DSH is disproportionate share hospital. FY is fiscal year. Uncompensated care is calculated using 2019 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) without adjustments made in the American Rescue Plan Act (P.L. 117-2). For further discussion of methodology and limitations, see Appendix XB.

Source: MACPAC, 2022, FY 2019 Medicare Cost Reports, the CMS Medicaid Budget Expenditure System, and AHA 2021.

TABLE 3A-9. FY 2022 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service, by State

State	FY 2022 unreduced DSH allotment (millions)		FY 2022 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2022 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	**$23,473.9**	**$13,435.5**	**$32.0**	**$18.3**	**$35.1**	**$20.1**
Alabama	**520.5**	376.7	**65.1**	47.1	**74.4**	53.8
Alaska	**49.9**	25.0	**25.0**	12.5	**25.0**	12.5
Arizona	**177.2**	124.0	**6.3**	4.4	**6.3**	4.4
Arkansas	**73.8**	52.8	**73.8**	52.8	**73.8**	52.8
California[1]	**2,685.6**	1,342.8	**206.6**	103.3	**335.7**	167.9
Colorado	**226.6**	113.3	**32.4**	16.2	**32.4**	16.2
Connecticut	**490.0**	245.0	**245.0**	122.5	**245.0**	122.5
Delaware	**19.2**	11.1	**6.4**	3.7	**6.4**	3.7
District of Columbia	**107.2**	75.0	**17.9**	12.5	**26.8**	18.8
Florida	**401.4**	245.0	**16.7**	10.2	**18.2**	11.1
Georgia	**492.4**	329.2	**19.7**	13.2	**22.4**	15.0
Hawaii	**22.3**	11.9	**11.1**	6.0	**11.1**	6.0
Idaho	**28.7**	20.1	**4.1**	2.9	**4.8**	3.4
Illinois	**515.5**	263.4	**43.0**	21.9	**46.9**	23.9
Indiana	**394.9**	261.8	**35.9**	23.8	**39.5**	26.2
Iowa	**77.6**	48.2	**8.6**	5.4	**8.6**	5.4
Kansas	**84.0**	50.5	**7.6**	4.6	**9.3**	5.6
Kentucky	**244.1**	177.6	**6.1**	4.4	**7.2**	5.2
Louisiana	**1,234.8**	839.9	**30.1**	20.5	**35.3**	24.0
Maine	**201.0**	128.6	**201.0**	128.6	**201.0**	128.6
Maryland	**186.8**	93.4	**18.7**	9.3	**23.4**	11.7
Massachusetts[2]	**747.2**	373.6	**—**	—	**—**	—
Michigan	**495.7**	324.6	**29.2**	19.1	**31.0**	20.3
Minnesota	**181.1**	91.5	**15.1**	7.6	**15.1**	7.6

TABLE 3A-9. (continued)

State	FY 2022 unreduced DSH allotment (millions)		FY 2022 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2022 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	**$23,473.9**	**$13,435.5**	**$32.0**	**$18.3**	**$35.1**	**$20.1**
Mississippi	**238.5**	186.8	**15.9**	12.5	**18.3**	14.4
Missouri	**874.5**	580.3	**36.4**	24.2	**38.0**	25.2
Montana	**21.4**	13.9	**3.1**	2.0	**3.6**	2.3
Nebraska	**60.0**	34.7	**4.6**	2.7	**4.6**	2.7
Nevada	**90.5**	56.7	**30.2**	18.9	**30.2**	18.9
New Hampshire	**392.2**	196.1	**98.1**	49.0	**98.1**	49.0
New Jersey	**1,577.1**	788.5	**65.7**	32.9	**68.6**	34.3
New Mexico	**33.9**	25.0	**4.8**	3.6	**5.6**	4.2
New York	**3,935.1**	1,967.5	**85.5**	42.8	**87.4**	43.7
North Carolina	**534.1**	361.4	**24.3**	16.4	**25.4**	17.2
North Dakota	**21.8**	11.7	**10.9**	5.9	**10.9**	5.9
Ohio	**776.3**	497.6	**43.1**	27.6	**45.7**	29.3
Oklahoma	**64.9**	44.4	**4.6**	3.2	**5.4**	3.7
Oregon	**92.1**	55.4	**9.2**	5.5	**9.2**	5.5
Pennsylvania	**1,305.0**	687.5	**33.5**	17.6	**38.4**	20.2
Rhode Island	**145.1**	79.6	**145.1**	79.6	**145.1**	79.6
South Carolina	**567.0**	401.2	**40.5**	28.7	**51.5**	36.5
South Dakota	**23.1**	13.5	**1.8**	1.0	**1.9**	1.1
Tennessee	**80.0**	53.1	**4.7**	3.1	**7.3**	4.8
Texas	**1,926.5**	1,171.3	**22.1**	13.5	**22.7**	13.8
Utah	**36.0**	24.0	**6.0**	4.0	**7.2**	4.8
Vermont	**48.8**	27.6	**48.8**	27.6	**48.8**	27.6
Virginia	**214.6**	107.3	**42.9**	21.5	**42.9**	21.5
Washington	**453.2**	226.6	**28.3**	14.2	**34.9**	17.4
West Virginia	**110.7**	82.7	**9.2**	6.9	**9.2**	6.9

TABLE 3A-9. (continued)

State	FY 2022 unreduced DSH allotment (millions)		FY 2022 unreduced DSH allotment per deemed DSH hospital (millions)		FY 2022 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	**$23,473.9**	**$13,435.5**	**$32.0**	**$18.3**	**$35.1**	**$20.1**
Wisconsin	**193.4**	115.8	**10.7**	6.4	**10.7**	6.4
Wyoming	**0.6**	0.3	**0.2**	0.1	**0.2**	0.1

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 90 DSH hospitals that did not submit a Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of 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. Totals reflect a federal medical assistance percentage (FMAP) without adjustments made by the American Rescue Plan Act (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 3B.

— Dash indicates that the category is not applicable.

[1] Analysis excludes 17 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 mechanism. These hospitals appear to meet deemed DSH criteria in FY 2017.

[2] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act allows it to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be categorized as DSH or deemed DSH hospitals.

Source: MACPAC, 2022, analysis of state plan rate year 2017 as-filed Medicaid DSH audits, the CMS Medicaid Budget Expenditure System, FYs 2017-2019, FYs 2017-2019 Medicare Cost Reports, and AHA 2021.

References

American Hospital Association (AHA). 2021. 2019 AHA annual survey data. Washington, DC: AHA. https://www.ahadata.com/aha-annual-survey-database.

Congressional Budget Office (CBO). 2021. The budget and economic outlook: 2021 to 2031. Washington, DC: CBO. https://www.cbo.gov/publication/57218.

Dobson, A., and J.E. DaVanzo. 2016. DSH allotment reduction projections. Washington, DC: Medicaid and CHIP Payment and Access Commission.

Keisler-Starkey, K., and L.N. Bunch. 2020. Health insurance coverage in the United States: 2019: Current population reports. Washington, DC: U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf.

U.S. Census Bureau (Census), U.S. Department of Commerce. 2020. American Community Survey. Washington, DC: Census. https://www.census.gov/programs-surveys/acs.

APPENDIX 3B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. In the following sections, 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 (SPRY) 2017 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, 2,598 hospitals receiving DSH payments are represented in our analyses of DSH audit data. We did not include audit data provided by states for hospitals that did not receive DSH payments. (Ninety-seven 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 appear only once in the data set.

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. (Eighty-seven 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. In total, 2,598 DSH hospitals were included in these analyses. We excluded 55 DSH hospitals without matching 2019 Medicare cost reports.

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, 442 hospitals were excluded from our analysis of FY 2019 margins.) Operating margins were 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, included 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 our 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* (MACPAC 2016). 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 2017.

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 Act. Consequently, Massachusetts does not have any hospitals that submit Medicaid DSH audits, while California has 17 public hospitals that do not submit Medicaid DSH audits. For these two states, MACPAC used Medicare cost report data to estimate deemed DSH status. Twenty-five 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 2019 Medicare cost reports and the 2019 AHA annual survey (Table 3B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the AHA annual survey.

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

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 data from Medicaid DSH audits, Medicare cost reports, and U.S. Census Bureau uninsured data using a methodology devised by Dobson DaVanzo & Associates, LLC (Dobson and DaVanzo 2016). DSH allotments for FY 2024 were calculated by increasing FY 2022 allotments based on the Consumer Price Index projections for All Urban Consumers and applying an $8 billion reduction, consistent with the current schedule of DSH allotment reductions in statute (CBO 2021).[45] MACPAC estimated the Medicaid inpatient factor and the uncompensated care factor using SPRY 2017 Medicaid DSH audits. MACPAC used 2019 American Community Survey (ACS) data to estimate the uninsured percentage factor. We did not use a budget neutrality factor adjustment in this report because budget neutrality information for FY 2024 was not available.

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 Rhode Island in FY 2024, and its 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 most recent report presents statistics on coverage based on information collected in the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). In prior years, the report also presented information from the

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.

CPS collects data from February through April about whether the respondent was insured on any day in the prior year. As a result, people who lost coverage during the pandemic are not included in the uninsured rates of the ASEC. By contrast, the ACS presents a point-in-time profile of the population's health insurance coverage status by collecting data samples from different households on a monthly basis throughout the calendar year. The survey asks whether a person is covered at the time of the interview. ACS's data collection methodology and larger sample size also allow it to provide state-level estimates, while CPS ASEC can be used only for national-level trends.

The COVID-19 pandemic affected survey collection for the 2019 CPS ASEC. The response rate for the 2019 CPS basic household survey was 10 percentage points lower in March 2020 compared with the same period in 2019 (Keisler-Starkey and Bunch 2021). For the CPS ASEC specifically, the Census Bureau estimates that the response rate was 61.1 percent in 2020, down from 67.6 percent in 2019 (Rothbaum 2020). Furthermore, families with higher income and more educational attainment were more likely than families with lower income and less educational attainment to respond to the 2019 CPS ASEC (Rothbaum and Bee 2020).

There were also challenges with 2020 ACS data that MACPAC typically uses to calculate state-level uninsured and non-elderly low-income rates. The 2020 ACS response rates for March through September 2020 were severely affected by the COVID-19 pandemic, and the standard 2020 ACS one-year data do not meet the Census Bureau's Statistical Data Quality Standards (Census 2021a). Instead, the Census Bureau released experimental estimates from the one-year data as a replacement for the standard estimates (Census 2021a). Due to the experimental nature of 2020 ACS data, we are using 2019 data to estimate DSH allotment reductions, state-level uninsured rates, and state-level non-elderly low-income rates instead of the most recent available data.

To examine any changes in the uninsured rate during the pandemic, we analyzed the Census Household Pulse Survey (HPS), a survey used to measure the social and economic effects of the pandemic on households that began collecting data on trends in April 2020. The HPS is a 20-minute survey released approximately every two weeks over several phases. Data collection for Phase 1 of the HPS began on April 23, 2020, and Phase 3.2 of the survey concluded on October 11, 2021. Due to the timing of the HPS release, our analyses for the third quarter of 2021 includes only July 2021.

There were methodological changes between Phase 1 and subsequent phases of the HPS. This resulted in significant changes in coverage and respondent characteristics between the results of Phase 1 and Phases 2 and 3 (Census 2021b). Therefore, we did not statistically compare Phase 1 data with data from other phases.

We also applied an insurance hierarchy to assign individuals to a coverage source and weighted estimates based on demographic differences (Census 2021b). The HPS insurance coverage estimates were calculated using an insurance hierarchy in the following order: Medicare; private with no Medicare; Medicaid with no Medicare or private; other type of insurance with no Medicare, private, or Medicaid; and uninsured.

Endnote

[45] The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) temporarily increased FY 2022 federal DSH allotments because of the COVID-19 pandemic for the remainder of the public health emergency. ARPA increased these allotments by estimating the total amount of DSH available to states (state share and federal allotment) for FY 2022 and calculated the federal share with an enhanced 6.2 percentage point federal medical assistance percentage

(FMAP) for each state. MACPAC estimated FY 2021's non-ARPA allotment using a similar method and used these estimates to project FY 2024's DSH allotment reductions.

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicaid program; State disproportionate share hospital allotment reductions. Final rule. Federal Register 84, no. 186 (September 25): 50308–50332. https://www.federalregister.gov/d/2019-20731.

Congressional Budget Office (CBO). 2021. *The budget and economic outlook: 2021 to 2031*. Washington, DC: CBO. https://www.cbo.gov/publication/57218.

Dobson, A., and J.E. DaVanzo. 2016. *DSH allotment reduction projections.* Washington, DC: Medicaid and CHIP Payment and Access Commission.

Keisler-Starkey, K., and L.N. Bunch. 2021. *Health insurance coverage in the United States: 2020: Current population reports*. Washington, DC: U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *Report to Congress on Medicaid disproportionate share hospital payments*. February 2016. Washington, DC: MACPAC. https://www.macpac.gov/publication/report-to-congress-on-medicaid-disproportionate-share-hospital-payments/.

Rothbaum, J. 2020. How does the pandemic affect survey response: Using administrative data to evaluate nonresponse in the Current Population Survey Annual Social and Economic Supplement. U.S. Census Bureau *Research Matters Blog*, September 15. https://www.census.gov/newsroom/blogs/research-matters/2020/09/pandemic-affect-survey-response.html.

Rothbaum, J., and A. Bee. 2020. *Coronavirus infects surveys, too: Nonresponse bias during the pandemic in the CPS ASEC*. September 2020. Washington, DC: U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/working-papers/2020/demo/sehsd-wp2020-10.pdf.

U.S. Census Bureau, U.S. Department of Commerce (Census). 2021a. Census Bureau announces changes for 2020 American Community Survey 1-year estimates. Washington, DC: U.S. Census Bureau. https://www.census.gov/newsroom/press-releases/2021/changes-2020-acs-1-year.html.

U.S. Census Bureau, U.S. Department of Commerce (Census). 2021b. Household Pulse Survey technical documentation. Washington, DC: U.S. Census Bureau. https://www.census.gov/programs-surveys/household-pulse-survey/technical-documentation.html.