Chapter 4:

Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Annual Analysis of Medicaid 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.
- The U.S. Department of Health and Human Services used several authorities under the COVID-19 public health emergency (PHE), which helped lower the uninsured rate, improve hospital finances, and increase DSH allotments.
  - The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) continuous coverage requirement helped to lower the uninsured rate in 2021. In 2021, 27.2 million people, or 8.3 percent of the U.S. population, were uninsured, a statistically significant decline from 2020 (28.3 million or 8.6 percent).
  - Fiscal year (FY) 2020 federal provider relief funding improved hospital finances during the PHE. Aggregate operating margin, which mostly accounts for patient care, was negative across all hospitals after accounting for DSH payments (-4 percent). However, aggregate total margin, which accounts for relief funding, DSH payments, and other government appropriations, was positive for all hospitals (7 percent).
  - The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increased FY 2023 DSH allotments by $1.5 billion. The ARPA-increased DSH allotments will phase out in FY 2024.
- Medicaid shortfall, the difference between the Medicaid base payments a hospital receives and its costs of providing services to Medicaid-enrolled patients, increased from $5.8 billion (31 percent) to $25 billion between 2019 and 2020, according to the American Hospital Association annual survey. However, the Medicaid payment-to-cost ratio has largely remained unchanged since 2013.
- Medicaid shortfall also varies quite extensively by state. Nationally among DSH hospitals in 2018, Medicaid shortfall was 86 percent of costs before accounting for DSH payments and 95 percent of costs after accounting for DSH payments. The 12 highest paying states paid DSH hospitals 99 percent of costs before DSH payments and 112 percent of costs after DSH payments. The 12 lowest paying states paid DSH hospitals 77 percent of costs before DSH payments and 85 percent of costs after DSH payments.
- DSH allotments are scheduled to be reduced by $8 billion in FY 2024, starting October 1, 2023. The Commission is concerned that the magnitude of cuts (54 percent in FY 2024) in DSH allotments under current law may disrupt the financial viability of some safety-net hospitals. The Commission previously recommended that should DSH allotment reductions go into effect, they should be phased in gradually to mitigate disruptions to DSH hospital finances.

CHAPTER 4: Annual Analysis of Medicaid 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 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 FY 2024.

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. We also update our findings with data from the first year of the COVID-19 pandemic. Overall, we observed that the COVID-19 pandemic had a considerable effect on hospital finances. The policy response to COVID-19 through various authorities granted to the U.S. Department of Health and Human Services (HHS) through the COVID-19 public health emergency (PHE) helped lower the uninsured rate, improve hospital finances, and increase DSH allotments. Specifically, we find the following:

- A total of 27.2 million people, or 8.3 percent of the U.S. population, were uninsured in 2021, a 0.3 percentage point decline from 2020 (Keisler-Starkey and Bunch 2022). Some of the decline in the uninsured rate may be attributed to the continuous coverage requirements implemented during the PHE (MACPAC 2022a).
- Hospitals reported $41.9 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2020. This represented a $1.4 billion (3.4 percent) increase in uncompensated care costs from FY 2019. 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 2015.
- Hospitals reported $24.8 billion in Medicaid shortfall on the American Hospital Association (AHA) annual survey for 2020, a 30.5 percent increase from 2019 (AHA 2021a, 2020). However, the Medicaid payment-to-cost ratio has largely remained unchanged since 2013, indicating the increase in Medicaid shortfall may be increasing Medicaid enrollment due to the continuous coverage requirements implemented during the PHE (AHA 2015).
- In FY 2020, the aggregate operating margin for all hospitals was much lower than it has been in previous years because of the financial

disruptions from the COVID-19 pandemic, but deemed DSH hospitals continued to report a lower aggregate operating margin than other hospitals (-7.4 percent for deemed DSH hospitals vs. -4.0 percent for all hospitals). However, after accounting for DSH payments and federal provider relief funding authorized during the PHE, the aggregate total margin was similar for both deemed DSH and other hospitals (7.0 vs. 7.1 percent, respectively). 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 project DSH allotments before and after implementation of federal DSH allotment reductions, which are currently scheduled to take effect on October 1, 2023. 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 to FY 2024. The amount of reductions is scheduled to be $8 billion a year between FY 2024 and FY 2027, which in FY 2024 is 54 percent of unreduced allotments.

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH policy (Box 4-1). In 2019, the Commission recommended changes to the DSH definition of Medicaid shortfall, which Congress enacted in the Consolidated Appropriations Act, 2021.[2] In March 2019, the Commission also made recommendations for how pending DSH allotment reductions should be structured if they take effect; these have not been implemented, and no reductions have been made. The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety net providers and that the methodology for implementing reductions is abrupt and does not improve the relationship between DSH allotments and measures of need for DSH funds.

In FY 2024, federal DSH allotments will also decline because of the phase out of the increased federal matching assistance percentage (FMAP) applied during the PHE. The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) temporarily increased federal DSH allotments during the PHE so that total state and federal DSH funding would be the same as it was before the application of the increased FMAP. In FY 2023, this ARPA policy increased federal DSH allotments by $1.5 billion. The Consolidated Appropriations Act, 2023 (P.L. 117-328), phases out the increased Medicaid FMAP between April 1, 2023, and December 31, 2023. The Biden administration has stated that the PHE will end in FY 2023. If the PHE does end on May 11, then there will be no ARPA increase in DSH allotments in FY 2024.

BOX 4-1. 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.
  - Note: This recommendation was partially implemented under Consolidated Appropriations Act, 2021 (P.L. 116-260), which requires the U.S. Department of Health and Human Services to establish a system for states to submit non-DSH supplemental payment data in a standard format, beginning October 1, 2021. However, this system does not include managed care payments or information on the sources of non-federal share necessary to determine net Medicaid payments at the provider level.

BOX 4-1. (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.
  - Note: Since this recommendation was made, Congress has delayed and restructured DSH allotment reductions to be $8 billion per year from FYs 2024–2027 (P.L. 116-260).
- 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.
  - Note: Consolidated Appropriations Act, 2021 (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 data needed to calculate hospital eligibility for this exemption are not readily available. CMS is developing a data source that states can use to determine which hospitals are exempt from this change to Medicaid shortfall. CMS intends to describe this exemption process in future rulemaking (CMS 2021b).

The Commission has long held the view 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. Medicaid payments generally fall into two broad categories: (1) base payments for services and (2) supplemental payments, which include DSH payments and are typically made in a lump sum for a fixed period of

time.[3] Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid; graduate medical school; supplemental payments authorized under Section 1115 demonstrations; and directed supplemental payments, which flow through managed care organizations.[4] Complete data on these supplemental payments and how they are financed are not publicly available.[5]

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. 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.[6,7] 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

BOX 4-2. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

DSH hospital. A hospital that receives Medicaid disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments; that is, a Medicaid inpatient utilization rate (MIUR) 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). MIUR is defined as the total number of Medicaid inpatient days divided by the total number of inpatient days.

Deemed DSH hospital. A DSH hospital with a MIUR of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate (LIUR) that exceeds 25 percent. LIUR is defined as the sum of two fractions. The first fraction is total Medicaid revenue for services plus other payments from state and local governments divided by the total amount of hospital revenue for patient services. The second fraction is the total amount of hospital charges for inpatient hospital services minus the total amount of revenue from state and local governments divided by total hospital charges. 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.

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 limits (Matherlee 2002, Klem 2000, Holahan et al. 1998).[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.

DSH allotments

To limit DSH spending, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments, referred to as allotments (Box 4-2). Allotments were initially established for FY 1993 and were generally based on each state's 1992 DSH spending. Although Congress has subsequently made several 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] However, because Medicaid spending has grown faster than DSH allotments, DSH spending as a share of overall Medicaid spending has declined from 15 percent in FY 1992 to 2.8 percent in FY 2018 (CRS 2020). States are not required to spend their entire allotment but do not receive federal funding for DSH payments that exceed the allotment.

In response to the COVID-19 pandemic, Congress increased the FMAP for all Medicaid expenditures, including DSH, by 6.2 percentage points under the Families First and Coronavirus Response Act of 2020 (FFCRA, P.L. 116-127), but at the time, Congress did not change federal DSH allotment policy. This caused total DSH funding (state and federal amounts) to decrease for FY 2020 since DSH payments are capped by federal allotments and states contributed less to the non-federal share for DSH payments. A year later, Congress increased DSH allotments under ARPA so that the total available state and federal DSH funding remained the same as it would have been before the FMAP increase. The ARPA DSH increases were retroactive to the second quarter of FY 2020.

In FY 2021, allotments to states for DSH payments totaled $14.3 billion.[10] State-specific DSH allotments that year ranged from less than $15 million in 6 states (Delaware, Hawaii, Montana, North Dakota, South Dakota, and Wyoming) to more than $1 billion in 3 states (California, New York, and Texas).

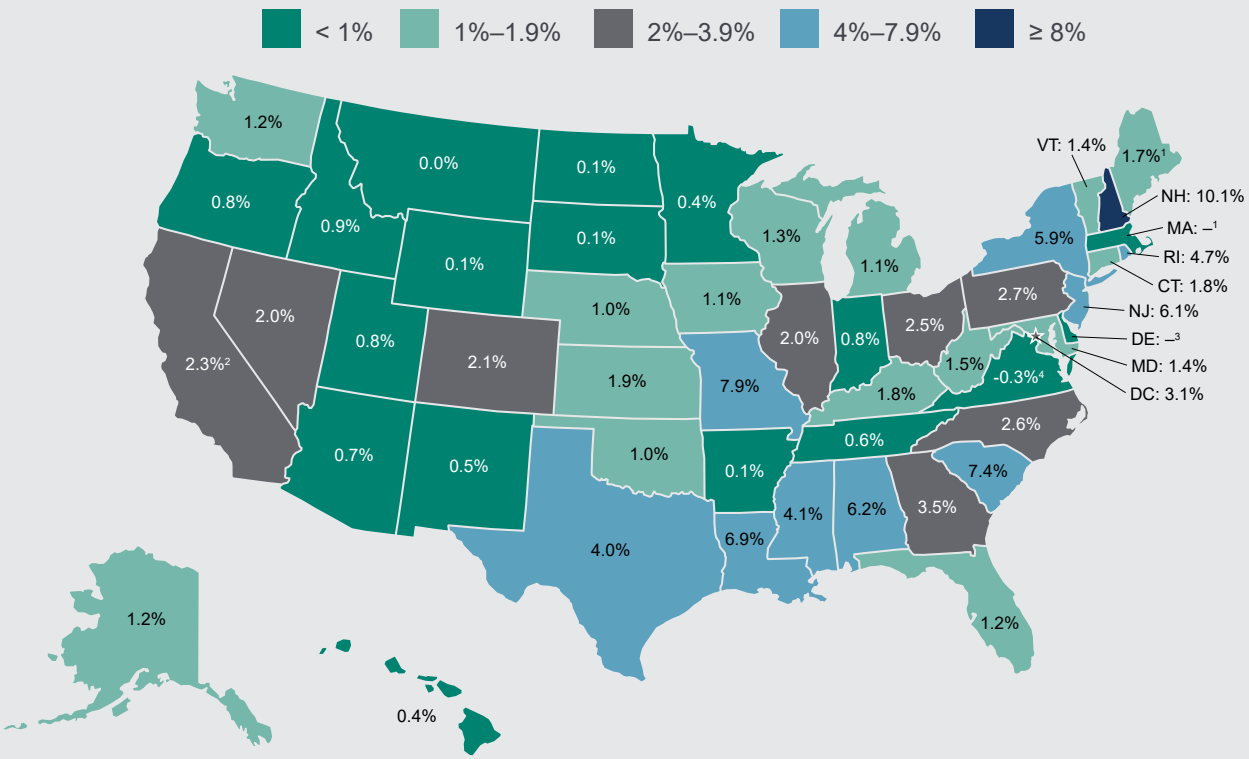
Total federal and state DSH spending was $18.9 billion in FY 2021 and accounted for 3 percent of total Medicaid benefit spending.[11] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 17 states to 10 percent in New Hampshire (Figure 4-1).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[12] As of the end of FY 2022, $1.9 billion (15 percent) in federal DSH allotments for FY 2020 allotments were unspent.[13]

There are two primary reasons that 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 2020, half of unspent DSH allotments were attributable to seven states (Connecticut, Indiana, Louisiana, Maine, New Jersey, Pennsylvania, and Virginia). All of these states, excluding Virginia and Indiana, had FY 2020 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on 2020 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.[14]

There are also regulatory or operational challenges to spending down DSH allotments in a timely manner when there are delays in Centers for Medicare & Medicaid Services (CMS) finalizing DSH allotments.[15] Although CMS provides states with preliminary allotments that they can use to make payments, some states are hesitant to spend their full DSH allotment until it is finalized because of concerns that CMS may later recoup funds if the final allotment is less than projected.[16]

FIGURE 4-1. DSH Spending as a Share of Total Medicaid Benefit Spending by State, FY 2021



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

— Dash indicates zero.

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

[2] DSH spending for California includes DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act.

[3] Delaware reported no DSH spending in FY 2020. States typically have two years to report DSH spending after the close of the fiscal year.

[4] Virginia's DSH spending in FY 2020 was negative, and therefore, DSH spending as a percent of Medicaid expenditures was also negative. States can have negative spending for a certain category of service if there was a prior period adjustment within the CMS-64 data.

Source: MACPAC, 2023, analysis of CMS-64 financial management report net expenditure data as of June 8, 2022.

DSH payments to hospitals

In state plan rate year (SPRY) 2018, 42 percent of U.S. hospitals received DSH payments (Table 4-1).[17,18] 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. More than half of public hospitals (53 percent) and teaching hospitals (63 percent) received DSH payments. Almost half of all rural hospitals (48 percent) received DSH payments, including many critical access hospitals (40 percent), which receive a special payment designation from Medicare because they are small and are supposed to be the only provider in their geographic areas.[19]

The proportion of hospitals receiving DSH payments varies widely by state (Figure 4-2). In SPRY 2018, five states made DSH payments to fewer than 10 percent of the hospitals in their states (Arkansas, Illinois, Iowa, Maine, and North Dakota). Conversely, one state, New York, made DSH payments to more than 90 percent of its hospitals.[20]

TABLE 4-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2018

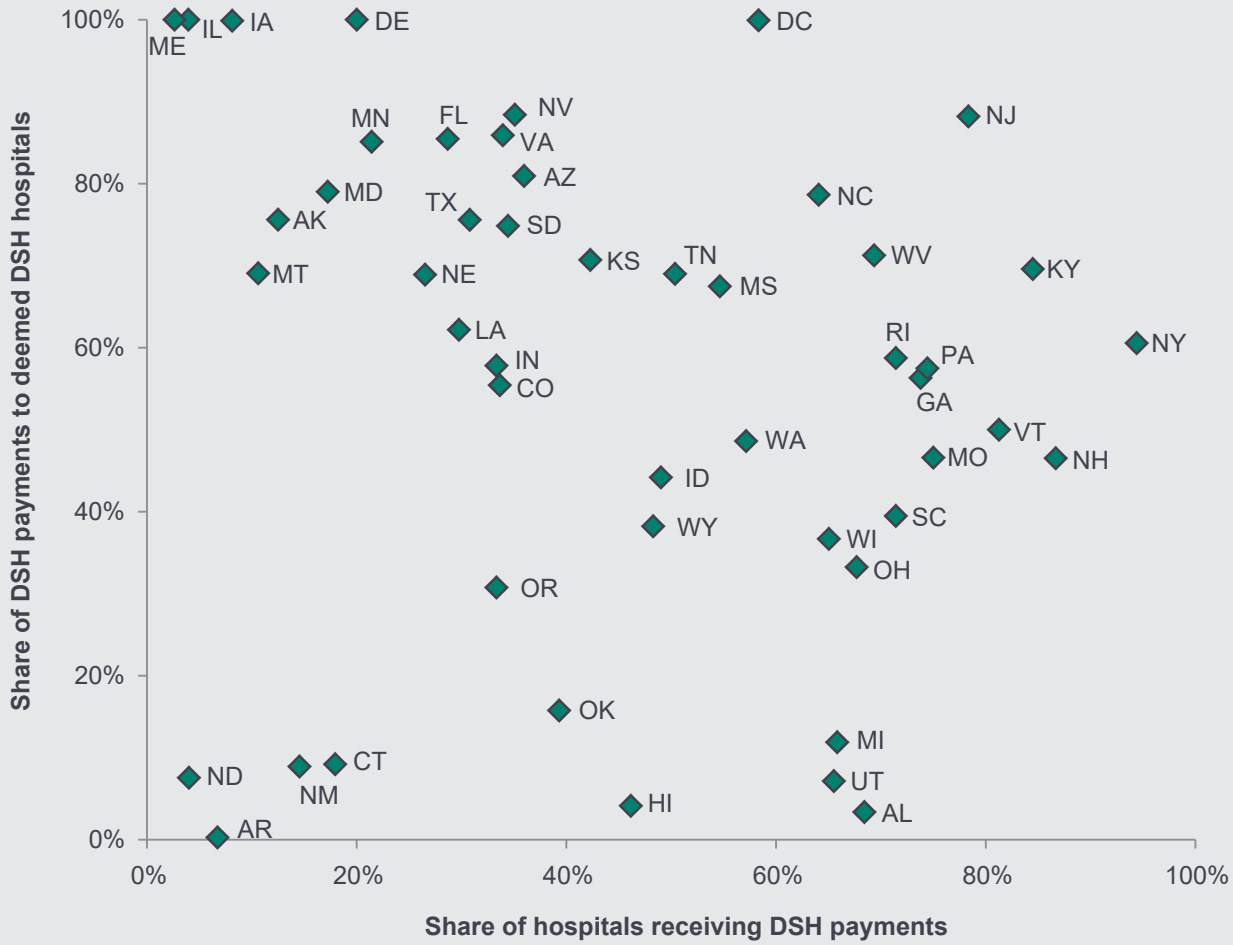
Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as a percentage of all hospitals in category	
Total	**2,507**	**5,957**	**42%**	**$16,775**
Hospital type				
Short-term acute care hospitals	1,754	3,216	55	13,095
Critical access hospitals	540	1,357	40	400
Psychiatric hospitals	141	616	23	2,867
Long-term hospitals	7	359	2	15
Rehabilitation hospitals	15	316	5	6
Children's hospitals	50	93	54	392
Urban or rural				
Urban	1,350	3,539	38	14,764
Rural	1,157	2,417	48	2,010
Hospital ownership				
For-profit	358	1,756	20	867
Non-profit	1,500	2,979	50	5,940
Public	649	1,222	53	9,967
Teaching status				
Non-teaching	1,686	4,665	36	4,763
Low-teaching	524	864	61	3,135
High-teaching	297	428	69	8,876
Deemed DSH status				
Deemed	749	749	100	10,076
Not deemed	1,758	5,208	34	6,699

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. Excludes 80 DSH hospitals that did not submit a fiscal year 2020 Medicare cost report. Low-teaching hospitals have an intern-and-resident-to-bed (IRB) ratio of less than 0.25, and high-teaching hospitals have an IRB ratio of 0.25 or greater. 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 excludes 25 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.

Sources: MACPAC, 2023, analysis of FY 2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

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 2018, about 13 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just under one-third (30 percent) of DSH hospitals but accounted for nearly two-thirds (60 percent) of all DSH payments, receiving $10 billion in DSH payments. States vary in how they target DSH payments to deemed DSH hospitals, from less than 10 percent of DSH payments to deemed DSH hospitals in 7 states (Alabama, Arkansas, Connecticut, Hawaii,

FIGURE 4-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals, by State, SPRY 2018



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the 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. Delaware has yet to submit a Medicaid DSH audit for SPRY 2018, and therefore, we are using Delaware's SPRY 2017 Medicaid DSH audit. The 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.

Sources: MACPAC, 2023, analysis of FY 2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

New Mexico, North Dakota, and Utah) to 100 percent in 4 states (Delaware, Illinois, Iowa, and Maine) and the District of Columbia.

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. 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, Connecticut, New Mexico, and North Dakota); conversely, some states that distribute DSH payments across most hospitals still target the largest share of DSH payments to deemed DSH hospitals (e.g., Kentucky and New Jersey) (Figure 4-2).

The methods states use to finance the non-federal share of DSH payments may affect their DSH targeting policies. For example, according to data from the U.S. Government Accountability Office, 10 states primarily financed DSH payments through provider contributions from publicly owned hospitals (intergovernmental transfers or certified public expenditures) (GAO 2021a, 2014). These states direct a larger share of their DSH payments to publicly owned providers (72 percent) than states that fund DSH payments through general revenue or a provider tax (43 percent and 34 percent, respectively). Conversely, the 12 states that predominately use a provider tax to generate the non-federal share of DSH payments do not appear to target DSH payments to a particular class of hospital. These states generally distribute DSH payments to a larger share of hospitals in their states (59 percent) than states that predominately fund DSH payments through other methods (39 percent).[21] 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: nearly 95 percent of the hospitals that received DSH payments in SPRY 2018 also received DSH payments in SPRY 2017. However, the amount that hospitals receive can change considerably in subsequent reporting years. For example, 23 percent of hospitals that received DSH payments in SPRY 2017 and SPRY 2018 reported that the amount of DSH payments they received in 2018 increased or decreased by more than 50 percent, compared with 2017.

Changes in the Number of Uninsured Individuals

In 2021, 27.2 million people (8.3 percent of the U.S. population) were uninsured, a statistically significant decrease from the number and share in 2020 (28.3 million and 8.6 percent, respectively) (Table 4-2) (Keisler-Starkey and Bunch 2022). At the beginning of the PHE in 2020, Congress implemented a countercyclical financing policy under FFCRA which provided an enhanced FMAP, contingent on each state maintaining its eligibility standards. CMS interpreted this continuous coverage requirement to prohibit states from disenrolling beneficiaries even if their eligibility circumstances change. MACPAC previously reported that this provision likely contributed to a significant increase in Medicaid enrollment (1 percentage point) and a significant decrease in the uninsured rate (1.1 percentage points) between August 2020 and July 2021 (MACPAC 2022a).

The uninsured rate in 2021 was highest for adults younger than age 65, individuals of Hispanic origin, and individuals with incomes below the federal poverty level (FPL) (Table 4-2). Between 2020 and 2021, the uninsured rate increased significantly for individuals older than age 64. In addition, there was a significant decrease in the uninsured rate for individuals younger than age 19; those who identify as Black, non-Hispanic; those with incomes between 200 and 300 percent FPL; and those living in states that did not expand Medicaid (Keisler-Starkey and Bunch 2022).

In 2021, the uninsured rate in states that did not expand Medicaid under the ACA to adults younger than age 65 with incomes at or below 138 percent FPL was nearly twice as high as the uninsured rate in states that expanded Medicaid (11.9 and 6.4 percent, respectively).[22] Nebraska expanded Medicaid in October 2020 and saw a decline in the uninsured rate of 1.2 percentage points between 2019 and 2021 (8.3 percent and 7.1 percent, respectively).

TABLE 4-2. Uninsured Rates by Selected Characteristics, United States, 2020–2021

Characteristic	2020	2021	Percentage point change
All uninsured	**8.6%**	**8.3%**	**-0.3%***
Age group			
Younger than age 19	5.6	5.0	-0.6*
Age 19–64	11.9	11.6	-0.3
Older than age 64	1.0	1.2	0.2*
Race and ethnicity			
White, non-Hispanic	5.4	5.2	-0.2
Black, non-Hispanic	10.4	9.0	-1.4*
Asian, non-Hispanic	5.9	6.2	0.3
Hispanic (any race)	18.3	18.3	0.0
Income-to-poverty ratio			
Less than 100 percent	17.2	16.2	-1.0
100–199 percent	13.5	13.2	-0.3
200–299 percent	12.0	11.0	-1.0*
300–399 percent	8.9	8.9	0.0
400 percent or more	3.4	3.3	-0.1
Medicaid expansion status in state of residence as of January 1, 2021			
Non-expansion	12.8	11.9	-0.9*
Expansion	6.5	6.4	-0.1

Notes: Uninsured rates are based on the Current Population Survey Annual Social and Economic Supplement. Medicaid expansion status reflects state expansion decisions as of January 1, 2021, and thus excludes Missouri and Oklahoma, which expanded in 2021.

* Indicates change is statistically different from zero at the 90 percent confidence level. MACPAC calculated significance using standard errors from Keisler-Starkey et al. 2022. This statistic includes only states that expanded Medicaid before January 1, 2021.

Sources: MACPAC, 2023, analysis of Keisler-Starkey and Bunch 2022.

Missouri and Oklahoma both expanded Medicaid at some point during 2021, therefore, the full effects of expansion on the uninsured rate may not be reflected in the 2021 American Community Survey (Table 4A-3 in Appendix 4A).[23]

When the continuous coverage requirement, which was enacted during the PHE, ends and states resume Medicaid eligibility redeterminations, Medicaid beneficiaries will be at a high risk of disruptions in coverage. HHS estimated that approximately 15 million Medicaid beneficiaries (including 9.7 million adults and 5.3 million children) could lose coverage when the continuous coverage requirement ends. HHS further estimates that more than 40 percent of these disenrolled individuals will remain eligible for Medicaid but will have lost coverage due to difficulties navigating the renewal process. This type of loss of coverage is known as “administrative churn” (ASPE 2022).

Changes in the Amount of Hospital Uncompensated Care

In considering the impending DSH allotment reductions, it is important to note that DSH payments cover both unpaid costs of care for uninsured individuals and Medicaid shortfall. The Commission has long held that DSH allotments should be allocated based on state levels of need and that states with lower levels of uncompensated care should receive a larger proportion of DSH allotment reductions. Unpaid costs of care for uninsured individuals have declined substantially relative to pre-2014 levels, before coverage was expanded under the ACA, particularly in states that have expanded Medicaid. However, as the number of Medicaid enrollees increased between 2014 and 2017, Medicaid shortfall increased as well.

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 4-3). 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.[24] 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 not due to CMS until approximately three years after DSH payments are made and then 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.

BOX 4-3. 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 (i.e., most U.S. hospitals with the exception of some freestanding children's hospitals). Medicare cost reports define hospital uncompensated care costs as charity care and bad debt.

Medicaid disproportionate share hospital (DSH) audit. A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-two percent of U.S. hospitals were included on DSH audits in 2018.

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 charity care provided to both uninsured individuals and patients with non-Medicare insurance who cannot pay deductibles, co-payments, or coinsurance.

BOX 4-3. (continued)

Bad debt. Expected payment amounts that a hospital is not able to collect from patients who are determined to have the financial capacity to pay according to the hospital's charity care policy. As noted previously, this amount excludes the bad debt that has been reimbursed by Medicare.

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 for whom Medicaid is the primary payer 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).

In our analysis of Medicaid DSH audits, we found that DSH payments were used to offset different types of uncompensated care in SPRY 2018 and that this was related to whether a state expanded Medicaid under the provisions of the ACA. DSH was primarily used to pay for costs incurred by hospitals related to care provided for the uninsured among non-expansion states, while DSH was used to offset Medicaid costs among expansion states. In the aggregate, Medicaid shortfall was responsible for a larger share of uncompensated care (76 percent) for DSH hospitals among expansion states compared with states that did not expand Medicaid (21 percent).

In the following sections, we review the most recent uncompensated care data available for all hospitals in FY 2020 as well as additional information about Medicaid shortfall reported for DSH hospitals in SPRY 2018.

Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $41.9 billion in charity care and bad debt in FY 2020, or about 4.1 percent of hospital operating expenses. This is a $1.4 billion increase from FY 2019 and a 0.05 percentage point increase as a share of hospital operating expenses.[25] Some of the increase in uncompensated care was likely offset by provider relief funding that was allocated to pay for COVID-19 testing and treatment for the uninsured (MACPAC 2021d).[26] 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.[27]

Charity care and bad debt, as a share of hospital operating expenses, varied widely by state in FY 2020 (Figure 4-3). In the aggregate, hospitals in states that expanded Medicaid under the ACA before September 30, 2020, reported less than half the uncompensated care that was reported in non-expansion states (2.7 percent of hospital operating expenses in Medicaid expansion states vs. 7.3 percent in states that did not expand Medicaid).

In FY 2020, about 53 percent of reported uncompensated care was for charity care for uninsured individuals ($22.4 billion), 14 percent was for charity care for insured individuals ($6.0 billion), and 33 percent was for bad debt expenses for both insured and uninsured individuals ($13.7 billion).[28] When individuals are unable to pay their cost sharing for medical expenses (e.g., deductibles, coinsurance, and other forms of cost sharing), this is reported as bad debt for the insured. These costs are increasing:

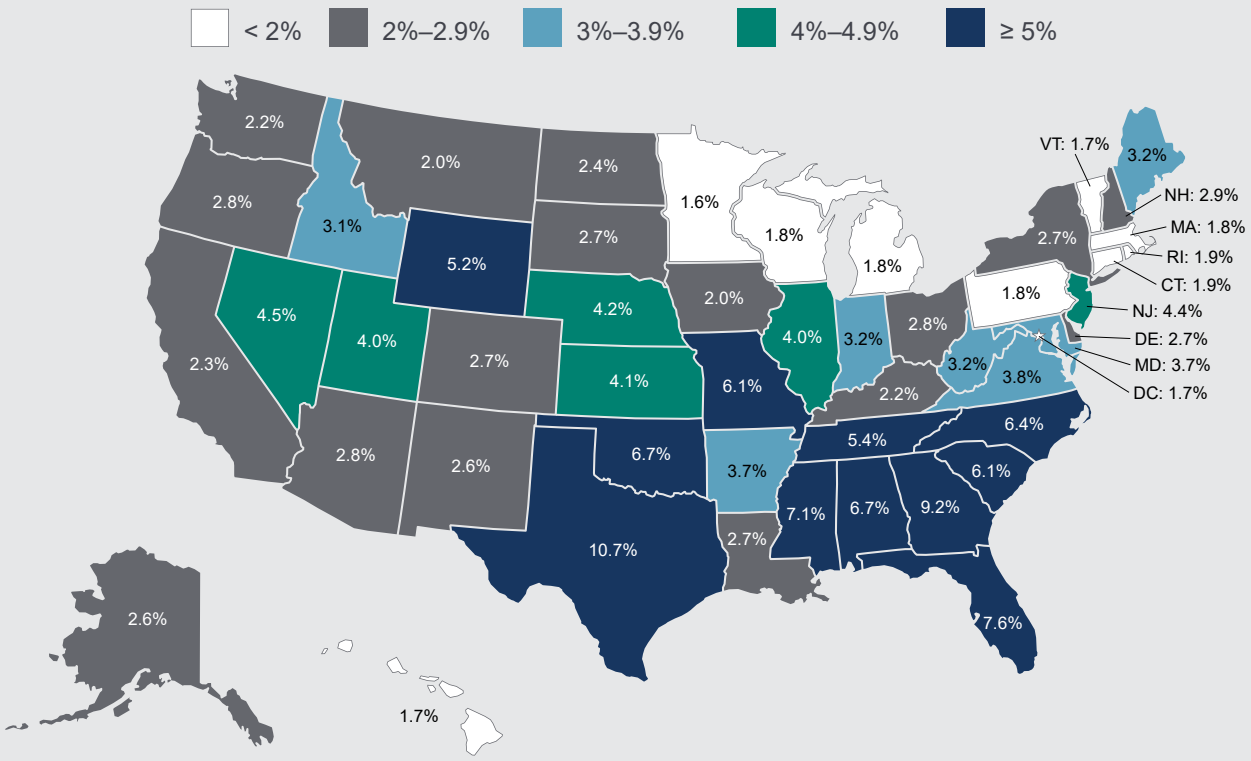
from 2016 to 2020, prices for medical care increased by 16 percent, more than double the rate of inflation (CBO 2022, HCCI 2022). Deductibles are also increasing along with the number of workers in high deductible health plans; for example, the average deductible for workers was $1,763 in 2022, which is an increase of 17 percent over the last 5 years and 61 percent over the last 10 years (KFF 2022a, 2021). Uncompensated care that can be attributed to insured individuals with high costs and high deductibles cannot be covered by Medicaid DSH.

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. According to the AHA annual survey, Medicaid shortfall for all hospitals increased by $5.8 billion between 2019 and 2020, from $19 billion to $24.8 billion (AHA 2021a, 2022a). In the same survey, the aggregate Medicaid payment-to-cost ratio was 88 percent in 2020, which means national shortfall as a percentage of costs has mostly remained unchanged since 2013 (AHA 2022a, 2021a, 2015).

In contrast to the AHA survey, which provides data for all U.S. hospitals, Medicaid DSH audits provide data on Medicaid shortfall for the subset of hospitals that receive Medicaid DSH payments (42 percent of U.S. hospitals in SPRY 2018). In SPRY 2018, DSH hospitals reported a total of $20.5 billion in Medicaid shortfall and an aggregate Medicaid payment-to-cost ratio of 86 percent before DSH payments.[29]

FIGURE 4-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2020



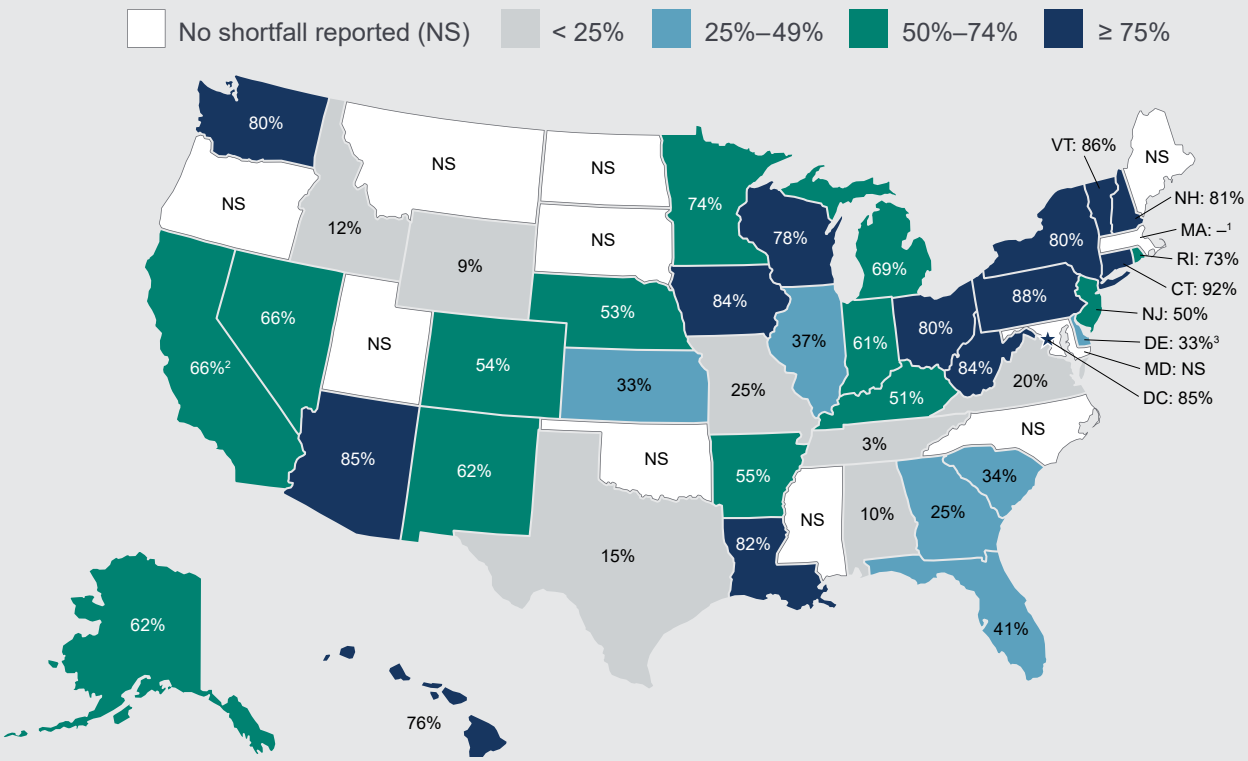
Notes: FY is fiscal year.

Source: MACPAC, 2023, analysis of FY 2020 Medicare cost reports.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 4-4). In SPRY 2018, 9 states reported no Medicaid shortfall for DSH hospitals and 27 states reported shortfall that exceeded 50 percent of DSH hospitals' total uncompensated care costs. There is also wide variation in Medicaid payment-to-cost ratios for DSH hospitals. Before DSH payments, Medicaid payments to DSH hospitals ranged from 64 percent of costs in Pennsylvania to 123 percent of costs in Utah in SPRY 2018.

Aggregate data on Medicaid shortfall for DSH hospitals may not reflect the experience of all hospitals

FIGURE 4-4. Medicaid Shortfall as a Share of Total Uncompensated Care Costs by State, SPRY 2018



Notes: SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. NS means no shortfall was reported in SPRY 2018. A total of 2,355 disproportionate share hospitals (DSH) hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. The analysis also excludes some hospitals in 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.

— Dash indicates zero.

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

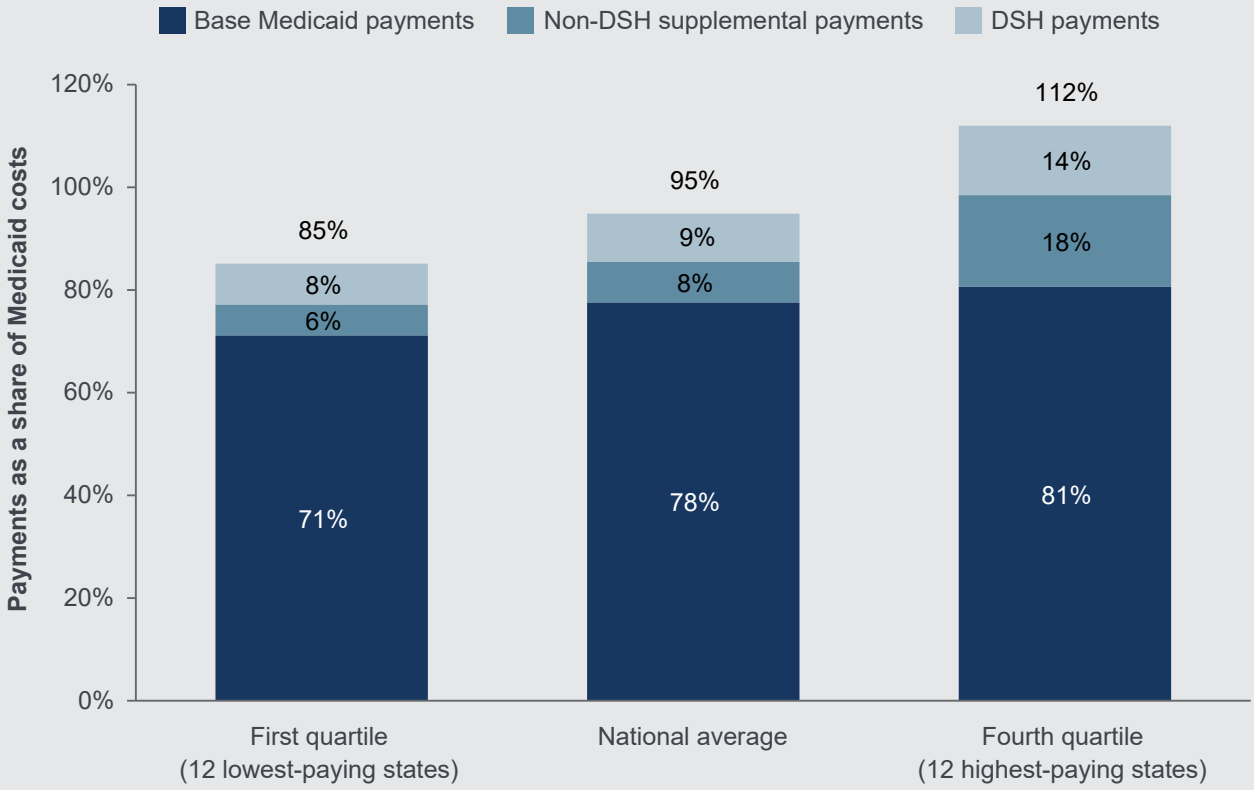
[2] DSH payments in California do not include DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act.

[3] Delaware has not submitted a SPRY 2018 as-filed DSH audit. This analysis uses SPRY 2017 Delaware DSH audit data.

Source: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits.

in a state because Medicaid payment rates vary by hospital and because the net payment that a hospital receives may be lower than the total payment reported on DSH audits. For example, in the aggregate, DSH hospitals in Mississippi did not report a Medicaid shortfall in SPRY 2018, but 28 of the 59 hospitals that received DSH payments reported Medicaid shortfall in that year.[30] Moreover, Mississippi finances DSH payments with provider taxes, and stakeholders report that net Medicaid payments to hospitals in the state are below costs after adding the costs of these taxes (MACPAC 2019).

FIGURE 4-5. Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs by National Average and Selected Quartiles, SPRY 2018



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. A total of 2,355 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. DSH payments can cover Medicaid and uninsured costs, but this figure calculates DSH and other Medicaid payments as a percentage of Medicaid costs. Quartiles were calculated based on each state's Medicaid payment to Medicaid cost ratio. Base Medicaid payments include fee for service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on Medicaid DSH audits). States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care base payment or as a supplemental payment. Payments shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers may not sum due to rounding.

Source: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits.

We can also use Medicaid DSH audits to see how base payments and all supplemental payments compare with Medicaid costs at DSH hospitals. We find that overall Medicaid base payments pay 78 percent of costs, non-DSH supplemental payments pay 8 percent of costs, and DSH payments pay 9 percent of costs, though these averages mask significant state variation (Figure 4-5).[31]

In SPRY 2018, DSH hospitals in the 12 states with the lowest Medicaid payment to cost ratios received total Medicaid payments that covered 85 percent of the costs of care for Medicaid enrolled patients in the aggregate, and DSH hospitals in the 12 states with the highest Medicaid payment to cost ratios received payments that covered 112 percent of Medicaid costs in the aggregate.[32] Similar to DSH payments, these supplemental payments are intended to support a variety of goals and may not be intended to offset Medicaid shortfall (state level tables on base and supplemental payments for DSH hospitals are available in Appendix 4A).

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 in the aggregate. MACPAC estimates both total and operating margins using a combination of Medicaid DSH audit and Medicare cost report data. Operating margin primarily includes only revenues and costs related to patient care, while total margin also includes revenue not directly related to patient care, such as the hospital's investment income or state and local subsidies. MACPAC analyzes both types of margins to have a fuller understanding of the financial health of safety-net hospitals.

COVID-19 effects on hospital margins. COVID-19 has had a large effect on hospital margins. Hospitals noted greater expenses due to the costs of treating complex COVID-19 hospitalizations and the costs associated with implementing new infection control practices to protect patients and staff, both of which increased hospital uncompensated care costs to the extent that they were not paid for by other sources (AHA 2021b). Hospitals also experienced declines in non-COVID-19 service use 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).

To 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), the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), the Consolidated Appropriations Act, 2021, and ARPA made available $186.5 billion in provider relief funding to hospitals and other providers to offset lost revenue or expenses during the pandemic; a portion of this funding was also used to pay for 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.[33]

At the time of the initial distribution of funds, MACPAC expressed concern that provider relief funding was not appropriately targeting safety-net providers (MACPAC 2020a, 2020b). Since initial disbursements were based on and then updated to be based on all-payer net patient revenue, funding was less targeted toward hospitals that serve a large percentage of the Medicaid population and instead was mostly distributed to hospitals with high patient revenue (Buxbaum and Rak 2021). HHS eventually made additional provider relief funding available to hospitals with a high number of COVID-19 admissions, rural hospitals, children's hospitals, tribal hospitals, and safety-net hospitals (GAO 2021b).[34]

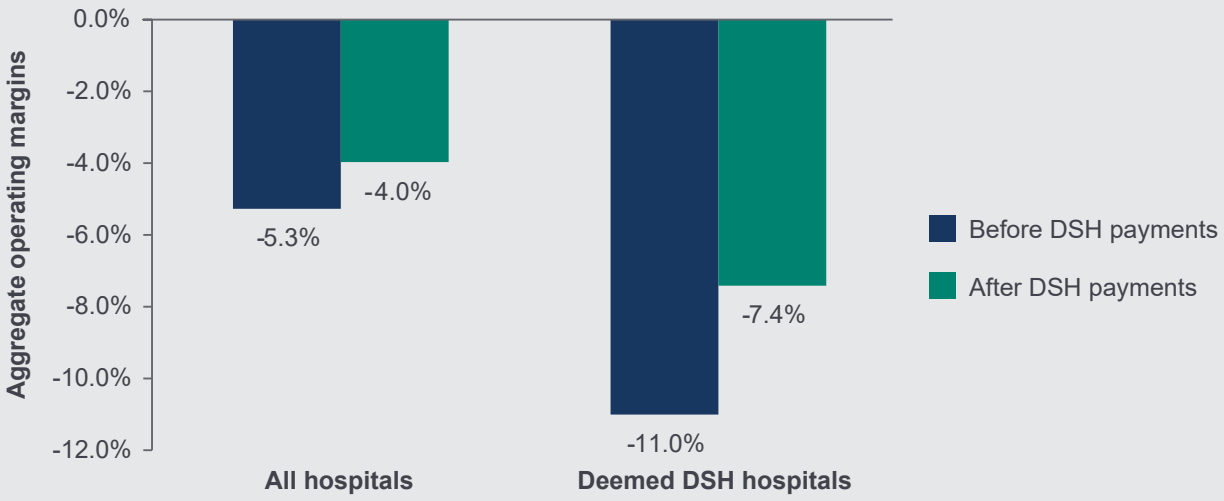
These funding allocations raised questions regarding how to define a safety-net hospital. In 2017, the Commission analyzed other criteria that could be used to identify hospitals that should receive DSH payments (MACPAC 2017). However, because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single, use-based standard that is applicable

to all hospitals and would be a clear improvement on current law. Academics, government agencies, and hospital associations have attempted to develop a common definition of a safety-net hospital. While the specific identification methods tend to vary, most use common factors such as patient mix (e.g., payer, patient demographics), geography, and measurements of hospital finances (e.g., amount of uncompensated care or total margin) (AHA 2022b, Dickson et al. 2022, MedPAC 2022). The Commission plans to monitor the extent to which DSH hospitals overlap with these definitions and other ways of evaluating the extent to which a hospital is part of the safety net.

Total and operating margins. In FY 2020, the aggregate operating margin was negative across all hospitals after counting DSH payments (-4.0 percent) and were 4.2 percentage points lower than in FY 2019.[35] Declines in operating margin were particularly acute for deemed DSH hospitals (Figure 4-6). Deemed DSH hospitals reported a negative aggregate operating margin both before and after counting DSH payments (-11.0 percent and -7.4 percent, respectively).

Due to federal provider relief funding, FY 2020 total margin for hospitals appeared healthier than operating margins. Total margin accounts for all types of income (e.g., investment income) and funding that hospitals received from federal and state governments during the PHE. The aggregate total margin for all hospitals after DSH payments was 7.1 percent in FY 2020, which was

FIGURE 4-6. Aggregate Hospital Operating Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2020



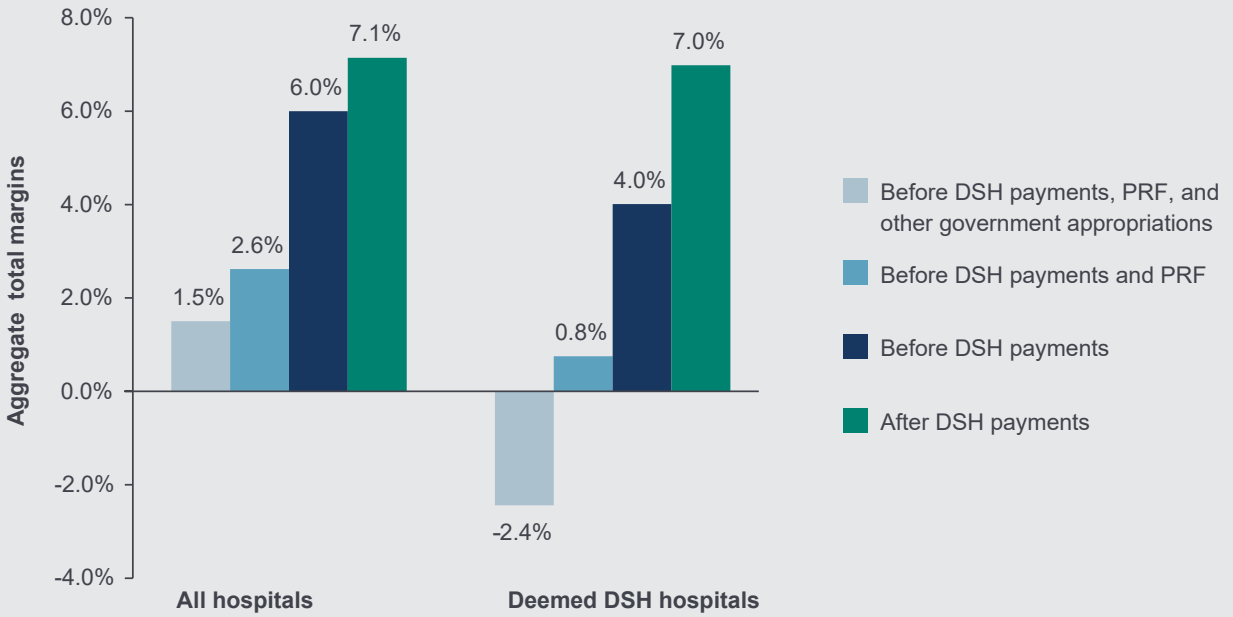
Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure income from patient care divided by net patient revenue. Operating margin before DSH payments in FY 2020 was estimated using state plan rate year (SPRY) 2018 DSH audit data. The analysis excluded outlier hospitals reporting an operating margin 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 4B.

Sources: MACPAC, 2023, analysis of FYs 2019–2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

0.2 percentage points higher than in FY 2019 (Figure 4-7). Before counting DSH payments, PHE related federal spending, and other government appropriations, deemed DSH hospitals reported an aggregate total margin of -2.4 percent in FY 2020. After counting these payments and appropriations, deemed DSH hospitals reported a positive aggregate total margin (7.0 percent), which was comparable to the aggregate total margin reported for all hospitals (7.1 percent).

MACPAC will continue to analyze hospital margins as more data on the economic disruptions caused by COVID-19 become available. Federal support for hospitals was smaller in FY 2021 than in FY 2020, and hospitals remain concerned that workforce shortages are contributing to increased labor costs, potentially straining their finances (Swanson 2022, Russell 2021). At the same time, research has found that provider relief funding was greater than COVID-19-related costs, which helped contribute to higher all-payer margins in 2021 among all hospitals compared with the 2017–2020 reporting years (MedPAC 2022b). We expect these effects to be reflected in our analyses of operating and total margins in future reports.

FIGURE 4-7. Aggregate Hospital Total Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2020



Notes: DSH is disproportionate share hospital. FY is fiscal year. PRF is provider relief funding and Paycheck Protection Program forgiven loans that were disbursed during the COVID-19 public health emergency and are reported on worksheet G3 of the Medicare cost reports. Total margin includes revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state and local subsidies to hospitals. Total margin before DSH payments in FY 2020 were estimated using state plan rate year (SPRY) 2018 DSH audit data. Other government appropriations include state or local subsidies to hospitals that are not Medicaid payments. Analysis excluded outlier hospitals reporting a total margin greater than 1.5 times the interquartile range from the first and third quartiles. COVID-19 PRF relates to funding that was authorized under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139). 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 4B.

Sources: MACPAC, 2023, analysis of FY 2019–2020 Medicare cost reports and SPRY 2017–2018 as-filed Medicaid DSH audits.

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 4-4).

Using data from 2020 Medicare cost reports and the 2020 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2018, almost all (93 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, 38 percent provided three or more of these services.

BOX 4-4. 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 may be the only hospital in their geographic areas. See Appendix 4B for further discussion of our methodology and its limitations.

DSH Allotment Reductions

In December 2020, Congress delayed implementation of the 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 beginning October 1, 2023:

- $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.

DSH funding remains an important source of revenue for many safety-net hospitals. The Commission is concerned that the magnitude of cuts in DSH funding under current law may disrupt the financial viability of some safety-net hospitals and the services that they provide. The Commission previously recommended that should DSH allotment reductions go into effect, they should be phased in gradually to help mitigate disruptions for DSH hospitals by providing more time

BOX 4-5. 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, a number that includes Hawaii, whose eligibility is based on a special statutory exception (§§ 1923(f)(5) and 1923(f)(6) of the Social Security Act).

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

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

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

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

to plan for potential changes before the full amount of reductions takes effect. Phasing in reductions will give states time to adjust to other types of Medicaid hospital payment policies to account for DSH funding changes. Under current law, DSH allotment reductions will amount to more than half of unreduced DSH allotment amounts in FY 2024 (54 percent), while scheduled reductions under previous legislation were applied more gradually (CRS 2021). Unreduced DSH allotments continue to increase each year based on inflation, so FY 2027 DSH allotment reductions will be a slightly smaller share of states' unreduced allotments (52.8 percent).[36] 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 4-5).

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.

BOX 4-6. COVID-19 Public Health Emergency Unwinding and DSH Allotments

The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increases federal disproportionate share hospital (DSH) allotments during the public health emergency (PHE) so that total available state and federal DSH funding is the same as it would have been without the application of the increased federal medical assistance percentage (FMAP) applied during the PHE. Without this adjustment, total available state and federal DSH funding would decrease when the FMAP increases.

Between FY 2020 and FY 2023, ARPA increased federal DSH allotments to correspond with the 6.2 percentage point increase in the FMAP added by the Families First and Coronavirus Response Act of 2020 (FFCRA) (P.L. 116-127). In FY 2023, this adjustment amounted to a $1.5 billion increase in federal DSH allotments above what they would be without ARPA. This change kept total DSH funding the same. Without the ARPA adjustment and with the enhanced FMAP under the FFCRA, total state and federal DSH funding would have been $2.5 billion lower than it would have been without ARPA.

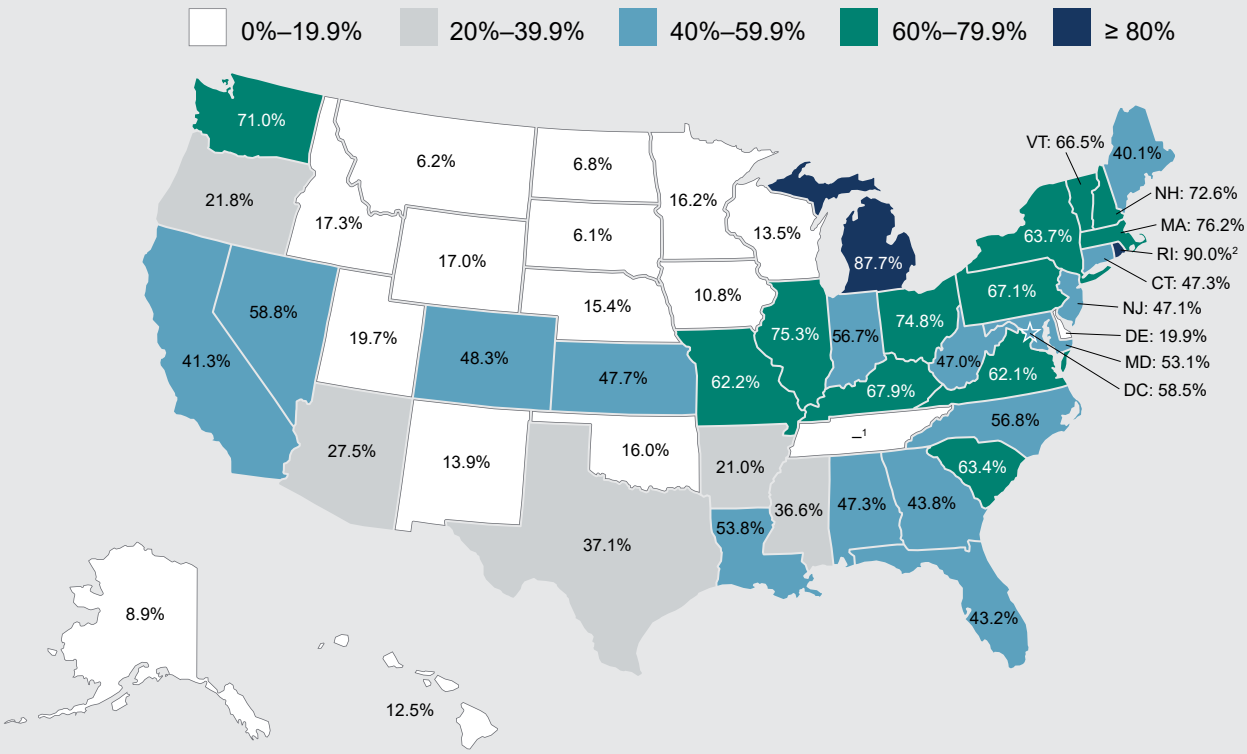
The Consolidated Appropriations Act, 2023 (P.L. 117-328), phases out the increased FMAP between April 1 and December 31, 2023. Specifically, from April to June 2023, the FMAP increase will be reduced from 6.2 percentage points to 5 percentage points; from July to September 2023, the FMAP increase will be reduced to 2.5 percentage points; from October to December 2023, the FMAP increase will be reduced to 1.5 percentage points; and after December 31, 2023, there will be no increased FMAP.

The Centers for Medicare & Medicaid Services have not yet issued guidance about how these changes to the increased FMAP will affect federal DSH allotments for FY 2023 and FY 2024. Because states have the flexibility to claim DSH payments at any point within a fiscal year, the changes in the FMAP for FY 2023 are not expected to affect FY 2023 DSH allotments. However, the Biden administration stated that the PHE will end May 11. If this were to occur, then states would not receive an ARPA adjustment to their DSH allotments for FY 2024. However, since the FMAP is increased by 1.5 percentage points at the start of FY 2024, then states will have less total DSH funding for DSH payments claimed between October and December 2023.

We used data from the 2021 American Community Survey and SPRY 2018 Medicaid DSH audits to estimate the reduction factors for each state and projected the DSH allotments in FY 2024 (Dobson and DaVanzo 2016). Because of the lack of available data, we did not attribute any reductions based on the budget neutrality factor. 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 between FY 2024 and FY 2027, assuming states do not change their DSH targeting policies and there are no changes in uninsured rates across states.

This analysis compares reduced allotments to unreduced allotments in FY 2024. DSH allotments have been increased during the PHE. When the PHE ends, states will face additional reductions in federal DSH allotments. In FY 2023 DSH allotments were increased by $1.5 billion due to ARPA, but this increase will phase out by FY 2024 (Box 4-6).

FIGURE 4-8. 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. This analysis compares reduced allotments with unreduced allotments. This analysis assumes that the public health emergency ends in FY 2023. When the public health emergency ends, the enhanced federal DSH funding authorized under the American Rescue Plan Act of 2021 (P.L. 117-2) will expire.

— Dash indicates a 0 percent reduction in state DSH allotments.

[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 DSH allotment reductions in Rhode Island.

Sources: MACPAC, 2023, analysis of preliminary unreduced and reduced allotment amounts using data provided by the Centers for Medicare & Medicaid Services as of October 11, 2022, and projected for FY 2024.

Reductions will affect states differently, with estimated reductions ranging from 6.1 percent to 90 percent of unreduced allotment amounts (Figure 4-8). 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 (15.2 percent in the aggregate) is much smaller than that of the other states (55.8 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, 2022 (59.3 percent in the aggregate), than for states that did not expand Medicaid (47.3 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors are included in Appendix 4A.)

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 2020. 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 2020 allotment.[37]

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.[38] 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; however, each type of Medicaid payment is subject to its own unique rules and limitations. For example, DSH payments can be used to pay for unpaid costs of care for the uninsured, while other types of supplemental payments pay only for Medicaid costs and cannot exceed a reasonable estimate of what Medicare would have paid for the same service.[39]

Relationship of DSH Allotments to the Statutorily Required Factors

As in our past reports, we find little meaningful relationship between FY 2023 DSH allotments and the factors that Congress asked MACPAC to consider.[40] In summary, we found the following:

- **Changes in number of uninsured individuals.** FY 2023 DSH allotments range from less than $100 per uninsured individual in four states to more than $1,000 per uninsured individual in 11 states and the District of Columbia. Nationally, the average FY 2023 DSH allotment per uninsured individual is $568.
- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2020 Medicare cost reports, FY 2023 federal DSH allotments range from less than 10 percent in five states to more than 80 percent in eight states and the District of Columbia. Nationally, these allotments are equal to 38.6 percent of hospital charity care and bad debt costs. At the state level, total FY 2023 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in 12 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.[41]
- **Number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.** Finally, there continues to be no meaningful relationship between state DSH allotments and the number of deemed DSH hospitals in the state that provided at least one of the services included in MACPAC's definition of essential community services.

Endnotes

[1] This chapter includes findings for fiscal year (FY) 2020, which includes the period from October 1, 2019, through September 30, 2020, and FY 2021, which covers October 1, 2020, through September 30, 2021. 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 2020 findings 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] 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 excludes enrollees who receive principal coverage through a third party (private insurance or Medicare) from calculations of Medicaid shortfall. The law also 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 from this change. 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).

[3] In addition to supplemental payments, some hospitals may also partially finance the non-federal share of DSH through provider taxes and other contributions. 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).

[4] Aggregate fee-for-service base and supplemental payments, excluding DSH payments, cannot exceed what is known as the "upper payment limit." The limit is a reasonable estimate of what Medicare fee for service would have paid for the same service. States must demonstrate that they are complying with the upper payment limit by submitting hospital-level supplemental payment data annually to the Centers for Medicare & Medicaid Services (CMS). CMS is developing a data source that will start collecting this information for all supplemental payments after October 1, 2021; however, MACPAC is not yet aware of any publicly available analyses of this data (CMS 2021a).

[5] In February 2016, the Commission recommended that the Secretary of HHS collect and report complete information on Medicaid payments to hospitals to help inform analyses about the targeting of DSH payments. The Consolidated Appropriations Act, 2021 (P.L. 116-260), requires HHS to collect and report data on non-DSH supplemental payments beginning October 1, 2021. The Consolidated Appropriations Act, 2021, 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, supplemental payments made through managed care (also known as directed payments) will not be included in this new supplemental payment database. Though CMS is supposed to report this information for all supplemental payments after October 1, 2021, MACPAC is not aware of any publicly available analyses of this data (CMS 2021b).

[6] Medicare also makes DSH payments. Hospitals are generally eligible for Medicare DSH payments based on their Medicaid share of total inpatient days and Medicare Supplemental Security Income share of total Medicare days. Historically, the amount of Medicare DSH percentage add-on that a hospital was eligible to receive was based solely on a hospital's Medicaid and Supplemental Security Income patient use, but since 2014, the ACA has required that most Medicare DSH funds be converted to uncompensated care payments, distributed to hospitals based on each hospital's uncompensated care relative to other Medicare DSH hospitals. In addition, the ACA linked the total amount of funding for Medicare uncompensated care payments to the uninsured rate.

[7] The Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) created and expanded the Boren Amendment, which removed the requirement for Medicaid to pay nursing facilities and hospitals according to Medicare cost principles. P.L. 97-35 also required states to consider the situation of hospitals that serve a disproportionate share of low-income patients with special needs when setting Medicaid provider

payment rates for inpatient services. These payments are now known as "DSH payments." For more on the history of DSH payments, please refer to Chapter 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments in MACPAC's *March 2016 Report to Congress on Medicaid and CHIP* (MACPAC 2016).

[8] 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 a temporary increase to DSH allotments for the remainder of the COVID-19 PHE. The increased DSH allotments did not change the total amount of DSH funding available (state and federal combined amounts) for the PHE but did increase the federal share of available funding by 6.2 percentage points.

[10] This amount is inclusive of the ARPA increase to DSH allotments, which were made retroactive to FY 2020.

[11] DSH spending in FY 2021 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.

[12] 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).

[13] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts ($1.5 billion in FY 2020) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[14] Uncompensated care is calculated differently on DSH audits and Medicare cost reports. Medicare cost reports define uncompensated care as charity care and bad debt for non-Medicare beneficiaries, 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.

[15] During the COVID-19 pandemic, the process for finalizing DSH allotments was delayed longer than usual, and FY 2018 DSH allotments were not finalized until March 2022 (CMS 2022a).

[16] Though CMS provides states with draft preliminary and draft final allotments before publication on the *Federal Register*, it is unclear if states receive them with enough advance notice to appropriately plan their spenddown.

[17] States report hospital-specific DSH data on a SPRY basis, which often corresponds with the state fiscal year and may not align with the federal fiscal year.

[18] At the time of drafting this report, Delaware had not submitted its SPRY 2018 as-filed DSH audit to CMS. Therefore, we are relying on data from Delaware's SPRY 2017 as-filed DSH audit in this report.

[19] The 1997 Balanced Budget Act (P.L. 105-33) created the critical access hospital (CAH) certification to ensure that hospital care is accessible to beneficiaries in rural communities. To be CAH designated, a hospital must meet two location requirements: (1) it must be 35 miles from another hospital (including a CAH) or (2) be located more than a 15-mile drive from another hospital in areas of mountainous terrain or areas with only one-lane state highways or other local roads. However, a 2013 report found that 64 percent of CAHs do not meet these location requirements (GAO 2013).

[20] California made DSH payments to 6 percent of hospitals as reported on the as-filed Medicaid DSH audits for state FY 2018. However, this analysis does not include additional payments that the state made through its Section 1115 demonstration waiver that are financed with DSH funds.

[21] Analysis excludes 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. Analysis excludes New York and Alabama, which has no majority financing source for DSH payments. Analysis excludes Montana because it did not participate in GAO's survey collecting information on how states finance the non-federal share of DSH payments.

[22] This statistic includes only states that expanded Medicaid before January 1, 2021. Therefore, it does not include Missouri (expanded in October 2021) and Oklahoma (expanded in July 2021) (KFF 2022b).

[23] Missouri expanded Medicaid in October 2021 but also reported issues processing applications for its expansion population (CMS 2022b, KFF 2022b). CMS put Missouri on a mitigation plan to help improve the state's enrollment application wait times (CMS 2022c).

[24] Medicare cost reports define bad debt as debt for non-Medicare beneficiaries that also is not reimbursable by Medicare through other means (e.g., Medicare DSH payments).

[25] It should be noted that while uncompensated care increases every year, it has not increased as a percentage of operating expenses since 2015.

[26] Providers were allowed to use provider relief funding only for uncompensated care costs related to COVID-19, such as reimbursement for testing and treatment. Reimbursing uncompensated care unrelated to COVID-19 was not an allowable use of provider relief funds (HRSA 2022). This is further discussed later in the chapter.

[27] In previous years, MACPAC compared Medicare cost reports with Medicaid DSH audits to compare reporting of uncompensated care costs for the uninsured. While there is a large degree of correlation, the two datasets 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 in FY 2017. This can partially be attributed to the different definitions of uncompensated care on cost reports when compared with Medicaid DSH audits. Medicaid DSH defines uncompensated care as unpaid costs of care for the uninsured and Medicaid shortfall, while cost report data on charity care includes both insured and uninsured individuals.

[28] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2020 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).

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

[30] Forty-five percent of hospitals in Mississippi are not included on the state's SPRY 2018 DSH audit because these hospitals did not receive DSH payments.

[31] Medicaid DSH audits include data on base payment amounts within fee for service and managed care. States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a base payment within managed care or as a supplemental payment.

[32] Analysis of Medicaid payment-to-cost ratios is limited to DSH hospitals with complete DSH audit data. This analysis excludes institutions for mental disease and hospitals that are outside of the state that the Medicaid program operates in.

[33] In addition, the Families First and Coronavirus Response Act of 2020 (P.L. 116-127) provided an option for states to provide Medicaid coverage for diagnostic testing to uninsured individuals with COVID-19.

[34] For the purposes of distributing provider relief funding, the Health Resources and Services Administration defined safety net providers as acute care facilities with a disproportionate patient percentage (a measure used for calculation of Medicare DSH payments) of more than 20.2 percent, annual uncompensated care of more than $25,000 per bed, and a profit margin of 3 percent or less. Children's hospitals were also included if more than 20.2 percent of their inpatients were Medicaid patients (HRSA 2021).

[35] FY 2020 cost report data includes fiscal quarters before the pandemic started (CDC 2022).

[36] 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.

[37] For states to spend the same amount of DSH funding in FY 2024 as they spent in FY 2020, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[38] 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).

[39] 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).

[40] All estimates of FY 2023 DSH allotments and the different measures of need are using the ARPA-enhanced allotments, which applied an enhanced FMAP of 6.2 percentage points to total DSH funding (state and federal amounts). To see our FY 2023 DSH allotment estimates with and without ARPA's enhanced allotments, please refer to Appendix 4A.

[41] For Medicaid DSH purposes, uncompensated care includes Medicaid shortfall, which is not included in the Medicare cost report definition of uncompensated care. As a result, the total amount of uncompensated care reported on Medicare cost reports may differ from the amount of uncompensated care costs that states can pay for with Medicaid DSH funds.

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APPENDIX 4A: State-Level Data

TABLE 4A-1. State DSH allotments, FYs 2023–2024 (millions)

State	FY 2023 without ARPA adjustment		FY 2023 with ARPA adjustment		FY 2024 without ARPA adjustment	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$14,466.6**	**$25,401.9**	**$16,041.5**	**$11,904.3**	**$6,824.2**
Alabama	**560.1**	405.7	**560.1**	440.4	**302.3**	219.0
Alaska	**53.7**	26.9	**53.7**	30.2	**50.2**	25.1
Arizona	**192.0**	133.6	**192.0**	145.5	**142.6**	99.2
Arkansas	**79.8**	56.9	**79.8**	61.9	**64.6**	46.0
California	**2,892.5**	1,446.3	**2,892.5**	1,625.6	**1,740.5**	870.2
Colorado	**244.1**	122.0	**244.1**	137.2	**129.3**	64.7
Connecticut	**527.7**	263.9	**527.7**	296.6	**284.8**	142.4
Delaware	**20.4**	11.9	**20.4**	13.2	**16.8**	9.8
District of Columbia	**115.4**	80.8	**115.4**	88.0	**49.1**	34.4
Florida	**439.4**	263.9	**439.4**	291.1	**255.8**	153.6
Georgia	**537.0**	354.6	**537.0**	387.9	**309.5**	204.3
Hawaii	**22.9**	12.9	**22.9**	14.3	**20.6**	11.5
Idaho	**30.9**	21.7	**30.9**	23.6	**26.2**	18.4
Illinois	**567.3**	283.6	**567.3**	318.8	**143.5**	71.8
Indiana	**429.5**	282.0	**429.5**	308.6	**190.6**	125.1
Iowa	**82.3**	52.0	**82.3**	57.1	**75.3**	47.5
Kansas	**91.1**	54.4	**91.1**	60.1	**48.8**	29.2
Kentucky	**265.1**	191.3	**265.1**	207.7	**87.2**	63.0
Louisiana	**1,344.5**	904.6	**1,344.5**	987.9	**637.2**	428.7
Maine	**218.9**	138.5	**218.9**	152.1	**134.3**	85.0
Maryland	**201.2**	100.6	**201.2**	113.1	**96.8**	48.4
Massachusetts	**804.8**	402.4	**804.8**	452.3	**196.1**	98.0
Michigan	**540.3**	349.6	**540.3**	383.1	**68.0**	44.0
Minnesota	**194.0**	98.5	**194.0**	110.6	**166.7**	84.7
Mississippi	**258.4**	201.2	**258.4**	217.2	**167.8**	130.6
Missouri	**949.7**	625.0	**949.7**	683.9	**368.0**	242.2
Montana	**23.4**	15.0	**23.4**	16.4	**22.5**	14.4
Nebraska	**64.5**	37.3	**64.5**	41.3	**55.9**	32.4

TABLE 4A-1. (continued)

State	FY 2023 without ARPA adjustment		FY 2023 with ARPA adjustment		FY 2024 without ARPA adjustment	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$25,401.9**	**$14,466.6**	**$25,401.9**	**$16,041.5**	**$11,904.3**	**$6,824.2**
Nevada	**97.4**	61.0	**97.4**	67.1	**41.1**	25.7
New Hampshire	**422.4**	211.2	**422.4**	237.4	**118.7**	59.4
New Jersey	**1,698.6**	849.3	**1,698.6**	954.6	**921.7**	460.9
New Mexico	**36.7**	26.9	**36.7**	29.1	**32.4**	23.7
New York	**4,238.2**	2,119.1	**4,238.2**	2,381.9	**1,578.0**	789.0
North Carolina	**574.8**	389.2	**574.8**	424.8	**254.7**	172.5
North Dakota	**24.4**	12.6	**24.4**	14.1	**23.3**	12.0
Ohio	**843.0**	536.0	**843.0**	588.2	**217.9**	138.5
Oklahoma	**70.9**	47.8	**70.9**	52.2	**61.1**	41.1
Oregon	**99.0**	59.7	**99.0**	65.9	**79.3**	47.8
Pennsylvania	**1,423.9**	740.5	**1,423.9**	828.7	**480.6**	249.9
Rhode Island	**158.9**	85.8	**158.9**	95.6	**16.3**	8.8
South Carolina	**612.2**	432.1	**612.2**	470.0	**229.7**	162.1
South Dakota	**25.7**	14.6	**25.7**	16.2	**24.7**	14.0
Tennessee[1]	**80.3**	53.1	**80.3**	58.1	**80.3**	53.1
Texas	**2,107.2**	1,261.6	**2,107.2**	1,392.2	**1,359.4**	813.9
Utah	**39.3**	25.9	**39.3**	28.3	**32.3**	21.3
Vermont	**53.2**	29.7	**53.2**	33.0	**18.2**	10.2
Virginia	**228.2**	115.6	**228.2**	129.7	**88.6**	44.9
Washington	**488.1**	244.1	**488.1**	274.3	**145.3**	72.6
West Virginia	**120.3**	89.1	**120.3**	96.5	**65.3**	48.3
Wisconsin	**207.5**	124.7	**207.5**	137.6	**184.0**	110.6
Wyoming	**0.6**	0.3	**0.6**	0.3	**0.5**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. ARPA is the American Rescue Plan Act of 2021 (P.L. 117-2), which provided increased DSH allotments to states during the COVID-19 public health emergency. This table assumes no ARPA increased DSH allotments for FY 2024. State and federal totals are different from data reported on the Centers for Medicare & Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES) because MBES estimates apply a traditional federal medical assistance percentage (FMAP) to the ARPA-increased federal allotment.

[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).

Sources: MACPAC, 2023, analysis of CMS MBES and CBO 2022.

TABLE 4A-2. FY 2024 DSH Allotment Reductions by State (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Reductions as a percent of unreduced allotments
Total	**$26,030.2**	**$14,824.2**	**$14,125.9**	**$8,000.0**	**54.0%**
Alabama	**574.0**	415.7	**271.7**	196.8	47.3
Alaska	**55.1**	27.5	**4.9**	2.4	8.9
Arizona	**196.8**	136.9	**54.2**	37.7	27.5
Arkansas	**81.8**	58.3	**17.2**	12.3	21.0
California	**2,964.3**	1,482.2	**1,223.8**	611.9	41.3
Colorado	**250.1**	125.1	**120.8**	60.4	48.3
Connecticut	**540.8**	270.4	**256.1**	128.0	47.3
Delaware	**20.9**	12.2	**4.2**	2.4	19.9
District of Columbia	**118.3**	82.8	**69.2**	48.4	58.5
Florida	**450.3**	270.4	**194.5**	116.8	43.2
Georgia	**550.4**	363.4	**240.9**	159.1	43.8
Hawaii	**23.5**	13.2	**2.9**	1.6	12.5
Idaho	**31.7**	22.2	**5.5**	3.8	17.3
Illinois	**581.4**	290.7	**437.8**	218.9	75.3
Indiana	**440.1**	289.0	**249.5**	163.9	56.7
Iowa	**84.3**	53.2	**9.1**	5.7	10.8
Kansas	**93.3**	55.8	**44.5**	26.6	47.7
Kentucky	**271.6**	196.0	**184.4**	133.1	67.9
Louisiana	**1,377.9**	927.0	**740.7**	498.3	53.8
Maine	**224.3**	142.0	**90.0**	57.0	40.1
Maryland	**206.2**	103.1	**109.4**	54.7	53.1
Massachusetts	**824.7**	412.4	**628.6**	314.3	76.2
Michigan	**553.7**	358.3	**485.7**	314.3	87.7
Minnesota	**198.8**	101.0	**32.1**	16.3	16.2
Mississippi	**264.8**	206.2	**97.0**	75.6	36.6
Missouri	**973.3**	640.5	**605.3**	398.4	62.2
Montana	**23.9**	15.3	**1.5**	0.9	6.2
Nebraska	**66.1**	38.3	**10.2**	5.9	15.4
Nevada	**99.8**	62.5	**58.7**	36.8	58.8
New Hampshire	**432.9**	216.5	**314.2**	157.1	72.6

TABLE 4A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Reductions as a percent of unreduced allotments
Total	**$26,030.2**	**$14,824.2**	**$14,125.9**	**$8,000.0**	**54.0%**
New Jersey	**1,740.7**	870.4	**819.0**	409.5	47.1
New Mexico	**37.6**	27.5	**5.2**	3.8	13.9
New York	**4,343.4**	2,171.7	**2,765.3**	1,382.7	63.7
North Carolina	**589.1**	398.8	**334.3**	226.4	56.8
North Dakota	**25.1**	12.9	**1.7**	0.9	6.8
Ohio	**863.9**	549.3	**646.0**	410.7	74.8
Oklahoma	**72.7**	49.0	**11.6**	7.8	16.0
Oregon	**101.5**	61.2	**22.2**	13.4	21.8
Pennsylvania	**1,459.3**	758.8	**978.7**	508.9	67.1
Rhode Island	**162.9**	87.9	**146.6**	79.1	90.0
South Carolina	**627.4**	442.8	**397.7**	280.7	63.4
South Dakota	**26.3**	14.9	**1.6**	0.9	6.1
Tennessee[1]	**80.3**	53.1	**—**	—	—
Texas	**2,159.5**	1,292.9	**800.1**	479.0	37.1
Utah	**40.2**	26.5	**7.9**	5.2	19.7
Vermont	**54.5**	30.4	**36.3**	20.2	66.5
Virginia	**233.9**	118.4	**145.2**	73.6	62.1
Washington	**500.2**	250.1	**355.0**	177.5	71.0
West Virginia	**123.3**	91.3	**58.0**	42.9	47.0
Wisconsin	**212.7**	127.8	**28.6**	17.2	13.5
Wyoming	**0.6**	0.3	**0.1**	0.1	17.0

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. This table assumes that FY 2024 DSH allotments are not increased based on the adjustment included in the American Rescue Plan Act of 2021 (P.L. 117-2) that applies during the public health emergency. MACPAC lacks the data to estimate the budget neutrality factor, and therefore, that factor is not used in our estimates. For further discussion of methodology and limitations, see Appendix 4B.

— Dash indicates zero.

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

Sources: MACPAC, 2023, analysis of CBO 2022, Census 2022, SPRY 2017-2018 as-filed Medicaid DSH Audits, and Dobson and DaVanzo 2016.

TABLE 4A-3. Number of Uninsured Individuals and Uninsured Rate by State, 2019–2021

State	2019		2021		Difference in uninsured (2019–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population
Total	**29,639**	**9.2%**	**28,227**	**8.6%**	**-1,412**	**-0.5%**
Alabama	469	9.7	489	9.9	20	0.1
Alaska	86	12.2	80	11.4	-6	-0.8
Arizona	809	11.3	766	10.7	-43	-0.6
Arkansas	271	9.1	273	9.2	2	0.0
California	3,002	7.7	2,713	7.0	-289	-0.7
Colorado	453	8.0	455	8.0	2	0.0
Connecticut	207	5.9	184	5.2	-23	-0.7
Delaware	63	6.6	57	5.7	-6	-0.8
District of Columbia	25	3.5	24	3.7	-1	0.2
Florida	2,784	13.2	2,598	12.1	-186	-1.1
Georgia	1,398	13.4	1,339	12.6	-59	-0.8
Hawaii	56	4.2	54	3.9	-2	-0.2
Idaho	191	10.8	166	8.8	-25	-2.0
Illinois	923	7.4	875	7.0	-48	-0.4
Indiana	578	8.7	504	7.5	-74	-1.2
Iowa	156	5.0	151	4.8	-5	-0.2
Kansas	262	9.2	264	9.2	2	0.0
Kentucky	283	6.4	251	5.7	-32	-0.8
Louisiana	404	8.9	345	7.6	-59	-1.3
Maine	107	8.0	78	5.7	-29	-2.3
Maryland	357	6.0	369	6.1	12	0.1
Massachusetts	204	3.0	173	2.5	-31	-0.5
Michigan	571	5.8	495	5.0	-76	-0.8
Minnesota	273	4.9	252	4.5	-21	-0.4
Mississippi	377	13.0	343	11.9	-34	-1.1
Missouri	604	10.0	571	9.4	-33	-0.6
Montana	87	8.3	89	8.2	2	-0.1
Nebraska	158	8.3	138	7.1	-20	-1.2
Nevada	348	11.4	362	11.6	14	0.2

TABLE 4A-3. (continued)

State	2019		2021		Difference in uninsured (2019–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population
Total	**29,639**	**9.2%**	**28,227**	**8.6%**	**-1,412**	**-0.5%**
New Hampshire	84	6.3	71	5.1	-13	-1.1
New Jersey	692	7.9	657	7.2	-35	-0.7
New Mexico	205	10.0	207	10.0	2	0.0
New York	1,007	5.2	1,019	5.2	12	0.0
North Carolina	1,157	11.3	1,078	10.4	-79	-0.8
North Dakota	51	6.9	59	7.9	8	1.0
Ohio	758	6.6	758	6.5	0	-0.1
Oklahoma	553	14.3	538	13.8	-15	-0.5
Oregon	299	7.2	255	6.1	-44	-1.1
Pennsylvania	726	5.8	702	5.5	-24	-0.3
Rhode Island	43	4.1	47	4.3	4	0.3
South Carolina	548	10.8	512	10.0	-36	-0.8
South Dakota	88	10.2	83	9.5	-5	-0.7
Tennessee	682	10.1	686	10.0	4	-0.2
Texas	5,234	18.4	5,224	18.0	-10	-0.4
Utah	307	9.7	299	9.0	-8	-0.6
Vermont	28	4.5	23	3.7	-5	-0.8
Virginia	658	7.9	574	6.8	-84	-1.1
Washington	496	6.6	488	6.4	-8	-0.2
West Virginia	118	6.7	107	6.1	-11	-0.6
Wisconsin	329	5.7	312	5.4	-17	-0.4
Wyoming	70	12.3	69	12.2	-1	-0.2

Notes: 0.0 indicates an amount between -5,000 and 5,000 that rounds to zero; 0.0 percent indicates an amount between 0.05 percent and 0.05 percent that rounds to zero. Data are taken from the U.S. Census Bureau's American Community Survey. The American Community Survey released synthetic data for calendar year 2020, which means that they are estimates of state-level uninsured rates using multiple sources. Therefore, we are showing changes in the uninsured rate between 2019 and 2021.

Sources: MACPAC, 2023, analysis of Census 2022 and Keisler-Starkey and Bunch 2022.

TABLE 4A-4. State Levels of Uncompensated Care, FYs 2019–2020

State	Total hospital uncompensated care costs, 2019		Total hospital uncompensated care costs, 2020		Difference in total hospital uncompensated care costs, 2020-2019	
	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	**$40,524**	**4.0%**	**$41,901**	**4.1%**	**$1,376**	**0.0%**
Alabama	**748**	6.5	**814**	6.7	**66**	0.2
Alaska	**53**	2.7	**51**	2.6	**-1**	-0.1
Arizona	**451**	2.7	**486**	2.8	**35**	0.1
Arkansas	**232**	3.3	**268**	3.7	**37**	0.5
California	**2,498**	2.0	**2,570**	2.3	**72**	0.3
Colorado	**409**	2.6	**446**	2.7	**37**	0.1
Connecticut	**239**	1.9	**264**	1.9	**26**	0.0
Delaware	**83**	2.5	**91**	2.7	**9**	0.1
District of Columbia	**64**	1.6	**65**	1.7	**1**	0.0
Florida	**3,891**	7.4	**4,111**	7.6	**220**	0.1
Georgia	**2,369**	8.7	**2,586**	9.2	**218**	0.5
Hawaii	**52**	1.5	**58**	1.7	**6**	0.2
Idaho	**203**	3.6	**182**	3.1	**-21**	-0.5
Illinois	**1,591**	3.9	**1,680**	4.0	**89**	0.1
Indiana	**862**	3.5	**805**	3.2	**-57**	-0.3
Iowa	**218**	2.2	**208**	2.0	**-9**	-0.2
Kansas	**403**	4.1	**416**	4.1	**13**	0.0
Kentucky	**342**	2.3	**332**	2.2	**-10**	-0.2
Louisiana	**406**	2.8	**414**	2.7	**8**	-0.1
Maine	**184**	3.0	**204**	3.2	**20**	0.2
Maryland	**550**	3.3	**625**	3.7	**76**	0.3
Massachusetts	**479**	1.7	**548**	1.8	**69**	0.2
Michigan	**619**	1.8	**619**	1.8	**-1**	0.0
Minnesota	**349**	1.7	**336**	1.6	**-13**	-0.1
Mississippi	**571**	7.0	**595**	7.1	**24**	0.2
Missouri	**1,267**	5.9	**1,336**	6.1	**68**	0.2
Montana	**88**	2.0	**92**	2.0	**4**	0.0
Nebraska	**310**	4.6	**297**	4.2	**-12**	-0.4

TABLE 4A-4. (continued)

State	Total hospital uncompensated care costs, 2019		Total hospital uncompensated care costs, 2020		Difference in total hospital uncompensated care costs, 2020-2019	
	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	**$40,524**	**4.0%**	**$41,901**	**4.1%**	**$1,376**	**0.0%**
Nevada	**274**	4.3	**296**	4.5	**22**	0.2
New Hampshire	**160**	3.0	**158**	2.9	**-2**	-0.1
New Jersey	**1,089**	4.3	**1,186**	4.4	**97**	0.1
New Mexico	**154**	2.6	**158**	2.6	**4**	0.0
New York	**2,299**	2.8	**2,300**	2.7	**0**	-0.2
North Carolina	**1,841**	6.2	**1,982**	6.4	**141**	0.3
North Dakota	**92**	2.2	**103**	2.4	**11**	0.3
Ohio	**1,153**	2.9	**1,165**	2.8	**13**	0.0
Oklahoma	**765**	6.9	**772**	6.7	**8**	-0.2
Oregon	**368**	2.7	**381**	2.8	**13**	0.1
Pennsylvania	**866**	1.9	**838**	1.8	**-28**	-0.2
Rhode Island	**67**	1.7	**73**	1.9	**6**	0.2
South Carolina	**920**	6.6	**918**	6.1	**-2**	-0.5
South Dakota	**134**	3.0	**132**	2.7	**-2**	-0.3
Tennessee	**1,167**	5.8	**1,131**	5.4	**-36**	-0.4
Texas	**6,899**	10.7	**7,298**	10.7	**399**	0.0
Utah	**366**	4.5	**336**	4.0	**-30**	-0.6
Vermont	**55**	2.0	**49**	1.7	**-6**	-0.3
Virginia	**1,097**	5.1	**839**	3.8	**-257**	-1.2
Washington	**519**	2.2	**534**	2.2	**15**	0.0
West Virginia	**197**	2.7	**237**	3.2	**40**	0.5
Wisconsin	**410**	1.8	**417**	1.8	**7**	0.0
Wyoming	**103**	5.7	**97**	5.2	**-6**	-0.5

Notes: FY is fiscal year. Uncompensated care is calculated using Medicare cost reports, which define uncompensated care as charity care and non-Medicare and non-reimbursable Medicare bad debt. 0.0 indicates an amount between -500,000 and 500,000 that rounds to zero; 0.0 percent indicates an amount between 0.05 percent and 0.05 percent that rounds to zero. 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.

Source: MACPAC, 2023, analysis of Medicare cost reports for FYs 2019–2020.

TABLE 4A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria by State, FY 2018

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	**5,957**	**2,507**	**42%**	**749**	**13%**	**695**	**12%**
Alabama	114	78	68	7	6	7	6
Alaska	24	3	13	1	4	1	4
Arizona	114	41	36	39	34	34	30
Arkansas	104	7	7	1	1	1	1
California[1]	408	26	6	23	6	15	4
Colorado	104	35	34	12	12	12	12
Connecticut	39	7	18	3	8	3	8
Delaware[2]	15	3	20	3	20	3	20
District of Columbia	12	7	58	5	42	4	33
Florida	251	72	29	33	13	32	13
Georgia	164	121	74	20	12	18	11
Hawaii	26	12	46	2	8	2	8
Idaho	51	25	49	7	14	6	12
Illinois	203	8	4	8	4	8	4
Indiana	165	55	33	11	7	10	6
Iowa	123	10	8	9	7	9	7
Kansas	149	63	42	18	12	18	12
Kentucky	116	98	84	43	37	38	33
Louisiana	205	61	30	39	19	36	18
Maine	38	1	3	1	3	1	3
Maryland	58	10	17	7	12	7	12
Massachusetts[3]	97	–	–	–	–	–	–
Michigan	161	106	66	9	6	9	6
Minnesota	140	30	21	10	7	10	7

TABLE 4A-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	**5,957**	**2,507**	**42%**	**749**	**13%**	**695**	**12%**
Mississippi	108	59	55	18	17	18	17
Missouri	136	102	75	23	17	22	16
Montana	66	7	11	4	6	4	6
Nebraska	98	26	27	9	9	9	9
Nevada	57	20	35	4	7	4	7
New Hampshire	30	26	87	4	13	4	13
New Jersey	97	76	78	25	26	25	26
New Mexico	55	8	15	5	9	4	7
New York	196	185	94	44	22	44	22
North Carolina	128	82	64	22	17	21	16
North Dakota	50	2	4	1	2	1	2
Ohio	229	155	68	15	7	15	7
Oklahoma	145	57	39	12	8	11	8
Oregon	63	21	33	10	16	10	16
Pennsylvania	223	166	74	34	15	28	13
Rhode Island	14	10	71	2	14	2	14
South Carolina	84	60	71	16	19	14	17
South Dakota	61	21	34	10	16	10	16
Tennessee	139	70	50	24	17	16	12
Texas	575	177	31	93	16	92	16
Utah	58	38	66	6	10	5	9
Vermont	16	13	81	1	6	1	6
Virginia	109	37	34	7	6	6	6
Washington	105	60	57	15	14	12	11

TABLE 4A-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	**5,957**	**2,507**	**42%**	**749**	**13%**	**695**	**12%**
West Virginia	62	43	69	14	23	13	21
Wisconsin	143	93	65	16	11	16	11
Wyoming	29	14	48	4	14	4	14

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 80 DSH hospitals that did not submit an FY 2020 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 (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] Delaware did not submit a state plan rate year (SPRY) 2018 DSH audit, and this analysis uses its SPRY 2017 DSH audit.

[3] 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 eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Sources: MACPAC, 2023, analysis of AHA 2022, Medicare cost reports for FY 2020, and SPRY 2017–2018 as-filed Medicaid DSH audits.

TABLE 4A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals by State, SPRY 2018

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	**772,886**	**441,276**	**57%**	**148,203**	**19%**	**43,091**	**26,920**	**62%**	**12,447**	**29%**
Alabama	14,661	13,006	89	842	6	697	633	91	105	15
Alaska	1,410	593	42	80	6	104	54	52	3	2
Arizona	15,249	7,434	49	7,233	47	996	669	67	658	66
Arkansas	9,354	978	10	127	1	374	32	8	2	0
California[1]	72,651	4,765	7	3,268	4	4,958	437	9	294	6
Colorado	10,757	4,753	44	1,990	19	673	365	54	195	29
Connecticut	7,672	1,174	15	553	7	493	66	13	47	10
Delaware[2]	2,632	473	18	473	18	147	35	24	35	24
District of Columbia	2,970	2,176	73	1,076	36	238	184	77	98	41
Florida	56,029	23,309	42	12,740	23	2,805	1,638	58	1,166	42
Georgia	22,138	18,337	83	5,202	23	1,227	1,092	89	473	39
Hawaii	2,651	2,267	86	261	10	183	171	93	48	26
Idaho	3,180	2,451	77	1,046	33	132	114	87	56	43
Illinois	30,205	1,865	6	1,865	6	1,682	118	7	118	7
Indiana	16,998	7,986	47	3,810	22	913	543	59	358	39
Iowa	7,344	2,580	35	2,534	35	337	216	64	213	63
Kansas	8,379	4,779	57	3,256	39	266	201	76	183	69
Kentucky	14,217	13,230	93	4,815	34	895	841	94	369	41
Louisiana	16,449	8,564	52	3,408	21	801	411	51	210	26
Maine	2,985	51	2	51	2	135	1	0	1	0
Maryland	12,544	2,449	20	1,721	14	819	115	14	45	5
Massachusetts[3]	18,733	–	–	–	–	1,456	–	–	–	–
Michigan	23,953	17,610	74	2,080	9	1,354	936	69	194	14
Minnesota	11,284	6,175	55	1,975	17	623	467	75	202	32
Mississippi	10,090	5,562	55	2,260	22	420	251	60	150	36
Missouri	18,194	13,994	77	2,523	14	933	595	64	164	18

TABLE 4A-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	**772,886**	**441,276**	**57%**	**148,203**	**19%**	**43,091**	**26,920**	**62%**	**12,447**	**29%**
Montana	2,927	351	12	231	8	108	17	16	12	11
Nebraska	5,571	3,758	67	1,409	25	184	174	95	103	56
Nevada	7,403	4,447	60	1,459	20	538	415	77	205	38
New Hampshire	2,787	2,561	92	859	31	122	118	97	73	60
New Jersey	21,380	19,816	93	6,472	30	1,081	1,034	96	464	43
New Mexico	4,297	1,018	24	217	5	339	87	26	13	4
New York	45,210	44,291	98	9,326	21	3,553	3,487	98	991	28
North Carolina	22,126	19,241	87	7,321	33	1,211	1,136	94	517	43
North Dakota	2,587	132	5	25	1	87	2	3	0	0
Ohio	32,142	26,922	84	5,432	17	1,790	1,525	85	581	32
Oklahoma	11,107	6,833	62	769	7	480	318	66	28	6
Oregon	6,940	3,921	56	1,704	25	444	309	70	175	39
Pennsylvania	35,818	32,266	90	6,614	18	1,825	1,744	96	606	33
Rhode Island	2,849	2,129	75	869	31	168	148	88	99	59
South Carolina	12,234	10,927	89	3,410	28	592	572	97	291	49
South Dakota	2,739	1,909	70	1,549	57	90	87	96	81	90
Tennessee	18,602	14,159	76	5,618	30	952	825	87	469	49
Texas	68,275	39,084	57	19,878	29	3,074	2,429	79	1,571	51
Utah	5,460	4,475	82	968	18	224	209	93	75	34
Vermont	1,135	972	86	415	37	52	52	100	30	58
Virginia	16,409	9,842	60	2,406	15	736	554	75	209	28
Washington	11,978	9,120	76	1,439	12	860	663	77	133	15
West Virginia	5,834	5,145	88	1,703	29	324	309	95	150	46
Wisconsin	12,986	10,639	82	2,679	21	573	513	90	180	31
Wyoming	1,364	758	56	245	18	22	11	50	4	19

TABLE 4A-6. (continued)

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Excludes 80 DSH hospitals that did not submit a fiscal year (FY) 2020 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 4B.

— 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] Delaware did not submit a SPRY 2018 DSH audit, and this analysis uses its SPRY 2017 DSH audit.

[3] 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 eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

Sources: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits and Medicare cost reports for FYs 2018–2020.

TABLE 4A-7. Medicaid Payments to DSH Hospitals as a Share of Costs by State, SPRY 2018

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**40%**	**78%**	**8%**	**9%**	**95%**	**69%**	**7%**	**8%**	**85%**
Alabama	68	72	25	20	**117**	58	21	16	**95**
Alaska	8	96	–	1	**97**	94	–	1	**95**
Arizona	35	64	10	4	**77**	61	9	4	**74**
Arkansas[1]	6	69	23	25	**118**	65	22	24	**111**
California[2]	6	86	6	13	**105**	84	5	13	**102**
Colorado	34	68	24	9	**101**	64	23	8	**95**
Connecticut	10	79	8	3	**90**	78	8	3	**89**
Delaware[3]	13	94	–	18	**112**	84	–	16	**100**
District of Columbia	25	67	4	15	**86**	64	4	14	**82**
Florida	27	74	12	3	**89**	61	10	3	**74**
Georgia	73	83	7	9	**99**	64	5	7	**76**
Hawaii	46	79	14	2	**96**	78	14	2	**94**
Idaho	49	97	2	4	**102**	85	1	3	**90**
Illinois	2	71	0	36	**107**	47	0	24	**71**
Indiana	33	89	1	10	**99**	83	1	10	**93**
Iowa	8	80	3	11	**94**	78	3	10	**91**
Kansas	40	85	5	8	**98**	70	4	7	**81**
Kentucky	78	96	0	5	**102**	94	0	5	**99**
Louisiana	28	67	1	36	**104**	62	1	34	**97**
Maryland	10	106	–	4	**110**	96	–	3	**99**
Michigan	62	90	4	5	**99**	88	4	5	**97**
Minnesota	18	86	5	1	**92**	83	5	1	**89**
Mississippi	55	86	19	15	**121**	71	16	13	**99**
Missouri	68	94	–	16	**110**	79	–	13	**93**

TABLE 4A-7. (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**40%**	**78%**	**8%**	**9%**	**95%**	**69%**	**7%**	**8%**	**85%**
Montana[1]	11	76	35	1	**112**	73	33	1	**106**
Nebraska	24	77	2	5	**84**	65	2	4	**71**
Nevada	35	71	13	6	**90**	66	12	5	**83**
New Hampshire	83	69	0	27	**95**	64	0	25	**89**
New Jersey	67	80	4	8	**93**	69	4	7	**80**
New Mexico	15	92	3	7	**101**	89	3	6	**98**
New York	84	74	3	12	**89**	70	3	12	**85**
North Carolina	59	71	34	6	**110**	57	27	5	**89**
North Dakota[1]	2	100	6	3	**109**	92	6	3	**100**
Ohio	66	78	4	7	**89**	74	4	6	**85**
Oklahoma	37	76	31	3	**110**	62	25	2	**89**
Oregon[1]	30	97	6	3	**105**	94	5	3	**103**
Pennsylvania	72	54	9	6	**70**	52	9	6	**67**
Rhode Island	71	87	2	12	**101**	83	2	12	**97**
South Carolina	63	84	4	16	**104**	69	3	13	**85**
South Dakota	33	98	2	1	**101**	88	2	1	**91**
Tennessee	47	82	18	2	**101**	70	15	2	**87**
Texas	29	79	14	17	**110**	57	10	12	**80**
Utah[1]	64	102	20	3	**126**	84	16	3	**103**
Vermont	81	77	–	6	**84**	74	–	6	**81**
Virginia	34	80	14	5	**99**	65	11	4	**79**
Washington	55	83	2	6	**91**	80	2	6	**88**
West Virginia	65	67	15	3	**86**	65	15	3	**83**
Wisconsin	63	82	1	2	**85**	79	1	2	**82**
Wyoming	48	79	18	1	**97**	58	13	0	**72**

TABLE 4A-7. (continued)

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. A total of 2,355 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2020 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. The analysis also excludes Massachusetts, which does not make DSH payments to hospitals because it has a demonstration waiver under Section 1115 of the Social Security Act that allows the commonwealth to distribute DSH funding to hospitals through safety-net care pools. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on Medicaid DSH audits). States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care payment or as a supplemental payment. Payments shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers may not sum due to rounding.

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

[1] These states had DSH payments more than 100 percent of Medicaid costs and unpaid costs of care for the uninsured, according to as-filed DSH audits. Because DSH payments cannot exceed a hospital's Medicaid costs and unpaid costs of care for the uninsured, the Centers for Medicare & Medicaid Services (CMS) will recoup these funds. Final DSH payment amounts may change after CMS finalizes its review of DSH audits.

[2] DSH payments in California do not include 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. California also has a special exception to DSH payments, and some hospitals can be paid up to 175% of uncompensated care costs.

[3] Delaware has not submitted a SPRY 2018 as-filed DSH audit. This analysis uses SPRY 2017 Delaware DSH audit data.

Source: MACPAC, 2023, analysis of SPRY 2017–2018 as-filed Medicaid DSH audits.

TABLE 4A-8. FY 2023 DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual by State

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per uninsured individual (thousands)		FY 2023 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$25,401.9**	**$16,041.5**	**$899.9**	**$568.3**	**$326.4**	**$206.1**
Alabama	**560.1**	440.4	**1,146.4**	901.4	**388.4**	305.4
Alaska	**53.7**	30.2	**671.1**	377.2	**353.1**	198.4
Arizona	**192.0**	145.5	**250.7**	189.9	**107.7**	81.6
Arkansas	**79.8**	61.9	**292.3**	226.6	**85.5**	66.3
California	**2,892.5**	1,625.6	**1,066.4**	599.3	**319.9**	179.8
Colorado	**244.1**	137.2	**536.0**	301.2	**223.7**	125.7
Connecticut	**527.7**	296.6	**2,875.4**	1,615.9	**828.6**	465.6
Delaware	**20.4**	13.2	**360.0**	232.9	**99.0**	64.0
District of Columbia	**115.4**	88.0	**4,764.9**	3,630.8	**822.0**	626.4
Florida	**439.4**	291.1	**169.1**	112.0	**82.5**	54.7
Georgia	**537.0**	387.9	**401.1**	289.7	**190.8**	137.8
Hawaii	**22.9**	14.3	**421.1**	262.2	**86.4**	53.8
Idaho	**30.9**	23.6	**186.4**	142.3	**65.2**	49.7
Illinois	**567.3**	318.8	**648.3**	364.3	**203.4**	114.3
Indiana	**429.5**	308.6	**851.5**	611.9	**263.6**	189.4
Iowa	**82.3**	57.1	**544.0**	377.2	**121.9**	84.5
Kansas	**91.1**	60.1	**345.3**	227.8	**133.7**	88.2
Kentucky	**265.1**	207.7	**1,056.9**	828.3	**204.0**	159.9
Louisiana	**1,344.5**	987.9	**3,891.5**	2,859.5	**918.9**	675.2
Maine	**218.9**	152.1	**2,819.1**	1,959.0	**829.4**	576.3
Maryland	**201.2**	113.1	**544.8**	306.2	**183.2**	102.9
Massachusetts	**804.8**	452.3	**4,661.1**	2,619.6	**702.7**	394.9
Michigan	**540.3**	383.1	**1,090.6**	773.3	**222.7**	157.9
Minnesota	**194.0**	110.6	**770.4**	439.1	**189.6**	108.1
Mississippi	**258.4**	217.2	**753.4**	633.3	**270.6**	227.5
Missouri	**949.7**	683.9	**1,663.6**	1,197.9	**641.7**	462.1
Montana	**23.4**	16.4	**261.1**	183.6	**89.3**	62.8
Nebraska	**64.5**	41.3	**468.8**	300.4	**155.2**	99.4
Nevada	**97.4**	67.1	**269.3**	185.4	**115.9**	79.8
New Hampshire	**422.4**	237.4	**5,991.0**	3,367.0	**2,324.8**	1,306.5
New Jersey	**1,698.6**	954.6	**2,586.4**	1,453.6	**1,024.3**	575.6

TABLE 4A-8. (continued)

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per uninsured individual (thousands)		FY 2023 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$25,401.9**	**$16,041.5**	**$899.9**	**$568.3**	**$326.4**	**$206.1**
New Mexico	**36.7**	29.1	**177.1**	140.7	**54.5**	43.3
New York	**4,238.2**	2,381.9	**4,158.0**	2,336.8	**947.4**	532.4
North Carolina	**574.8**	424.8	**533.1**	394.0	**214.1**	158.2
North Dakota	**24.4**	14.1	**411.6**	237.7	**149.4**	86.3
Ohio	**843.0**	588.2	**1,112.5**	776.3	**302.4**	211.0
Oklahoma	**70.9**	52.2	**131.9**	97.0	**59.2**	43.5
Oregon	**99.0**	65.9	**387.6**	257.8	**101.8**	67.7
Pennsylvania	**1,423.9**	828.7	**2,029.7**	1,181.3	**531.6**	309.4
Rhode Island	**158.9**	95.6	**3,385.3**	2,036.6	**720.2**	433.2
South Carolina	**612.2**	470.0	**1,195.8**	918.1	**447.8**	343.8
South Dakota	**25.7**	16.2	**308.2**	194.0	**132.3**	83.2
Tennessee	**80.3**	58.1	**117.1**	84.7	**43.4**	31.4
Texas	**2,107.2**	1,392.2	**403.4**	266.5	**256.6**	169.6
Utah	**39.3**	28.3	**131.4**	94.8	**55.7**	40.2
Vermont	**53.2**	33.0	**2,275.0**	1,411.0	**465.9**	289.0
Virginia	**228.2**	129.7	**397.4**	225.9	**139.5**	79.3
Washington	**488.1**	274.3	**1,000.2**	562.1	**335.8**	188.7
West Virginia	**120.3**	96.5	**1,126.3**	903.5	**230.3**	184.8
Wisconsin	**207.5**	137.6	**664.7**	440.7	**175.0**	116.1
Wyoming	**0.6**	0.3	**8.6**	4.8	**4.6**	2.6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Non-elderly low-income individuals are defined as individuals younger than age 65 with family incomes less than 200 percent of the federal poverty level. Totals show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 4B.

Sources: MACPAC, 2023, analysis of Census 2022, Keisler-Starkey and Bunch 2022, SPRY 2017–2018 Medicaid as-filed DSH audits, and the CMS MBES.

TABLE 4A-9. FY 2023 DSH Allotment as a Percentage of Hospital Uncompensated Care Costs by State, FY 2020

State	FY 2023 federal DSH allotment (millions)	FY 2023 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2020	FY 2023 DSH funding (state and federal, millions)	FY 2023 total DSH funding as a percentage of hospital uncompensated care in the state, FY 2020
Total	**$16,041.5**	**38.6%**	**$25,401.9**	**61.1%**
Alabama	440.4	54.1	560.1	68.8
Alaska	30.2	59.2	53.7	105.3
Arizona	145.5	29.9	192.0	39.5
Arkansas	61.9	23.0	79.8	29.7
California	1,625.6	64.0	2,892.5	113.8
Colorado	137.2	30.8	244.1	54.8
Connecticut	296.6	112.2	527.7	199.6
Delaware	13.2	14.5	20.4	22.4
District of Columbia	88.0	135.1	115.4	177.3
Florida	291.1	7.1	439.4	10.7
Georgia	387.9	15.1	537.0	21.0
Hawaii	14.3	24.5	22.9	39.4
Idaho	23.6	13.2	30.9	17.3
Illinois	318.8	19.1	567.3	33.9
Indiana	308.6	38.3	429.5	53.3
Iowa	57.1	27.4	82.3	39.5
Kansas	60.1	14.4	91.1	21.9
Kentucky	207.7	63.8	265.1	81.5
Louisiana	987.9	240.2	1,344.5	326.9
Maine	152.1	74.5	218.9	107.2
Maryland	113.1	18.1	201.2	32.2
Massachusetts	452.3	82.6	804.8	147.0
Michigan	383.1	62.0	540.3	87.5
Minnesota	110.6	33.0	194.0	57.8
Mississippi	217.2	36.6	258.4	43.6
Missouri	683.9	51.2	949.7	71.1
Montana	16.4	17.9	23.4	25.4
Nebraska	41.3	13.9	64.5	21.7
Nevada	67.1	22.7	97.4	32.9
New Hampshire	237.4	149.8	422.4	266.6
New Jersey	954.6	81.0	1,698.6	144.1
New Mexico	29.1	18.6	36.7	23.4

TABLE 4A-9. (continued)

State	FY 2023 federal DSH allotment (millions)	FY 2023 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2020	FY 2023 DSH funding (state and federal, millions)	FY 2023 total DSH funding as a percentage of hospital uncompensated care in the state, FY 2020
Total	**$16,041.5**	**38.6%**	**$25,401.9**	**61.1%**
New York	2,381.9	103.8	4,238.2	184.8
North Carolina	424.8	21.4	574.8	29.0
North Dakota	14.1	13.6	24.4	23.6
Ohio	588.2	50.8	843.0	72.7
Oklahoma	52.2	6.8	70.9	9.2
Oregon	65.9	17.3	99.0	26.0
Pennsylvania	828.7	100.0	1,423.9	171.8
Rhode Island	95.6	130.8	158.9	217.4
South Carolina	470.0	51.4	612.2	67.0
South Dakota	16.2	12.3	25.7	19.5
Tennessee	58.1	5.3	80.3	7.3
Texas	1,392.2	19.5	2,107.2	29.6
Utah	28.3	8.4	39.3	11.7
Vermont	33.0	67.3	53.2	108.5
Virginia	129.7	15.5	228.2	27.2
Washington	274.3	52.7	488.1	93.7
West Virginia	96.5	41.2	120.3	51.4
Wisconsin	137.6	33.0	207.5	49.8
Wyoming	0.3	0.4	0.6	0.6

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 show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 4B.

Sources: MACPAC, 2023, analysis of AHA 2022, the CMS MBES, and SPRY 2018 as-filed Medicaid DSH audits.

TABLE 4A-10. FY 2023 DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service by State

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per deemed DSH hospital (millions)		FY 2023 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	**$25,401.9**	**$16,041.5**	**$33.9**	**$21.4**	**$36.5**	**$23.1**
Alabama	**560.1**	440.4	**80.0**	62.9	**80.0**	62.9
Alaska	**53.7**	30.2	**53.7**	30.2	**53.7**	30.2
Arizona	**192.0**	145.5	**4.9**	3.7	**5.6**	4.3
Arkansas	**79.8**	61.9	**79.8**	61.9	**79.8**	61.9
California[1]	**2,892.5**	1,625.6	**125.8**	70.7	**192.8**	108.4
Colorado	**244.1**	137.2	**20.3**	11.4	**20.3**	11.4
Connecticut	**527.7**	296.6	**175.9**	98.9	**175.9**	98.9
Delaware	**20.4**	13.2	**6.8**	4.4	**6.8**	4.4
District of Columbia	**115.4**	88.0	**23.1**	17.6	**28.9**	22.0
Florida	**439.4**	291.1	**13.3**	8.8	**13.7**	9.1
Georgia	**537.0**	387.9	**26.9**	19.4	**29.8**	21.5
Hawaii	**22.9**	14.3	**11.5**	7.1	**11.5**	7.1
Idaho	**30.9**	23.6	**4.4**	3.4	**5.2**	3.9
Illinois	**567.3**	318.8	**70.9**	39.9	**70.9**	39.9
Indiana	**429.5**	308.6	**39.0**	28.1	**42.9**	30.9
Iowa	**82.3**	57.1	**9.1**	6.3	**9.1**	6.3
Kansas	**91.1**	60.1	**5.1**	3.3	**5.1**	3.3
Kentucky	**265.1**	207.7	**6.2**	4.8	**7.0**	5.5
Louisiana	**1,344.5**	987.9	**34.5**	25.3	**37.3**	27.4
Maine	**218.9**	152.1	**218.9**	152.1	**218.9**	152.1
Maryland	**201.2**	113.1	**28.7**	16.2	**28.7**	16.2
Massachusetts[2]	**804.8**	452.3	**–**	–	**–**	–
Michigan	**540.3**	383.1	**60.0**	42.6	**60.0**	42.6
Minnesota	**194.0**	110.6	**19.4**	11.1	**19.4**	11.1

TABLE 4A-10. (continued)

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per deemed DSH hospital (millions)		FY 2023 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	**$25,401.9**	**$16,041.5**	**$33.9**	**$21.4**	**$36.5**	**$23.1**
Mississippi	**258.4**	217.2	**14.4**	12.1	**14.4**	12.1
Missouri	**949.7**	683.9	**41.3**	29.7	**43.2**	31.1
Montana	**23.4**	16.4	**5.8**	4.1	**5.8**	4.1
Nebraska	**64.5**	41.3	**7.2**	4.6	**7.2**	4.6
Nevada	**97.4**	67.1	**24.3**	16.8	**24.3**	16.8
New Hampshire	**422.4**	237.4	**105.6**	59.4	**105.6**	59.4
New Jersey	**1,698.6**	954.6	**67.9**	38.2	**67.9**	38.2
New Mexico	**36.7**	29.1	**7.3**	5.8	**9.2**	7.3
New York	**4,238.2**	2,381.9	**96.3**	54.1	**96.3**	54.1
North Carolina	**574.8**	424.8	**26.1**	19.3	**27.4**	20.2
North Dakota	**24.4**	14.1	**24.4**	14.1	**24.4**	14.1
Ohio	**843.0**	588.2	**56.2**	39.2	**56.2**	39.2
Oklahoma	**70.9**	52.2	**5.9**	4.3	**6.4**	4.7
Oregon	**99.0**	65.9	**9.9**	6.6	**9.9**	6.6
Pennsylvania	**1,423.9**	828.7	**41.9**	24.4	**50.9**	29.6
Rhode Island	**158.9**	95.6	**79.5**	47.8	**79.5**	47.8
South Carolina	**612.2**	470.0	**38.3**	29.4	**43.7**	33.6
South Dakota	**25.7**	16.2	**2.6**	1.6	**2.6**	1.6
Tennessee	**80.3**	58.1	**3.3**	2.4	**5.0**	3.6
Texas	**2,107.2**	1,392.2	**22.7**	15.0	**22.9**	15.1
Utah	**39.3**	28.3	**6.5**	4.7	**7.9**	5.7
Vermont	**53.2**	33.0	**53.2**	33.0	**53.2**	33.0
Virginia	**228.2**	129.7	**32.6**	18.5	**38.0**	21.6
Washington	**488.1**	274.3	**32.5**	18.3	**40.7**	22.9

TABLE 4A-10. (continued)

State	FY 2023 DSH allotment (millions)		FY 2023 DSH allotment per deemed DSH hospital (millions)		FY 2023 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	**$25,401.9**	**$16,041.5**	**$33.9**	**$21.4**	**$36.5**	**$23.1**
West Virginia	**120.3**	96.5	**8.6**	6.9	**9.3**	7.4
Wisconsin	**207.5**	137.6	**13.0**	8.6	**13.0**	8.6
Wyoming	**0.6**	0.3	**0.1**	0.1	**0.1**	0.1

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 80 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 show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 4B.

— 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.

[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 instead; for this reason, no hospitals in the state can be categorized as DSH or deemed DSH hospitals.

Sources: MACPAC, 2023, analysis of AHA 2022, CMS MBES, and SPRY 2018 as-filed Medicaid DSH audits.

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APPENDIX 4B: 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 2018 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, 2,507 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. (Sixty-one 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 dataset.

Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded hospitals in U.S. territories, religious non-medical health care institutions, and hospitals participating in special Medicare demonstration projects. (Ninety-one 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, 2,507 DSH hospitals were included in these analyses. We excluded 80 DSH hospitals without matching 2020 Medicare cost reports.

When using Medicare cost reports to analyze hospital uncompensated care, we excluded hospitals that reported uncompensated care costs that were greater than hospital operating expenses or had missing uncompensated care fields or the operating expenses. A total of 1,471 hospitals were excluded under this criterion.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that were more than 1.5 times the interquartile range above the highest quartiles or below the lowest quartile. (Under this criterion, 386 hospitals were excluded from our analysis of fiscal year (FY) 2020 operating margins.) Operating margins were calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by NPR: (NPR – OE) ÷ NPR. Total margins, in contrast, included additional types of hospital revenue, such as investment income, 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*. 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 2018.

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 2020 American Hospital Association annual survey (Table 4B-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 American Hospital Association annual survey.

TABLE 4B-1. Essential Community Services by Data Source

American Hospital Association annual survey	Burn services
	HIV/AIDS care
	Obstetrics and gynecology services
	Substance use disorder services
Medicare cost reports	Graduate medical education

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 areas 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 determining what FY 2023 allotments would have been without the increase from the American Rescue Plan Act of 2021 (P.L. 117-2), increasing this amount by 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 2022).[42] MACPAC estimated the Medicaid inpatient factor and the uncompensated care factor using state plan rate year 2018 Medicaid DSH audits. MACPAC used 2021 American Community Survey data to estimate the uninsured percentage factor. We could not apply the 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 (Section 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.

Endnote

[42] The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) increased FYs 2020–2023 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 each year and calculated the federal share with an enhanced 6.2 percentage point federal medical assistance percentage (FMAP) for each state. MACPAC estimated FY 2023's non-ARPA enhanced allotment using a similar method and used these estimates to project FY 2024's DSH unreduced and reduced allotment amounts.

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