Chapter 1:

Countercyclical Medicaid Disproportionate Share Hospital Allotments

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Recommendations

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

1.2 Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.

1.3 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on adjusted matching rates;
- an increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
- an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group)

1.4 To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

Key Points

- Unlike other Medicaid payments, DSH payments are capped at the state level by federal allotments.
- Because DSH allotments are set on a federal funding basis, total available state and federal DSH funding decreases when the FMAP increases.
- Periods of normal economic growth result in less total DSH funding for states with declining per capita incomes relative to other states.
- When Congress increases the FMAP during economic recessions, the total available DSH funding for all states is reduced, although the need for DSH payments is greater.
- Calculating DSH allotments on a total funding basis would ensure total DSH funding is not affected by changes in the FMAP, similar to how other limits on Medicaid spending are set.

CHAPTER 1: Countercyclical Medicaid Disproportionate Share Hospital Allotments

Medicaid disproportionate share hospital (DSH) payments are statutorily required payments intended to offset hospitals' uncompensated care costs and support the financial stability of safety-net hospitals. Similar to other Medicaid payments, DSH payments are jointly financed by states and the federal government, and the share of federal funding is determined by the federal medical assistance percentage (FMAP). However, unlike other Medicaid payments, the federal share of DSH funding available in each state is capped by federal allotments.

Because DSH allotments are set on a federal funding basis, total available state and federal DSH funding decreases when a state's FMAP increases. During periods of normal economic growth, this policy results in less total DSH funding for states with declining per capita incomes relative to other states. When Congress increases the FMAP during economic recessions or other disruptive events, this policy results in less total DSH funding for all states.

In the Commission's view, DSH allotments should be calculated on a total funding basis so that DSH funding is not affected by changes in the FMAP. This policy is similar to how other limits on Medicaid spending are set, and it would ensure that states are not adversely affected by declines in their per capita income relative to other states. Congress enacted a similar policy during the COVID-19 public health emergency (PHE), which which ended May 11, 2023. During interviews with states and providers, we found that most stakeholders preferred this approach to other policies to adjust DSH allotments because it preserves funding for providers, supports states, and is relatively easy for states to implement.

A change in the calculation of DSH allotments does not address the Commission's long-standing concern that DSH allotments have little meaningful relationship to measures of need for DSH payments, such as levels of uncompensated care and the number of Medicaid-enrolled or uninsured individuals. Current allotments are largely based on states' historical DSH spending before federal limits were established in 1992, and they vary widely by state. In March 2019, the Commission made a series of recommendations to improve the relationship between DSH allotments and measures of need for DSH payments by changing the formula for distributing pending DSH allotment reductions, which have not yet been enacted by Congress.

Under current law, federal DSH allotments are scheduled to be reduced by $8 billion in FY 2024 (54 percent of unreduced amounts), and the wide variation in state DSH allotments is projected to continue after reductions take effect. Chapter 4 of MACPAC's March 2023 report to Congress examines the potential state and hospital effects of these pending reductions, which were initially included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) but have been delayed several times.

Although the Commission is concerned that the magnitude of DSH reductions may affect the financial viability of some safety-net providers, the Commission's prior analyses focused on budget-neutral ways to restructure funding under current law. Specifically, the Commission recommended that Congress minimize the effects of reductions on hospitals that currently rely on DSH funding by phasing in reductions more gradually and applying reductions to unspent DSH funding first. To align reduced DSH allotments with measures of need, the Commission recommended that Congress change the formula for distributing reductions to gradually improve the relationship between DSH allotments and the number of non-elderly low-income individuals in each state (MACPAC 2019).

In this chapter, the Commission reaffirms its prior DSH allotment recommendations while also recommending that Congress permanently change the calculation of DSH allotments from a federal funding basis to a total funding basis. In addition, the Commission reaffirms its March 2021 recommendation that Congress implement a countercyclical adjustment to the FMAP during economic recessions. The Commission also recommends that Congress make a technical change to allow the Centers for Medicare & Medicaid Services (CMS) to finalize DSH allotments sooner so that states can make DSH payments on a timelier basis to

support providers. In sum, the Commission makes four recommendations:

- In order to reduce the wide variation in state DSH allotments based on historical 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 (HHS) to develop a methodology to distribute reductions in a way that gradually improves the relationship between total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.
- Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal DSH funding is not affected by changes in the FMAP.
- Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office (GAO) as the basis. The Commission recommends this policy change should also include:
  - an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
  - an upper bound of 100 percent on adjusted matching rates;
  - an increase in federal DSH allotments so that total available DSH funding does not change as a result of changes to the FMAP; and
  - an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).
- To provide states and hospitals with greater certainty about available DSH allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that CMS compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

This chapter summarizes the Commission's analyses, which informed the development of these recommendations. The chapter begins by reviewing current DSH and FMAP policies and the effects of previous adjustments to DSH allotments during economic recessions. Then, it reviews the state-by-state effects of calculating DSH allotments on a total funding basis during periods of normal economic growth. The chapter concludes with more information about the rationale and implications for each of the Commission's recommendations.

Background

Unlike other Medicaid payments, state DSH spending is limited by allotments that are set on a federal funding basis. As a result, when the FMAP increases, total available state and federal DSH funding decreases. This section provides an overview of current DSH policy, the FMAP calculation, and how these policies interact.

DSH policy

State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients.[1] The total amount of such payments a state can make is limited by annual DSH allotments. States can distribute DSH payments to any qualifying hospital in their state, but DSH payments to a hospital cannot exceed the total amount of uncompensated care that the hospital provides.[2] 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.

DSH allotments. DSH allotments vary widely among states, reflecting the evolution of federal policy over time. States were first authorized to make Medicaid DSH payments in 1981, when Medicaid hospital

payment methods and amounts were uncoupled from Medicare payment standards.[3] Initially, states were slow to make these payments, but after Congress clarified that DSH payments were not subject to Medicaid hospital upper payment limits, total state and federal DSH spending grew rapidly in the early 1990s—from $1.3 billion in 1990 to $17.7 billion in 1992 (Matherlee 2002, Klemm 2000, Holahan et al. 1998).[4]

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." Allotments were initially established in 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.

Under current law, federal DSH allotments increase each year based on the change in the consumer price index for all urban consumers. However, because Medicaid spending has grown faster than DSH allotments, DSH spending as a share of overall Medicaid spending has declined from 15.2 percent in FY 1992 to 3.6 percent in FY 2016 (CRS 2016).

States are not required to spend their entire allotment, but the allotment sets an upper bound on federal funding. States do not receive federal matched funds for DSH payments that exceed the allotment. States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[5] As of the end of FY 2022, $1.9 billion (15 percent) of FY 2020 DSH allotments were unspent.[6]

DSH payments. In FY 2021, DSH payments to hospitals totaled $14.1 billion, which was approximately 7 percent of all Medicaid payments to hospitals (MACPAC 2023a).[7] States set their own DSH payment policy and can send DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent. States are also required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid and low-income patients and account for about 13 percent of all hospitals nationwide (MACPAC 2023b).[8]

DSH funding is an important source of revenue for many deemed DSH hospitals. For example, in FY 2020, DSH payments accounted for 3.6 percent of operating revenue for deemed DSH hospitals, compared to 1.3 percent of operating revenue for all hospitals. Even after DSH payments, deemed DSH hospitals report lower operating and total margins than other hospitals in the aggregate (MACPAC 2023b).

Total state and federal DSH payments to an individual hospital cannot exceed the hospital's uncompensated care costs, which are defined as Medicaid shortfall plus unpaid costs of care for uninsured individuals. Although states can address Medicaid shortfall by increasing other types of Medicaid payments to hospitals, DSH is the only type of Medicaid payment in statute that can explicitly pay for unpaid costs of care for uninsured individuals.[9]

DSH financing. Similar to other Medicaid payments, states can finance the non-federal share of DSH payments through a variety of sources, including state general revenue, provider taxes, and intergovernmental transfers (IGTs) or certified public expenditures from state and local government sources, such as publicly owned hospitals. Compared to other Medicaid payments, states are more likely to finance DSH payments with provider taxes or funds from local governments. For example, in state FY 2018, 34 percent of DSH payments were financed by state funds, compared to 68 percent of all Medicaid payments (MACPAC 2023a).[10]

The methods states use to finance the non-federal share of DSH payments may affect how they choose to distribute DSH payments. For example, among the 10 states that primarily financed DSH payments through funds from local governments in state FY 2018, 72 percent of DSH payments were targeted to publicly owned hospitals, which is a larger share compared to states that fund DSH payments through general revenue or a provider tax (43 percent and 34 percent, respectively) (MACPAC 2023b). 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).[11] Because provider taxes are required to be broad based, broadly distributing DSH payments can help ensure that most hospitals are able to offset the costs of the provider tax (MACPAC 2021a). More

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

DSH payments that are financed through a provider tax or an IGT from publicly owned hospitals effectively lower the payment that a provider receives, after accounting for the provider contribution to the non-federal share. For example, in state plan rate year 2011, provider taxes reduced net payments to DSH hospitals by 4 percent, and IGTs from publicly owned hospitals reduced net payments by an additional 7 percent (Nelb et al. 2016).

FMAP calculation

The FMAP determines the federal share of Medicaid expenditures and is based on a rolling three-year average of each state's per capita income relative to the national average. States with lower per capita incomes have a higher FMAP (up to the statutory maximum of 83 percent), and states with higher per capita incomes have a lower FMAP (with a statutory minimum of 50 percent). This policy is intended to reflect states' differing abilities to fund Medicaid from their own revenues. The District of Columbia is an exception to this policy, and its FMAP is fixed in statute at 70 percent. In addition, the statute provides different FMAPs for some services and populations (MACPAC 2023c).

Under current law, FMAPs are not adjusted automatically when there is an economic recession. Congress must act to modify FMAPs outside of annual updates. In general, Congress has temporarily increased the FMAP to provide fiscal relief and stimulus to states during economic recessions or other disruptive events, such as natural disasters. For example, during the COVID-19 PHE, Congress increased the FMAP by 6.2 percentage points.

Countercyclical increases in federal funding for Medicaid help offset increasing Medicaid enrollment and declining state revenue during economic recessions (Holahan 2011). Medicaid enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment, which in turn contributes to both increases in the low-income population and the number of people losing employer-sponsored insurance (KFF 2008). States also differ in their ability to generate revenue to finance the state share of increased Medicaid spending because of differences in local economic conditions. During an economic downturn, state revenue often declines due to reduced sales tax and income tax collections. After the recession in 2008, each 1 percentage point rise in unemployment led to a 3–4 percent decrease in state general fund revenues (Dorn et al. 2008).

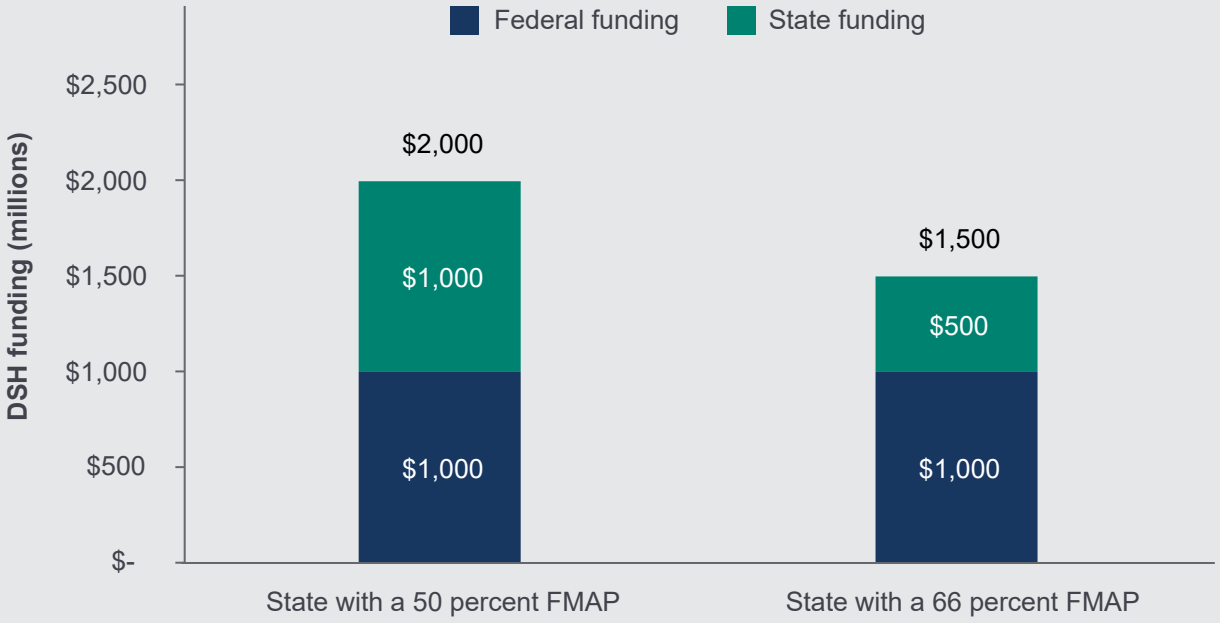
In 2021, the Commission recommended that Congress implement an automatic countercyclical FMAP using a prototype developed by the GAO as the basis (MACPAC 2021b). If Congress were to implement the Commission's recommendation, the model would increase a state's FMAP commensurate to changes in the state's employment rate when a national recession is triggered.[12] For example, the increases in unemployment at the start of the COVID-19 PHE would have triggered an increased FMAP under the GAO model, ranging from 1.34 to 9.11 percentage points in July through September 2020 (MACPAC 2021b).

Interaction between DSH allotments and the FMAP

For most Medicaid spending that is not subject to federal allotments, a higher FMAP will result in more total funding for the same level of state contribution, compared to a lower FMAP. For example, a state that spends $2 billion on medical assistance and has a 50 percent FMAP would need to contribute $1 billion in state share. However, a state that spends $2 billion on medical assistance and has a 66.7 percent FMAP would need to contribute only $666 million in state share.

The opposite is true for DSH funding, which is limited on a federal funding basis. Under current law, the total amount of state and federal DSH funding available to a state is determined by dividing the federal DSH allotment by the FMAP. A higher FMAP will result in less total DSH funding for a given allotment compared to a lower FMAP. For example, a state with a $1 billion federal allotment and a 50 percent FMAP could make a total of $2 billion in DSH payments. However, a state with a $1 billion allotment and a 66.7 percent FMAP could make only a total of $1.5 billion in total DSH payments (Figure 1-1). In both circumstances, a state's ability to claim all available DSH funding is dependent on states providing the state share for these expenditures.

FIGURE 1-1. State and Federal DSH Funding for a Hypothetical State under Two FMAP Scenarios



Notes: DSH is disproportionate share hospital. FMAP is federal medical assistance percentage.

Source: MACPAC analysis

FMAP exceptions for DSH. Because a higher FMAP decreases total DSH funding, Congress has excluded DSH payments from some FMAP increases in the past. For example, Congress excluded DSH payments from FMAP increases during the 2007–2009 financial crisis. However, Congress applied an increased FMAP to DSH payments for states that had a large influx of refugees due to Hurricane Katrina in 2005, resulting in less total available DSH funding for affected states (Deficit Reduction Act of 2005, P.L. 109-171).

Comparison to other Medicaid funding limits. As a point of comparison, many other limits on Medicaid spending are established on a total funding basis and are not affected by changes in the FMAP. For example, budget neutrality limits for Section 1115 demonstrations and upper payment limits (UPL) on fee-for-service payment rates are based on total state and federal spending (MACPAC 2023a, 2021c). For the UPL, states must annually demonstrate that total fee-for-service payments to hospitals and other institutional providers do not exceed a reasonable estimate of what Medicare would have paid for the same service in the aggregate for a class of providers. In UPL demonstrations, CMS collects data only on total state and federal spending. In Section 1115 demonstrations, federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration (MACPAC 2021d). However, CMS calculates this federal limit using projections of total state and federal spending and multiplying this amount by the FMAP.[13]

Analyses of Previous Countercyclical DSH Policies

During the past two economic recessions, Congress made temporary changes to DSH allotment policy. This section reviews the federal, state, and hospital effects of these policies, based on MACPAC's quantitative analyses and interviews with state officials, hospital associations, and CMS.

Specifically, the Commission examined the following policy changes made during the 2007–2009 financial crisis and the COVID-19 pandemic:

- **Increased federal allotment without FMAP change:** The American Rescue and Recovery Act (ARRA, P.L. 111-5) increased DSH allotments by a fixed amount (2.5 percent) but did not change the FMAP for DSH payments. All Medicaid payments except for DSH received an enhanced FMAP of 6.2 percent. ARRA was the first time that Congress created a countercyclical increase for DSH payments.
- **Increased FMAP without federal allotment change:** The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) increased the FMAP for all Medicaid expenditures, including DSH, by 6.2 percentage points, but it did not change federal DSH allotments, and total DSH funding decreased.
- **Increased FMAP and allotment based on total funding:** The American Rescue Plan Act (ARPA, P.L. 117-2) increased federal DSH allotments to ensure that total DSH funding would remain the same as it would have been without the application of the 6.2 percent enhanced FMAP.

Changes to DSH policies during the COVID-19 pandemic occurred alongside other policy changes that also affected hospital finances. For example, at the start of the COVID-19 PHE, Congress also created a $178 billion provider relief fund to help offset provider losses during the pandemic, much of which has been allocated to hospitals (MACPAC 2022a). This new funding source was an unprecedented action, and as such, provider relief funding may not be available for future economic downturns.

Effects on state and federal DSH funding

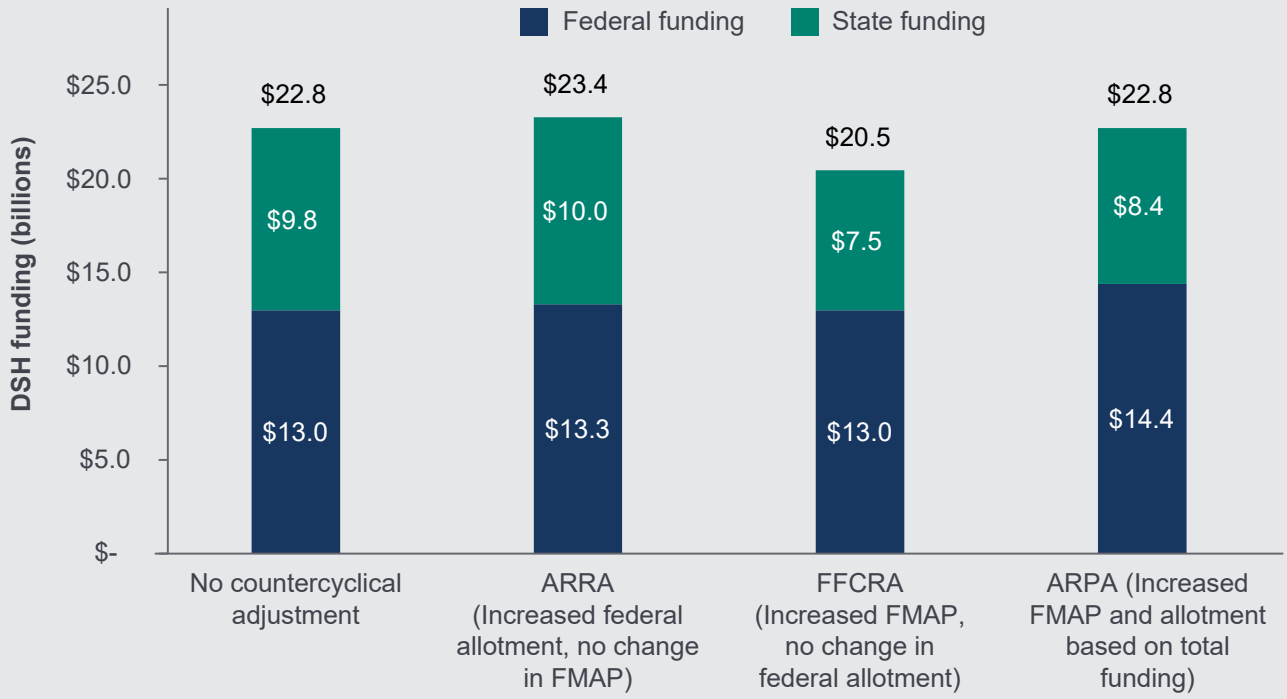
To understand the potential effects of these policies on available state and federal DSH funding, we examined what their effects would have been on FY 2021 DSH allotments (Figure 1-2).

- Without a countercyclical adjustment to the FMAP or DSH allotments, a total of $22.8 billion in state and federal DSH funding would have been available ($13 billion in federal allotments and $9.8 billion in state matching funds).
- If federal allotments were increased 2.5 percent without a change in the FMAP, as they were under ARRA, then total available funding would have also increased 2.5 percent, to $23.4 billion. However, for states to spend all available funding, they would have had to increase the amount of state matching funds that they provided from $9.8 billion to $10.0 billion.
- If the FMAP was increased without a change in federal allotments, as was done under FFCRA, the required state share of DSH funding would decline from $9.8 billion to $7.5 billion, but total available DSH funding would also decline accordingly, from $22.8 billion to $20.5 billion.
- The ARPA policy of basing DSH funding on a total funding while also increasing the FMAP keeps total DSH funding at the same amount as it would have been without a countercyclical adjustment ($22.8 billion), but it also provides state fiscal relief by reducing the required state share from $9.8 billion to $8.4 billion. However, the federal spending under this approach is higher ($14.4 billion) than the other countercyclical policies.

Potential hospital effects

The effects of these policies on individual hospitals depend on how states respond to changes in their DSH allotments. During economic recessions, hospitals may be eligible for more DSH funding because of increases in hospital uncompensated care costs, but states may not always choose to spend their full DSH allotments or may respond by changing other types of Medicaid payments to hospitals. In addition, changes in the FMAP may affect hospitals differently, depending on how DSH payments are financed.

FIGURE 1-2. DSH Allotments under Different Countercyclical Policy Scenarios, FY 2021 (billions)



Notes: DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. ARRA is American Recovery and Reinvestment Act of 2009 (P.L. 111-5). FFCRA is Families First Coronavirus Response Act (P.L. 116-127). ARPA is American Rescue Plan Act (P.L. 117-2). No countercyclical adjustment assumes no changes to DSH allotments or the FMAP from before the COVID-19 pandemic. ARRA increased DSH allotments by 2.5 percent. FFCRA increased the FMAP for Medicaid payments by 6.2 percentage points. ARPA changed the basis of DSH allotments from federal funding to total funding. Totals may not sum due to rounding.

Source: MACPAC, 2023, analysis of Medicaid Budget and Expenditure System.

Changes in hospital uncompensated care. Economic recessions are associated with higher levels of unemployment and declines in employer-sponsored coverage, which can result in increased Medicaid enrollment and an increased number of uninsured individuals (MACPAC 2021b). These coverage changes can result in increased hospital uncompensated care for Medicaid and uninsured individuals, thus increasing hospitals' need for DSH payments to offset these costs (Garthwaite et al. 2015). Furthermore, economic recessions may affect states differently, either in the duration or severity of the downturn. Increases in uncompensated care may be more considerable in states with larger increases in unemployment.

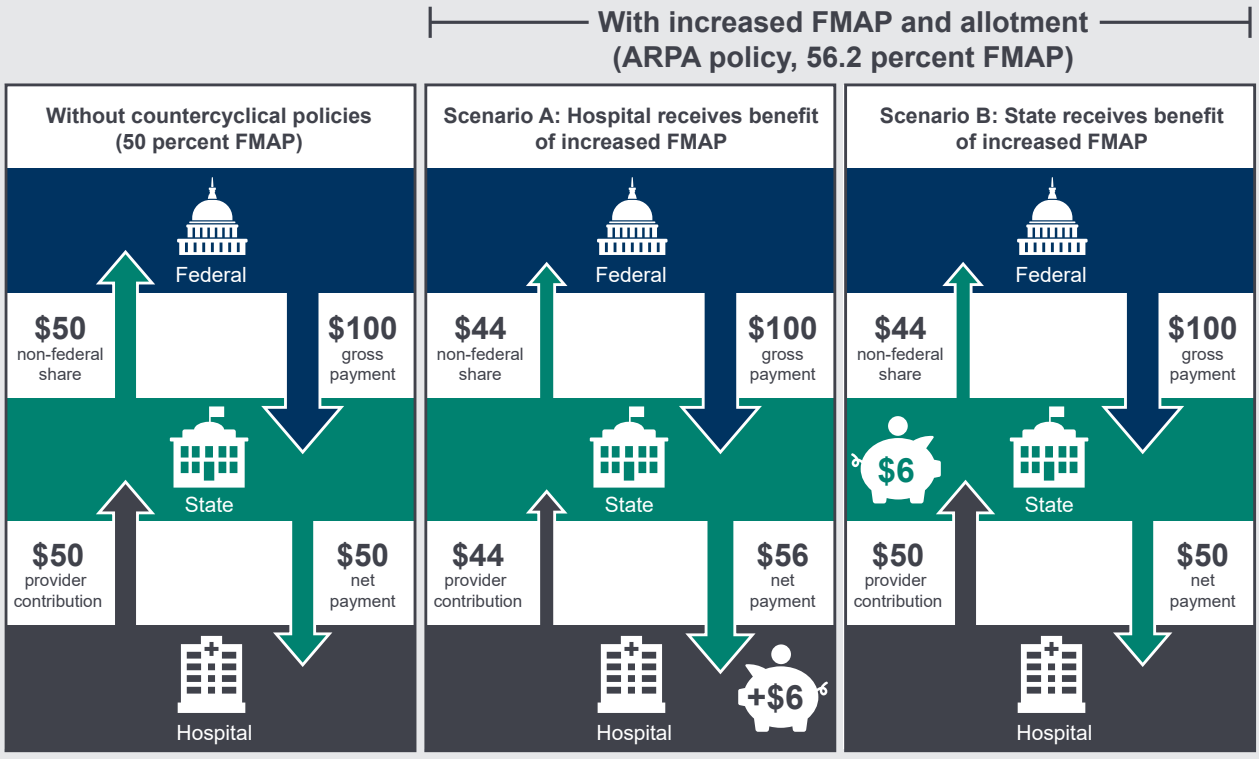
Unspent DSH allotments. Even if hospitals report enough uncompensated care to exhaust available DSH funding, some states do not spend their full DSH allotment because of challenges in financing the non-federal share of DSH payments. These challenges may become more pronounced during an economic recession, since some states may have declines in revenue due to rising unemployment. In these states, hospitals may not benefit from higher federal allotments without a corresponding increase in the FMAP, as was done under ARRA, because states would need to generate additional state matching funds to make more DSH payments.

Effects of state financing methods. States may react to legislative changes in their DSH allotment differently based on how they finance the non-federal share of DSH payments. DSH allotment adjustments may not automatically result in providers receiving additional federal funds if states do not provide state matching funds.

Conversely, if a provider finances the non-federal share of DSH payments using provider taxes or IGTs, and the amount that the provider contributes to the non-federal share declines when the FMAP increases, then the net payments that the provider receives would increase. For example, in a state with a 50 percent FMAP that finances DSH payments from providers, a 6.2 percent increase in the FMAP would result in a 12.4 percent increase in the net payments the provider receives if the state decides to pass on the benefits of the increased FMAP to the hospital in the form of either tax relief or a smaller IGT transfer from publicly owned hospitals.[14] However, a state could also choose to keep the provider contribution the same, retain the 6.2 percent increase in the FMAP, and use additional federal contribution to address state fiscal challenges during a downturn (Figure 1-3).

Changes to other Medicaid hospital payments to cover uncompensated care. Although DSH is the only statutory Medicaid payment that is intended to pay for unpaid costs of care for uninsured individuals,

FIGURE 1-3. Scenarios for Net Payments to Hospitals that Finance the State Share of DSH Payments



Notes: DSH is disproportionate share hospital. FMAP is federal medical assistance percentage. ARPA is American Rescue Plan Act (P.L. 117-2). ARPA temporarily transitioned allotments from a federal funding basis to a total funding basis. Under ARPA all Medicaid payments, including DSH, have an FMAP increased by 6.2 percentage points during the COVID-19 public health emergency. Provider contributions can be in the form of a provider tax, intergovernmental transfer, or certified public expenditure. The piggy bank illustrates whether the state or the hospital receives the benefit of the increased FMAP.

Source: MACPAC analysis

states can increase Medicaid base payment rates or make other supplemental payments to pay for the costs of care for Medicaid-enrolled patients. These other types of Medicaid payments also require states to finance the non-federal share of Medicaid payments. In general, it is more difficult for states to target non-DSH Medicaid payments to hospitals for unpaid costs associated with uninsured individuals because these payments are typically based on Medicaid use (MACPAC 2021b, MACPAC 2019).[15]

Stakeholder perspectives

State Medicaid officials and hospital associations in five states with different methods of financing and targeting DSH payments offered perspectives on how prior countercyclical DSH policies affected DSH payments to hospitals, particularly during the PHE.[16]

DSH has been an important source of funding that offsets uncompensated care during an economic recession. All stakeholders noted the importance of DSH funding in offsetting uncompensated care during economic recessions. Compared to other types of Medicaid payments, states appreciated the flexibility to target DSH funding to safety-net hospitals. For example, one state used existing flexibility to accelerate DSH payments to providers at the start of the pandemic to ensure safety-net providers had enough cash flow to manage the initial disruptions in care (NM HSD 2020). Many also made other types of non-DSH supplemental payments to hospitals but noted it would be administratively difficult to try to offset declines in DSH funding with these other types of Medicaid payments.

Hospital associations highlighted the challenges that hospitals typically face during economic recessions. They also noted that the COVID-19 pandemic was different from prior recessions because of the Medicaid continuous coverage requirement, which prevented a large increase in the number of uninsured individuals, and federal provider relief funding, which helped to offset hospital losses during the early stage of the pandemic (Karpmen and Zuckerman 2021, MACPAC 2020). Given that these additional sources of support may not be available in future recessions, stakeholders noted the continued need for stable and predictable DSH funding.

States and providers assessed available DSH funding on a total funding basis. At the state level, state officials and hospital associations preferred to measure DSH funding on a total funding basis. As a result, these stakeholders viewed the FFCRA FMAP increase as a reduction in DSH funding even though the federal DSH allotment amounts were unchanged. Because of these concerns, some hospital associations joined a multistate coalition to advocate for the ARPA policy to transition allotments to a total funding basis, so that total DSH payments could remain the same as prepandemic levels.

Stakeholders were generally supportive of the ARPA policy of basing DSH allotments on total funding during the pandemic. Stakeholders noted that changing the basis for DSH allotments to total funding preserved DSH funding and supported states and was relatively administratively simple for states to implement. Preserving DSH funding also prevented the need for states to make state statutory or regulatory changes to their DSH payment policies or other Medicaid payments to offset the effects of any changes.

Increased FMAP supported state and local government budgets. States generally used the increased FMAP provided by FFCRA and ARPA to support state budgets rather than increase Medicaid payments to providers. Before ARPA was implemented, two states responded to FFCRA by increasing payments to DSH hospitals using unmatched state funds to preserve the same amount of funding that providers would have received before the pandemic. Once ARPA was implemented, these states retroactively adjusted their payments to claim federal matching funds to support their state budgets.

In two states that financed DSH payments with a provider tax, the tax rate remained the same after the increased FMAP took effect and the savings from reductions in the non-federal share for DSH payments accrued to the state rather than providers. One state has a mechanism in place to adjust provider taxes based on the size of the total DSH allotment, but even after the passage of FFCRA and ARPA, the state calculated the provider tax amount needed for the non-federal share based on the state's traditional FMAP. The state's savings from the increased FMAP during the PHE were directed to a

separate account that benefited the state's overall budget rather than benefiting providers directly.

In one of the states that financed DSH with IGTs from public hospitals, the benefits of the increased FMAP accrued to the public hospital and their affiliated local governments. After the FMAP increased, these hospitals contributed less of the state share for DSH and therefore received larger net DSH payments. The state officials and hospitals association in this state noted the benefits of increasing net payments to these hospitals because of the important role that these public hospitals play in providing care to Medicaid-enrolled and uninsured patients.

States were concerned about their ability to finance increases to hospital payments during economic recessions. State officials noted challenges with contributing more to the non-federal share of DSH or other Medicaid hospital payments during economic recessions, when state revenue is typically limited. Some hospital associations would have preferred a countercyclical policy that increased total state and federal DSH funding, similar to the ARRA policy that was implemented during the 2007–2009 economic recession. These associations were less concerned about the state's ability to finance DSH payments than stakeholders in other states because of state-specific policies requiring the state to spend all available DSH funding.

Stakeholders preferred certainty to help plan for the future. Although the ARPA policy addressed many concerns raised by stakeholders, states and hospitals expressed concern that Congress waited more than a year into the PHE to make this change. The ARPA policy was retroactively applied to the start of the PHE, but the delay in implementing ARPA still created uncertainty over how much DSH funding would be available to states and providers during the first year of the PHE.

In addition to concerns about delays by Congress, stakeholders also raised concerns about CMS's delay in finalizing DSH allotments. For example, FY 2020 and FY 2021 preliminary DSH allotments were not posted to the *Federal Register* until March 2022 (CMS 2022). Final DSH allotments take even longer for CMS to finalize, and some states noted that they often leave some DSH funding unspent until allotments are finalized. CMS officials noted that the statutory requirement for them to compare DSH allotments to state spending was the primary reason for this delay, since spending amounts are typically not finalized until two years after the close of the fiscal year.

DSH Allotments during Periods of Normal Economic Growth

Total DSH funding is affected by annual changes in the FMAP due to changes in a state's per capita income relative to other states. Although states with lower per capita incomes have a higher share of non-elderly low-income individuals in their states, states with declining per capita incomes have less total available DSH funding because their FMAP increases.

To examine this issue, this section describes how the FMAP affected total DSH funding during a period of normal economic growth (FYs 2014–2019) and analyzes the state effects of applying a different policy that would base allotments on total funding.

Relationship between FMAP and measures of need for DSH payments

States with higher FMAPs are likely to have a greater need for DSH payments because their per capita income is lower than other states, on average. For example, in 2019, state per capita income was highly correlated with the share of non-elderly low-income individuals in each state, a measure that the Commission recommended that Congress use to rebase DSH allotments if DSH allotment reductions take effect (Figure 1-4). The Commission chose this measure because it is correlated with state levels of uncompensated care and is not affected by state choices to expand Medicaid under the ACA to adults younger than age 65 with incomes less than 138 percent of the federal poverty level (FPL) (MACPAC 2019). In 2019, states with low per capita income had a higher percentage of low-income individuals. Conversely, states with high per capita income had a lower percentage of low-income individuals, and many of these states have an FMAP at the statutory minimum (50 percent).

FIGURE 1-4. State Per Capita Income by the Percentage of Non-Elderly Population That Is Low Income and by Whether a State Has an FMAP at the Statutory Minimum of 50 Percent, 2019

Notes: FMAP is federal medical assistance percentage. Percentage of non-elderly population that is low income is the percentage of the population younger than age 65 that has a household income less than 200 percent of the federal poverty level. Per capita income is the state income divided by the state population. R is the Pearson correlation coefficient. States include all 50 states but not the District of Columbia, which has a statutorily set FMAP of 70 percent. Correlation is between the state per capita income and percentage of non-elderly population that is low income and is represented by the Pearson correlation coefficient. A coefficient of 0 represents no linear correlation, and a coefficient of -1 represents a perfect linear negative correlation.

Source: MACPAC, 2023, analysis of BLS 2023 and Census 2023.

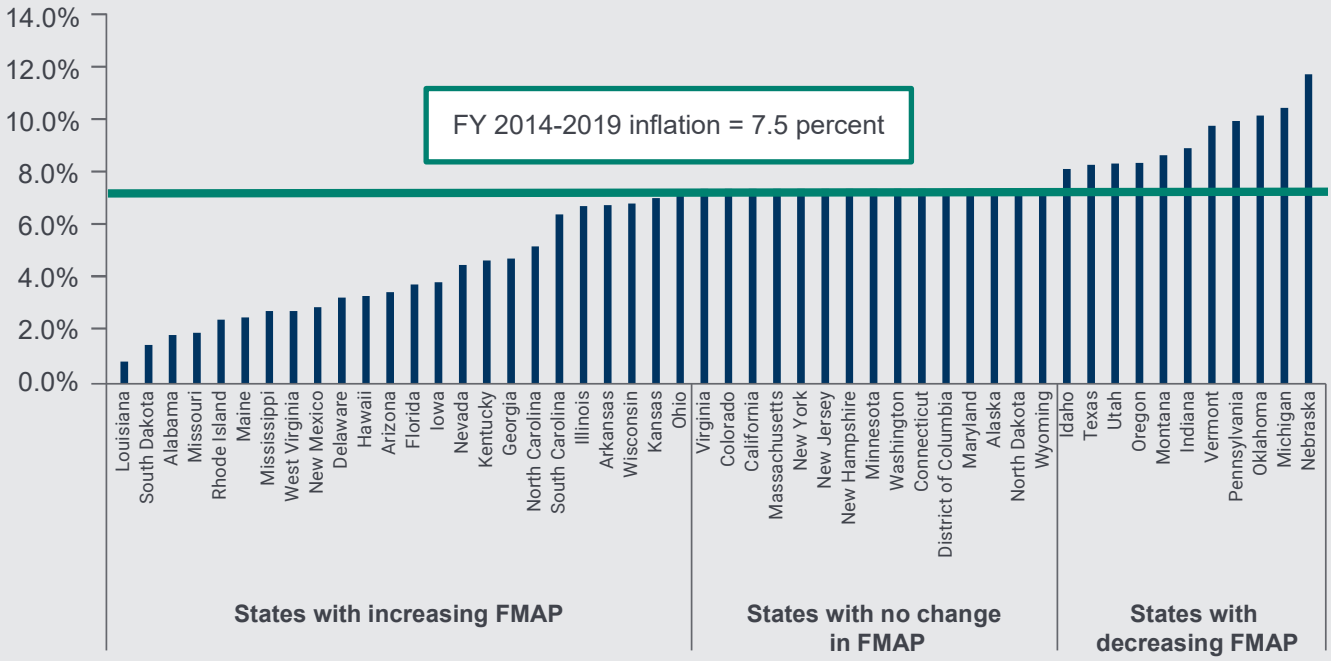
Current variation in DSH funding based on FMAP changes

The effects of the FMAP on total DSH funding can be observed by examining changes in total available DSH funding over time. Although federal DSH allotments increase annually based on inflation in all states under current law, states with increasing FMAPs have total DSH funding that increases slower than inflation, and states with decreasing FMAPs have total DSH funding that increases faster than inflation.

For example, although inflation increased 7.5 percent between FY 2014 and FY 2019, increases in DSH funding ranged from 0.8 percent (Louisiana) to 11.9 percent (Nebraska) (Figure 1-5). Over the five-year period from 2014 to 2019, Louisiana had a 4.0 percentage point increase in its FMAP, and Nebraska had a 2.2 percentage point decline in its FMAP. Additional state-by-state data are available in Appendix 1A.

The changes in the two states with the largest and smallest increases in total DSH funding between FY 2014 and FY 2019 illustrate the current lack of alignment between annual DSH adjustments and measures of need. During this period, Louisiana had the lowest increase in total DSH funding of any state (0.8 percent), but in 2019, Louisiana had the ninth lowest per capita income ($47,668) and the fifth highest rate of low-income and non-elderly individuals in the country (38.1 percent). Conversely, Nebraska had the greatest increase in total DSH funding between 2014 and 2019 (11.9 percent), even though Nebraska's rate of low-income non-elderly individuals is more than 10 percentage points lower than Louisiana (27.1 percent). In future years, the specific states that are affected most by current law will change as state per capita incomes change, but in general, the current policy benefits states with a lower share of low-income individuals.

FIGURE 1-5. Percentage Change in DSH Funding Relative to Inflation, FYs 2014–2019



Notes: DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. DSH funding is the combined federal allotment and the state share. Chart shows state and federal combined DSH funding percentage growth between FY 2014 and FY 2019. Chart shows that states with increasing FMAPs between 2014 and 2019 had less DSH funding growth when compared to states with decreasing FMAPs. The green line shows the rate of inflation between FY 2014 and FY 2019. Figure excludes Tennessee, which did not have a DSH allotment in FY 2014 because its allotment is set in statute under Section 1923(f) of the Social Security Act.

Source: MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

State effects of setting DSH allotments based on total funding

If DSH allotments are set on a total funding basis instead of a federal funding basis, then total DSH funding would not be affected by changes in the FMAP. Instead of increasing federal allotments annually based on inflation, total DSH funding would increase by the same rate in all states under this policy. For example, between FY 2014 and FY 2019, all states would have received a 7.5 percentage point increase in total DSH funding under the total funding basis policy instead of the wide variation in total DSH funding growth under current law (Table 1-1).

States with increasing FMAPs would benefit the most from a total funding basis policy. For example, the 24 states that saw an increase in their FMAP between FY 2014 and FY 2019 would have had a larger increase in their federal DSH allotment on average (11.3 percent) under this policy than they had under current law (7.5 percent).

Conversely, states with declining FMAPs would not benefit from a total funding basis policy because they would receive less federal funding compared to current law. For example, the 11 states that saw a decrease in their FMAP between FY 2014 and FY 2019 would have had a smaller increase in their federal DSH allotment (5.8 percent) under a total funding basis policy than they had under current law (7.5 percent). However, these states would still have received an increase in total available DSH funding that kept pace with inflation.

The states with no change in their FMAPs would have had no change in their DSH allotments as a result of a total funding basis policy. These include all 14 states that had the statutory minimum 50 percent FMAP in 2019 and the District of Columbia, whose FMAP is fixed in statute (MACPAC 2022b). Overall, these states account for almost half of total DSH funding (47.5 percent in 2019). Because the FMAP in these states cannot decrease further, permanently basing DSH allotments on total funding would

TABLE 1-1. Changes in DSH Funding during Periods of Normal Economic Growth with a Federal vs. Total Funding Basis, FYs 2014–2019

Change in state FMAP	Number of states	Average percent change in federal DSH allotment		Average percent change in total available state and federal DSH funding	
		Allotment based on federal funding (Current law)	Allotment based on total funding (MACPAC recommendation)	Allotment based on federal funding (Current law)	Allotment based on total funding (MACPAC recommendation)
Increased FMAP	24	7.5%	11.3%	3.9%	7.5%
Decreased FMAP	11	7.5	5.8	9.3	7.5
No change to FMAP	15	7.5	7.5	7.5	7.5

Notes: DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. Under current law, DSH allotments are based on federal funding, and the federal allotment grows with inflation. MACPAC's recommendation would change the basis of allotments to state and federal funding, and the total funding allotment would grow with inflation. Under either policy, states must provide non-federal funding to spend all available state and federal DSH funds. Number of states includes the District of Columbia and excludes Tennessee, which did not have a DSH allotment in FY 2014 because its allotment is set in statute under Section 1923(f) of the Social Security Act.

Source: MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

benefit these states only if their FMAP increased in the future. More detailed estimates of the state-by-state effects of setting limits on DSH spending at the combined state and federal amount between FY 2014 and FY 2019 and between FY 2018 and FY 2019 are available in Appendix 1A.

Commission Recommendations

The Commission makes four recommendations on actions that Congress can take to improve federal policy for DSH allotments and the calculation of the FMAP.

Recommendation 1.1

In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical 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 total state and federal DSH funding and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

Rationale

The Commission has long held that DSH allotments should better relate to current measures of need rather than historical spending. To the extent that Congress makes changes to calculate DSH allotments on a total funding basis, it should also ensure that efforts to rebase DSH allotments on measures of need are also based on total state and federal DSH funding.

In March 2019, the Commission made a similar recommendation to restructure pending DSH allotment reductions to improve the relationship between DSH allotments and measures of need. The Commission concluded that a new statutory formula was needed because the DSH allotment reduction methodology currently prescribed in statute is projected to preserve much of the historical variation in DSH allotments.

As discussed further in the March 2019 report, the Commission considered a variety of measures of need for DSH payments that could be used in a new formula, including hospital uncompensated care costs, the number of uninsured individuals in a state, and the number of Medicaid-enrolled individuals. Ultimately, the Commission concluded that the number of non-elderly low-income individuals in a state is the best measure to use because this measure is correlated with state levels of uncompensated care and is not affected by state decisions about whether to expand Medicaid coverage under the ACA to adults younger than age 65 with incomes less than 138 percent of the FPL. The Commission also noted the importance of adjusting allotments to account for differences in hospital costs in different geographic areas.

In March 2019, the Commission also recommended that Congress phase in DSH allotment reductions gradually and that DSH allotment reductions be applied to unspent DSH funding first. The Commission reaffirms its support for these recommendations, but there is not a need for a conforming change to the text of these recommendations if the calculation of DSH allotments are changed to a total funding basis.

Implications

Federal spending. The Congressional Budget Office (CBO) did not estimate the effects of this recommendation as a stand-alone policy separate from the Commission's other DSH allotment recommendations in its March 2019 report (phasing in reductions more gradually and applying reductions to unspent DSH funding first). Overall, these policies were designed to be budget neutral for the federal government.

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

all states. Additional information about the state-by-state effects of this policy are provided in MACPAC's March 2019 report to Congress.

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

Plans. This recommendation would likely have no direct effect on Medicaid managed care plans.

Providers. This policy would affect providers differently based on which states they are located in, but the federal amount of reductions in DSH funding is unchanged.

Recommendation 1.2

Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital (DSH) funding is not affected by changes in the federal medical assistance percentage.

Rationale

Because DSH allotments are currently set on a federal funding basis, increases in the FMAP decrease total available state and federal DSH funding. This outcome negatively affects states that have an increase in their FMAP because of declining per capita income relative to other states, and it also negatively affects all states when Congress increases the FMAP during an economic recession or other disruptive event.

During the COVID-19 PHE, Congress temporarily set DSH funding on a total funding basis so that the amount of DSH payments a state could make would not be affected by the increased FMAP. Stakeholders preferred this policy to other mechanisms to adjust DSH funding because it preserved funding for hospitals and supported states and was relatively easy for states to implement.

Compared to current law, calculating DSH allotments on a total funding basis would result in small reductions in federal DSH allotments for states that have increasing per capita income relative to other states. However, these states also have lower rates of low-income non-elderly individuals, a potential measure of need for DSH payments. Overall, this policy has no net effect on federal spending during periods of normal economic growth, and it is consistent with how other types of Medicaid spending are affected by changes in the FMAP.

Design considerations

To implement this policy, CMS could choose to recalculate federal DSH allotments when the FMAP changes, or it could choose to publish limits only on total DSH spending by state and determine the federal share of DSH when states submit claims for federal matching funds. CMS currently publishes the federal share of DSH allotments annually, but publishing a limit on total spending by state would be more consistent with the process used for other Medicaid spending, and it may make it easier for CMS to respond to mid-year changes in the FMAP.

The annual changes in the FMAP are published two years before the start of the fiscal year, so CMS should have time to incorporate any changes in the FMAP into its calculation of federal DSH allotments. Current regulations require CMS to post federal DSH allotments by April of the fiscal year.

During economic recessions or other disruptive events, such as natural disasters, Congress may make changes to the FMAP that apply partway through the year, which would require CMS to recalculate federal DSH allotments when the FMAP changes. For example, the 6.2 percentage point increase in the FMAP during the COVID-19 PHE was applied in the second quarter of FY 2020. Under ARPA, FY 2020 DSH allotments were increased for the full year so that total DSH funding would be the same as it would have been if the 6.2 percentage point increase in the FMAP were not in effect.

The ARPA policy will expire in FY 2023, and a 1.5 percentage point FMAP increase is currently scheduled for the first quarter of FY 2024. Unlike

prior FMAP increases, this increase is contingent on state compliance with specific requirements for unwinding the continuous coverage provisions.[17] Because CMS will not know in advance whether a state's FMAP will be reduced because of this penalty, it could be challenging for CMS to determine the federal share of DSH funding in advance. Instead, if Congress implements the Commission's recommendation, it might be administratively easier for CMS to publish the limit on total DSH funding and calculate the federal share of DSH funding at the time when a state submits its claim for DSH payments. This would remove the need for CMS to update allotments on the *Federal Register* whenever there is a mid-year change in the FMAP, though CMS would need to update the data systems that record DSH payments to reflect this new policy.

Implications

Federal spending. According to the CBO, this recommendation will not result in a change in federal spending during periods of normal economic growth. During an economic recession or other disruptive event, this recommendation would increase federal spending on DSH proportionate to any increased FMAP that Congress provides.

States. This policy would help ensure that total DSH funding is not affected by increases in the FMAP. Compared to current law, states with increasing FMAPs would have higher federal allotments, while states with declining FMAPs would have lower federal allotments. When Congress increases the FMAP during economic recessions or other disruptive events, this policy would uniformly increase federal DSH allotments for all states.

Enrollees. This policy would likely have no direct effect on enrollees, though this policy may indirectly affect patients served by DSH hospitals. In particular, by preventing reductions in DSH funding when Congress increases the FMAP during an economic recession, this policy could also help DSH hospitals maintain access to care for Medicaid enrollees and uninsured individuals.

Plans. This recommendation would likely have no direct effect on Medicaid managed care plans.

Providers. This policy would help prevent changes in DSH funding when a state's FMAP changes. States would not need to reduce payments to DSH hospitals when Congress provides statutory increases to the FMAP. During periods of normal economic growth, providers would see the same level of DSH payments since DSH funding would grow with inflation.

Recommendation 1.3

Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on adjusted matching rates;
- a temporary increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
- an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group).

Rationale

Recessions are a common feature in the US economy. Since 1990, a recession occurred in 1990, 2001, 2007, and 2020. An automatic countercyclical financing mechanism based on the GAO prototype model would have been triggered in each of those recessions and helped states respond more quickly during an economic crisis.

As described in the MACPAC March 2021 report to Congress, the GAO countercyclical financing model is a helpful prototype that aligns with the Commission's goals. The GAO model uses objective and timely indicators of an economic downturn, ensuring that

federal assistance would flow to states several fiscal quarters before Congress acts. The model uses unemployment and employment data that is published monthly and therefore is a timely and comparable measure across states. The model's trigger also is sufficiently sensitive that it would have been triggered during each of the previous three recessions over the last 20 years but not sensitive enough to trigger an FMAP increase due to minor economic fluctuations.[18] The GAO model also targets federal support to states that need it most.[19]

Including DSH allotments in the countercyclical financing model would ensure that there is not a decline in DSH funding when the FMAP is automatically adjusted upward. Basing DSH allotments on total funding would ensure that once the model is triggered, the federal share of DSH payments would automatically increase without decreasing payment levels. This would provide more certainty for states and providers about the total amount of DSH funding available for uncompensated care. States and hospitals have expressed concerns about the length of time it took for Congress to establish a countercyclical DSH allotment policy during the PHE, which affected the timing of DSH payments and the ability for states to plan their spending of DSH funds.

Implications

Federal spending. This recommendation would increase federal spending on Medicaid in the form of a fiscal stimulus to states when the countercyclical financing model is triggered. According to CBO, implementing this recommendation would cost $10 billion in FY 2024 and about $70 billion from FY 2023 to FY 2033. The DSH provision within this recommendation accounts for 1.1 percent ($750 million) of the $70 billion 10-year estimate.

In MACPAC's March 2021 report to Congress, CBO estimated that a similar countercyclical financing model would have cost $1 billion in the first year and $30 billion–$40 billion over the next 10 years (MACPAC 2021a). CBO's higher estimate in this report is attributed to updated economic data that increases the likelihood of a recession in the coming year compared to the likelihood of a recession in 2021.

These estimates assume that Congress will not otherwise act to increase the FMAP in future downturns. If Congress does not adopt this recommendation, it could still decide to provide an FMAP increase in response to a future economic recession as it has done several times in the past, and such changes would increase federal spending. For example, in 2009, Congress authorized a 27-month increase in Medicaid FMAP that added $32 billion in federal Medicaid outlays in FY 2009 and $40 billion in FY 2010 (CBO 2009). These types of stimulus expenditures cannot be factored into routine budgeting processes and are not included in the Medicaid baseline once their authority expires.

States. This policy would provide fiscal stimulus to states for Medicaid when the countercyclical financing model is triggered. Increases in federal spending would offset reductions in state spending commensurate with the declines in the state-level unemployment and wage and salary data. Introducing DSH language into MACPAC's previous recommendation ensures that DSH payments receive the same fiscal relief as most other Medicaid payments.

Enrollees. The availability of additional federal funding and the maintenance of effort requirement will help ensure that states have the funds and the incentive to support increased Medicaid enrollment during an economic downturn. This policy may also indirectly benefit enrollees by preserving total available funds for DSH hospitals, which could help these hospitals maintain access to care for Medicaid enrollees and uninsured individuals.

Plans. This recommendation would likely have no direct effect on Medicaid managed care plans.

Providers. The availability of a predictable source of additional federal funding would help states more effectively determine how to allocate their budgets and may enable them to delay or prevent provider and plan rate cuts that would otherwise be made to meet a state balanced budget requirement. This policy would not reduce DSH funding when the financing model is triggered, when hospital uncompensated care costs are expected to increase. Publicly owned hospitals may benefit if states choose to reduce provider contributions to the non-federal share in response to

the countercyclical FMAP. Hospitals that fund DSH payments through a provider tax may also benefit if the state passes along the FMAP savings in the form of tax relief; however, tax relief may not be realized until subsequent fiscal years.

Recommendation 1.4

To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services (CMS) compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

Rationale

MACPAC has found that some states did not spend their full DSH allotments in the year that they were intended because there is a substantial delay before CMS finalizes DSH allotments. For example, finalized FY 2018 DSH allotments were not posted until March 2022. Currently, CMS provides states only with preliminary estimates of the amount of DSH funding available, but the states were cautious about spending this full amount before allotments were finalized in case they may have to recoup funds from hospitals later.

FIGURE 1-6. National DSH Expenditures as a Share of Medical Expenditures, 1989–2016

Notes: DSH is disproportionate share hospital. DSH expenditures include both state and federal funds. Medical expenditures include state and federal medical spending, which does not typically include administrative spending.

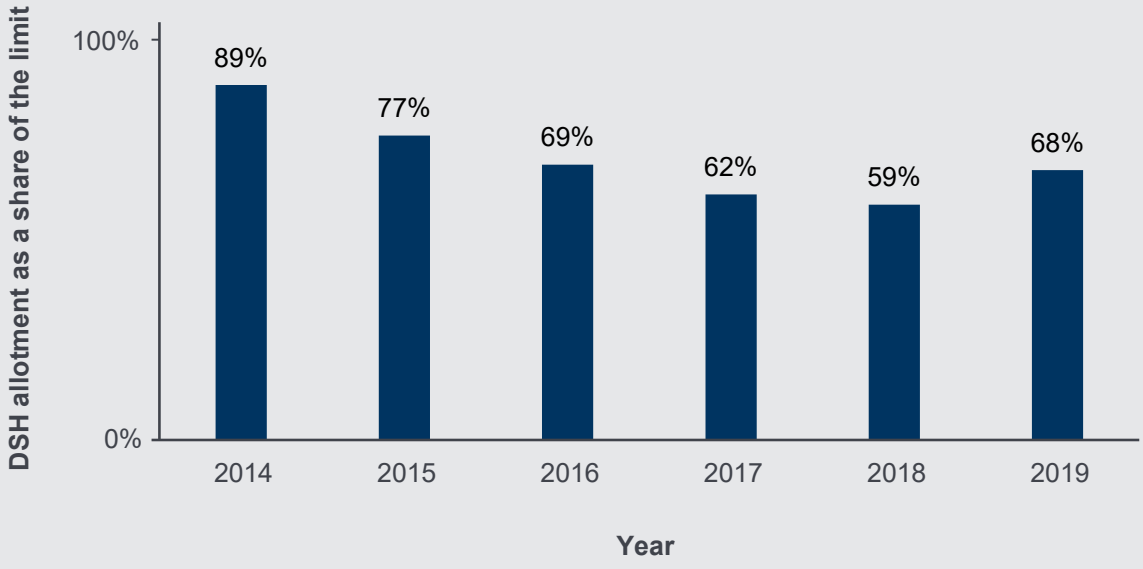
Source: MACPAC, 2023, analysis of CMS Medicaid Budget and Expenditure System and CMS 2016.

The statutory requirement that CMS compare DSH allotments to total state Medicaid spending creates delays in finalizing allotments. Section 1923(f)(3)(B) of the Social Security Act specifies that DSH allotments cannot exceed 12 percent of medical assistance spending at the individual state level.[20] However, state Medicaid spending amounts are not finalized until at least two years after the payments are made, which delays CMS's ability to perform this calculation.

This limit was put in place in the 1990s to ensure that DSH spending remained below 12 percent of the national amount of medical assistance expenditures (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. 102-234) (CRS 2016) (42 CFR § 447.297). However, the limit no longer has any practical effect on DSH spending. When this legislation was passed, total DSH spending was 15.2 percent of Medicaid spending, but in FY 2016, total DSH payments were 3.6 percent of Medicaid spending (Figure 1-6).

In recent years, no state has had its DSH allotment lowered to meet the limit described in Section 1923(f)(3)(B) of the Social Security Act (CMS 2022, 2019, 2018, 2017, 2016).[21] In our review of CMS data, no state has been within 10 percent of the limit since 2014, when many states expanded Medicaid coverage to adults younger than age 65 with incomes below 138 percent of the FPL. In 2014, New Hampshire was closest to the limit with an allotment that was 89 percent of the limit, and by 2019, New Hampshire's allotment was 68 percent of the limit (Figure 1-7).[22] Because Medicaid spending tends to grow faster than inflation, and DSH allotments are pegged to inflation, it is unlikely that any state would exceed the 12 percent limit in the future.

FIGURE 1-7. State with the Highest Allotment as a Percent of the Section 1923(f)(3)(B) Limit



Notes: DSH is disproportionate share hospital. The bar chart shows the final allotment as a percentage of the CMS calculated DSH allotment limit as outlined under Section 1923(f)(3)(B) of the Social Security Act. According to this provision, DSH allotments are not allowed to exceed 12 percent of total medical assistance spending in the state. In 2014 and 2017–2019, New Hampshire's DSH allotment was closest to the limit. From 2015 to 2016, Louisiana's DSH allotment was closest to the limit.

Source: MACPAC analysis of CMS 2022, 2019, 2018, 2017, 2016.

Implications

Federal spending. According to the CBO, this recommendation would have no effect on federal spending because no state is likely to have DSH spending close to the existing limit on DSH allotments as a share of state Medicaid spending. This recommendation would reduce federal administrative burden needed to finalize DSH allotments because CMS would no longer need to review medical spending data before finalizing DSH allotments.

States. This recommendation would help provide more certainty to states about available DSH funds in a timely manner. By helping CMS to finalize DSH allotments sooner, this policy would help states plan for how to spend available DSH funds with fewer concerns about needing to recoup funding at a later date.

Enrollees. This recommendation would likely have no direct effect on enrollees.

Plans. This recommendation would likely have no direct effect on Medicaid managed care plans.

Providers. This recommendation would help hospitals receive DSH payments in a timelier manner, since states would be able to send out DSH payments on a more rapid basis when DSH allotments are finalized with less concern about these payments being recouped.

Endnotes

[1] 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 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 and 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.

[2] A hospital qualifies to receive DSH payments if the facility meets specific statutory requirements. This includes having a Medicaid inpatient utilization rate of 1 percent and having 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). Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days divided by the total number of inpatient days.

[3] 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. The Omnibus Budget Reconciliation Act of 1981 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).

[4] Medicaid DSH payments are not subject to this upper payment limit, but Medicaid DSH payments to an individual hospital are limited to that hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

[5] 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 (Appeals 2002).

[6] 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.

[7] This analysis excludes DSH payments to institutions for mental diseases and Section 1115 supplemental payments that are financed by DSH allotments and diverted to the Section 1115 demonstration.

[8] Deemed DSH hospitals are hospitals with a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receives Medicaid payments or a low-income utilization rate that

exceeds 25 percent. Low-income utilization rate is defined as the sum of two fractions. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act). For more on deemed DSH and other DSH hospitals, please refer to Chapter 4: Annual analysis of Medicaid disproportionate share hospital allotments to states in MACPAC's March 2023 Report to Congress on Medicaid and CHIP (MACPAC 2023b).

[9] Under Section 1115 demonstration authority, CMS has authorized uncompensated care pools in some states that also pay for unpaid costs of care to uninsured individuals.

[10] DSH payment data is provided to CMS from states on Medicaid DSH audits. These audits are reported on a state plan rate year basis, which often corresponds to the state fiscal year and does not align with the federal fiscal year.

[11] 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 have 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.

[12] The GAO prototype model triggers an enhanced FMAP that is automatically implemented nationally when 26 or more states show increased unemployment (defined as a decrease in the three-month average employment-to-population ratio over the prior year) for two consecutive months. The GAO model ends temporary assistance once fewer than half of states show a decline in their year-over-year employment-to-population ratio over two consecutive months (GAO 2011).

[13] Because Section 1115 demonstrations often include multiple populations with different FMAP rates, CMS applies an average FMAP rate (referred to as the "composite federal share") that is based on federal funding for all demonstration expenditures divided by total state and federal spending under the demonstration.

[14] Providers in states that generate the non-federal share for DSH payments through a provider tax or an assessment would benefit if the state reduces the provider contribution in the form of tax relief. However, provider tax relief would not be implemented immediately. Many states have laws that require funds generated through a provider tax in a separate fund, which can be used only to finance payments for the taxed providers. States may find themselves with a surplus in the fund at the end of the year, which they will use to reduce the tax or assessment in the subsequent year.

[15] States can target non-DSH Medicaid payments by creating different payment policies for classes of hospitals that meet state-specified characteristics.

[16] These states were chosen because they have different characteristics regarding the unspent allotment within the state and state strategies in financing the non-federal share for DSH payments.

[17] For each month from April 1, 2023, through June 30, 2024, states must submit data related to the unwinding that the Secretary of HHS (the Secretary) must make publicly available. Although the Consolidated Appropriations Act of 2023 requires that the data must be submitted to the Secretary on a timely basis, the law does not specify a timeline for sharing the data publicly. The required data reporting includes the number of eligibility renewals initiated, the total number of beneficiaries renewed, and the beneficiaries renewed on an ex parte basis; the number of individuals whose Medicaid, CHIP, or pregnancy-related coverage was terminated and the number terminated for procedural reasons; the number of children enrolled in separate CHIP; the number of individuals determined eligible for a qualified health plan or the basic health program, and of these, the number of eligible individuals who selected a qualified health plan or were enrolled in the basic health program; in states using the federal exchange or a non-integrated state-based exchange, the number of account transfers to the exchange; call center volume, average wait times, and call abandonment rates; and other information related to eligibility redeterminations and renewals as identified by the Secretary.

[18] The automatic countercyclical financing model is triggered when a majority of states have a decline in their three-month average employment-to-population ratio for two consecutive months when compared with the prior year. The use of the three-month average helps to smooth out monthly outliers, while the use of a year-over-year trend over two consecutive months controls for seasonal employment differences.

[19] State-level increases in the FMAP are determined by measuring the degree to which employment and salaries declined. States with lower levels of employment and salary or wage declines would receive a greater federal match. Both measures indicate the extent to which Medicaid would

need to cover a growing share of the population and the degree to which states can finance the non-federal share as its tax revenue declines.

[20] A 12 percent DSH allotment limit means that federal allotments cannot be greater than the total amount of Medicaid medical assistance expenditures (i.e., federal and state medical benefit spending, which does not include spending on administrative activities).

[21] Tennessee did not receive a DSH allotment in FY 2014, and its DSH allotment is set to $53,100,000 from FY 2015 to FY 2025 under the provisions of Section 1923(f)(6). Louisiana was not subject to the 12 percent limit until FY 2015 because its allotment is determined under provisions under Section 1923(f)(3)(C) and (D), which froze Louisiana's DSH allotment at FY 2004 levels (CRS 2016).

[22] New Hampshire's non-DSH-related medical spending declined by $2.1 billion (11 percent) in FY 2019 when compared with the year prior.

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APPENDIX 1A. State Effects of DSH Allotment Policy

TABLE 1A-1. DSH Allotments under Different Policy Scenarios, FY 2018 and FY 2019 (millions)

State	Percentage point change in FMAP (2018–2019)	Federal DSH allotment					Total available state and federal DSH funding				
			Allotment based on federal funding (current law)		Allotment based on total funding			Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2018	FY 2019	Percent change	FY 2019	Percent change	FY 2018	FY 2019	Percent change	FY 2019	Percent change
Total		**$12,244**	**$12,538**	**2.4%**	**$12,593**	**2.9%**	**$21,706**	**$22,135**	**2.0%**	**$22,227**	**2.4%**
Alabama	0.44%	345	353	2.4	355	3.0	482	491	1.8	494	2.4
Alaska	–	23	23	2.4	23	2.4	46	47	2.4	47	2.4
Arizona	-0.08	113	116	2.4	116	2.3	162	166	2.5	166	2.4
Arkansas	-0.36	48	50	2.4	49	1.9	68	70	2.9	70	2.4
California	–	1,229	1,258	2.4	1,258	2.4	2,457	2,516	2.4	2,516	2.4
Colorado	–	104	106	2.4	106	2.4	207	212	2.4	212	2.4
Connecticut	–	224	230	2.4	230	2.4	448	459	2.4	459	2.4
Delaware	1.12	10	10	2.4	11	4.4	18	18	0.4	18	2.4
District of Columbia	–	69	70	2.4	70	2.4	98	100	2.4	100	2.4
Florida	-0.92	224	230	2.4	226	0.9	363	377	3.9	371	2.4
Georgia	-0.88	301	308	2.4	304	1.1	440	456	3.7	450	2.4
Hawaii	-0.86	11	11	2.4	11	0.8	20	21	4.0	20	2.4
Idaho	-0.04	18	19	2.4	19	2.3	26	27	2.5	27	2.4
Illinois	-0.43	241	247	2.4	245	1.5	475	490	3.3	486	2.4
Indiana	0.37	240	245	2.4	247	3.0	365	372	1.8	374	2.4
Iowa	1.45	44	45	2.4	46	4.9	75	75	-0.1	77	2.4
Kansas	2.36	46	47	2.4	49	6.8	84	83	-1.8	86	2.4
Kentucky	0.50	163	166	2.4	168	3.1	228	232	1.7	234	2.4
Louisiana	1.31	768	787	2.4	803	4.5	1,207	1,211	0.3	1,235	2.4
Maine	0.18	118	120	2.4	121	2.7	183	187	2.1	187	2.4
Maryland	–	85	88	2.4	88	2.4	171	175	2.4	175	2.4
Massachusetts	–	342	350	2.4	350	2.4	684	700	2.4	700	2.4

TABLE 1A-1. (continued)

State	Percentage point change in FMAP (2018–2019)	Federal DSH allotment					Total available state and federal DSH funding				
			Allotment based on federal funding (current law)		Allotment based on total funding			Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2018	FY 2019	Percent change	FY 2019	Percent change	FY 2018	FY 2019	Percent change	FY 2019	Percent change
Total		**$12,244**	**$12,538**	**2.4%**	**$12,593**	**2.9%**	**$21,706**	**$22,135**	**2.0%**	**$22,227**	**2.4%**
Michigan	-0.33%	297	304	2.4	303	1.9	458	472	2.9	469	2.4
Minnesota	–	84	86	2.4	86	2.4	167	171	2.4	171	2.4
Mississippi	0.74	171	175	2.4	177	3.4	226	229	1.4	231	2.4
Missouri	0.79	531	544	2.4	550	3.7	822	831	1.2	841	2.4
Montana	0.16	13	13	2.4	13	2.7	19	20	2.2	20	2.4
Nebraska	0.03	32	32	2.4	32	2.5	60	62	2.3	62	2.4
Nevada	-0.88	52	53	2.4	52	1.0	79	82	3.8	81	2.4
New Hampshire	–	179	184	2.4	184	2.4	359	367	2.4	367	2.4
New Jersey	–	721	739	2.4	739	2.4	1,443	1,478	2.4	1,478	2.4
New Mexico	0.10	23	23	2.4	23	2.5	32	32	2.3	32	2.4
New York	–	1,800	1,843	2.4	1,843	2.4	3,600	3,687	2.4	3,687	2.4
North Carolina	-0.45	331	339	2.4	336	1.7	489	504	3.1	501	2.4
North Dakota	–	11	11	2.4	11	2.4	21	22	2.4	22	2.4
Ohio	0.31	455	466	2.4	469	2.9	725	739	1.9	743	2.4
Oklahoma	3.81	41	42	2.4	44	9.1	69	67	-3.9	71	2.4
Oregon	-1.06	51	52	2.4	51	0.7	80	83	4.1	82	2.4
Pennsylvania	0.43	629	644	2.4	649	3.2	1,214	1,233	1.6	1,243	2.4
Rhode Island	1.12	73	75	2.4	76	4.6	142	142	0.2	145	2.4
South Carolina	-0.36	367	376	2.4	374	1.9	513	528	2.9	525	2.4
South Dakota	1.37	12	13	2.4	13	4.9	22	22	-0.1	23	2.4
Texas	1.31	1,072	1,097	2.4	1,123	4.8	1,884	1,886	0.1	1,929	2.4
Utah	-0.55	22	23	2.4	22	1.6	31	32	3.2	32	2.4

TABLE 1A-1. (continued)

State	Percentage point change in FMAP (2018–2019)	Federal DSH allotment					Total available state and federal DSH funding				
			Allotment based on federal funding (current law)		Allotment based on total funding			Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2018	FY 2019	Percent change	FY 2019	Percent change	FY 2018	FY 2019	Percent change	FY 2019	Percent change
Total		**$12,244**	**$12,538**	**2.4%**	**$12,593**	**2.9%**	**$21,706**	**$22,135**	**2.0%**	**$22,227**	**2.4%**
Vermont	0.42%	25	26	2.4	26	3.2	47	48	1.6	48	2.4
Virginia	–	98	101	2.4	101	2.4	196	201	2.4	201	2.4
Washington	–	207	212	2.4	212	2.4	415	425	2.4	425	2.4
West Virginia	1.10	76	77	2.4	79	3.9	103	104	0.9	106	2.4
Wisconsin	0.60	106	108	2.4	110	3.4	180	183	1.4	185	2.4
Wyoming	–	0	0	2.4	0	2.4	1	1	2.4	1	2.4

Notes: DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. Under current law, federal DSH allotments increase based on inflation, and under our recommendation to base allotments on total funding, total available DSH funding increases based on inflation. Under either policy, states must provide non-federal funding to spend all available state and federal DSH funds. List of states does not include Tennessee because its federal DSH allotment was $0 in FY 2014 and is set in statute through FY 2025 and does not increase automatically based on inflation like other states.

– Dash indicates zero. 0.0% and $0 are non-zero amounts that round to zero.

Source: MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

TABLE 1A-2. DSH Allotments under Different Policy Scenarios, FY 2014 and FY 2019 (millions)

State	Percentage point change in FMAP (2014–2019)	Federal DSH allotment					Total available state and federal DSH funding				
			Allotment based on federal funding (current law)		Allotment based on total funding			Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2014	FY 2019	Percent change	FY 2019	Percent change	FY 2014	FY 2019	Percent change	FY 2019	Percent change
Total		**$11,663**	**$12,538**	**7.5%**	**$12,648**	**8.4%**	**$20,759**	**$22,135**	**6.6%**	**$22,316**	**7.5%**
Alabama	3.76%	328	353	7.5	372	13.4	482	491	1.9	518	7.5
Alaska	–	22	23	7.5	23	7.5	43	47	7.5	47	7.5
Arizona	2.58	108	116	7.5	121	11.6	161	166	3.5	173	7.5
Arkansas	0.41	46	50	7.5	50	8.1	66	70	6.9	71	7.5
California	–	1,170	1,258	7.5	1,258	7.5	2,341	2,516	7.5	2,516	7.5
Colorado	–	99	106	7.5	106	7.5	197	212	7.5	212	7.5
Connecticut	–	214	230	7.5	230	7.5	427	459	7.5	459	7.5
Delaware	2.24	10	10	7.5	11	11.9	17	18	3.3	19	7.5
District of Columbia	–	65	70	7.5	70	7.5	93	100	7.5	100	7.5
Florida	2.08	214	230	7.5	238	11.3	363	377	3.8	390	7.5
Georgia	1.69	287	308	7.5	316	10.3	435	456	4.8	468	7.5
Hawaii	2.07	10	11	7.5	12	11.8	20	21	3.4	22	7.5
Idaho	-0.51	18	19	7.5	19	6.7	24	27	8.3	26	7.5
Illinois	0.31	230	247	7.5	248	8.2	459	490	6.8	493	7.5
Indiana	-0.96	228	245	7.5	242	6.0	341	372	9.1	367	7.5
Iowa	2.00	42	45	7.5	47	11.2	73	75	3.9	78	7.5
Kansas	0.19	44	47	7.5	47	7.9	77	83	7.1	83	7.5
Kentucky	1.84	155	166	7.5	171	10.3	222	232	4.7	238	7.5
Louisiana[1]	4.02	732	787	7.5	839	14.6	1,200	1,211	0.8	1,290	7.5
Maine	2.97	112	120	7.5	126	12.7	182	187	2.6	196	7.5
Maryland	–	81	88	7.5	88	7.5	163	175	7.5	175	7.5
Massachusetts	–	326	350	7.5	350	7.5	651	700	7.5	700	7.5

TABLE 1A-2. (continued)

State	Percentage point change in FMAP (2014–2019)	Federal DSH allotment					Total available state and federal DSH funding				
			Allotment based on federal funding (current law)		Allotment based on total funding			Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2014	FY 2019	Percent change	FY 2019	Percent change	FY 2014	FY 2019	Percent change	FY 2019	Percent change
Total		**$11,663**	**$12,538**	**7.5%**	**$12,648**	**8.4%**	**$20,759**	**$22,135**	**6.6%**	**$22,316**	**7.5%**
Michigan	-1.87%	283	304	7.5	296	4.5	427	472	10.6	459	7.5
Minnesota	–	80	86	7.5	86	7.5	159	171	7.5	171	7.5
Mississippi	3.34	163	175	7.5	183	12.4	223	229	2.8	240	7.5
Missouri	3.37	506	544	7.5	573	13.3	815	831	2.0	876	7.5
Montana	-0.79	12	13	7.5	13	6.2	18	20	8.8	20	7.5
Nebraska	-2.16	30	32	7.5	31	3.3	55	62	11.9	59	7.5
Nevada	1.77	49	53	7.5	55	10.5	78	82	4.6	84	7.5
New Hampshire	–	171	184	7.5	184	7.5	342	367	7.5	367	7.5
New Jersey	–	687	739	7.5	739	7.5	1,374	1,478	7.5	1,478	7.5
New Mexico	3.06	22	23	7.5	24	12.3	31	32	2.9	34	7.5
New York	–	1,715	1,843	7.5	1,843	7.5	3,429	3,687	7.5	3,687	7.5
North Carolina	1.38	315	339	7.5	346	9.8	479	504	5.3	515	7.5
North Dakota	–	10	11	7.5	11	7.5	20	22	7.5	22	7.5
Ohio	0.07	434	466	7.5	467	7.6	688	739	7.4	740	7.5
Oklahoma	-1.64	39	42	7.5	40	4.7	60	67	10.3	65	7.5
Oregon	-0.58	48	52	7.5	51	6.5	77	83	8.5	82	7.5
Pennsylvania	-1.27	599	644	7.5	629	4.9	1,119	1,233	10.1	1,203	7.5
Rhode Island	2.46	69	75	7.5	78	12.8	138	142	2.5	149	7.5
South Carolina	0.65	350	376	7.5	379	8.5	495	528	6.5	533	7.5
South Dakota	3.17	12	13	7.5	13	13.9	22	22	1.5	24	7.5
Texas	-0.50	1,021	1,097	7.5	1,088	6.6	1,739	1,886	8.4	1,870	7.5
Utah	-0.63	21	23	7.5	22	6.5	30	32	8.5	32	7.5

TABLE 1A-2. (continued)

State	Percentage point change in FMAP (2014–2019)	Federal DSH allotment					Total available state and federal DSH funding				
			Allotment based on federal funding (current law)		Allotment based on total funding			Allotment based on federal funding (current law)		Allotment based on total funding	
		FY 2014	FY 2019	Percent change	FY 2019	Percent change	FY 2014	FY 2019	Percent change	FY 2019	Percent change
Total		**$11,663**	**$12,538**	**7.5%**	**$12,648**	**8.4%**	**$20,759**	**$22,135**	**6.6%**	**$22,316**	**7.5%**
Vermont	-1.22%	24	26	7.5	25	5.1	44	48	9.9	47	7.5
Virginia	–	94	101	7.5	101	7.5	187	201	7.5	201	7.5
Washington	–	197	212	7.5	212	7.5	395	425	7.5	425	7.5
West Virginia	3.25	72	77	7.5	81	12.4	101	104	2.8	109	7.5
Wisconsin	0.31	101	108	7.5	109	8.1	171	183	6.9	184	7.5
Wyoming	–	0	0	7.5	0	7.5	0	1	7.5	1	7.5

Notes: DSH is disproportionate share hospital. FY is fiscal year. FMAP is federal medical assistance percentage. Under current law, federal DSH allotments increase based on inflation, and under our recommendation to base allotments on total funding, total available DSH funding increases based on inflation. Under either policy, states must provide non-federal funding to spend all available state and federal DSH funds. List of states does not include Tennessee because its federal DSH allotment was $0 in FY 2014 and is set in statute through FY 2025 and does not increase automatically based on inflation like other states.

– Dash indicates zero. 0.0% and $0 are non-zero amounts that round to zero.

[1] Louisiana's FMAP represents its FMAP for DSH payments. Louisiana had an enhanced FMAP in 2014 that was increased under the Stafford Act; however, the Stafford Act FMAP increase only applies to non-DSH Medicaid payments.

Source: MACPAC, 2023, analysis of the Medicaid Budget Expenditure System.

Commission Vote on Recommendations

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

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

The Commission voted on these recommendations on April 14, 2023.

Automatic Adjustments to Medicaid Disproportionate Share Hospital Allotments

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

1.2 Congress should amend Section 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.

1.3 Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends this policy change should also include:

- an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment;
- an upper bound of 100 percent on adjusted matching rates;
- an increase in federal disproportionate share hospital (DSH) allotments so that total available DSH funding does not change as a result of changes to the federal medical assistance percentage (FMAP); and
- an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments (e.g., territories) and other services and populations that receive special matching rates (e.g., for the new adult group)

1.4 To provide states and hospitals with greater certainty about available disproportionate share hospital (DSH) allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that the Centers for Medicare & Medicaid Services compare DSH allotments to total state Medicaid medical assistance expenditures in a given year before finalizing DSH allotments for that year.

1.1-1.4 voting results	#	Commissioner
Yes	15	Allen, Bella, Bjork, Brooks, Carter, Cerise, Davis, Duncan, Gerstorff, Giardino, Gordon, Johnson, Medows, Scanlon, Weno
Not present	1	Heaphy