Chapter 3:

Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

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Key Points

- State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid and other low-income patients.
- State DSH spending is limited by federal allotments, which vary widely by state based on states' historical DSH spending before federal limits were established in 1992.
- MACPAC continues to find no meaningful relationship between 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.
- Under current law, federal DSH allotments are scheduled to be reduced by $8 billion in fiscal year 2024, which is about half of unreduced allotment amounts.
  - At the time of this chapter's drafting, Congress has delayed the implementation of these reductions until March 9, 2024.
  - The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety-net providers.
- MACPAC has made several recommendations for statutory changes to improve Medicaid DSH policy.
  - Congress has partially implemented MACPAC's recommendations on data transparency and the treatment of third-party payments in the definition of Medicaid shortfall.
  - The Commission's recommendations on restructuring DSH allotments and adjusting DSH allotments to account for changes in the federal matching assistance percentage have not yet been implemented.
- The Commission is currently engaging in a long-term work plan to further examine all types of Medicaid payments to hospitals using newly available data on non-DSH supplemental payments and managed care directed payments.
  - In recent years, some states have begun substituting other types of Medicaid payments for DSH payments.
  - In the Commission's view, DSH policy should be assessed in the context of all other Medicaid payments to hospitals.

CHAPTER 3: 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. Generally, DSH payments 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 if federal DSH allotment reductions take effect.

In this report, we update our previous findings to reflect new information on changes in the number of uninsured individuals and levels of hospital uncompensated care. We also provide updated information on deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. We also update our findings with data on hospital finances in fiscal year (FY) 2021, which include the effects of the COVID-19 pandemic. Although the COVID-19 pandemic disrupted hospital finances, policy responses during the COVID-19 public health emergency (PHE) helped lower the uninsured rate, increased DSH allotments, and provided other fiscal relief to hospitals. Specifically, we find the following:

- A total of 25.9 million people, or 7.9 percent of the U.S. population, were uninsured in 2022, a 0.4 percentage point decline from 2021 (Keisler-Starkey et al. 2023).[2] Some of the decline in the uninsured rate may be attributed to the continuous coverage requirements implemented during the PHE (MACPAC 2022a).[3]
- Hospitals reported $39.3 billion in hospital charity care and bad debt costs on Medicare cost reports in FY 2021. This amount represented a $1.3 billion (0.4 percentage point) decrease in uncompensated care costs from FY 2020. 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.[4]
- In FY 2021, the aggregate operating margin for all hospitals was negative across all hospitals (-0.8 percent) and was lower for deemed DSH hospitals (-4.6 percent).[5] These negative operating margins may be partially attributed to financial disruptions of the COVID-19 pandemic. We also calculated total margin, which accounts for all forms of hospital revenue, including federal provider relief funding authorized during the PHE. The aggregate total margin was similar for both deemed DSH and other hospitals (9.3 vs. 10.1 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. DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid and the health insurance exchanges would lead to reductions in hospital uncompensated care and thereby lessen the need for DSH payments. DSH allotment reductions have been delayed several times, and in recent years, Congress has acted to eliminate some of the reductions.

Under current law, $8 billion in federal DSH allotment reductions are scheduled to take effect in FY 2024. However, at the time of this chapter's drafting, Congress has delayed the implementation of these reductions until March 9, 2024 (Further Additional Continuing Appropriations and Other Extensions Act, 2024, P.L. 118-135). The House of Representatives has passed legislation that would eliminate DSH reductions for FY 2024 and FY 2025 and retain DSH allotment reductions of $8 billion annually for FY 2026 and FY 2027 (H.R. 5378). While this legislation has not been taken up by the Senate, a similar delay of the DSH allotment reductions was introduced in the Senate (S. 3430). Due to the uncertainty of when the allotment reductions may be implemented, the analyses in this chapter assume the federal DSH allotment reductions will begin in FY 2026. In FY 2026, the $8 billion reduction is projected to be 48.7 percent of unreduced allotments.

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH policy (Box 3-1). Congress has partially implemented MACPAC's recommendations on data transparency and the treatment of third-party payments in the definition of Medicaid shortfall. However, the Commission's recommendations on restructuring DSH allotments and adjusting DSH allotments to account for changes in the federal matching assistance percentage (FMAP) have not been implemented. The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety-net providers but has not taken a position on whether Congress should proceed with reductions in current law. However, if Congress proceeds with DSH allotment reductions, it should change the methodology to phase in reductions and gradually improve the relationship between DSH allotments and measures of need for DSH funds.

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. To this end, the Commission has begun a long-term work plan to further examine all types of Medicaid payments to hospitals and assess whether payment policies are consistent with the statutory goals of efficiency, economy, quality, and access (MACPAC 2023a).

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. Then the chapter reviews DSH allotment reductions under current law and how they relate to the factors that Congress asked the Commission to consider. The chapter concludes by discussing the relationship between DSH and other types of Medicaid payments and by reviewing next steps for MACPAC's work in this area.

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 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]

BOX 3-1. Prior MACPAC Recommendations Related to Disproportionate Share Hospital Policy

February 2016

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

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

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 DSH allotment reductions, but it has not adopted a more gradual phase-in of reductions.
- 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.

BOX 3-1. (continued)

June 2019

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

- To avoid Medicaid making disproportionate share hospital (DSH) 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: 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.

June 2023

Automatic Medicaid disproportionate share hospital allotments

- 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 (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 federal medical assistance percentage (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.

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 3-2). 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 3 percent in FY 2022 (MACPAC 2023e, 2023f; CRS 2023). States are not required to spend their entire allotment and do not receive federal funding for DSH payments that exceed the allotment.

BOX 3-2. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

Disproportionate share hospital (DSH) hospital. A hospital that receives Medicaid DSH payments and meets the minimum statutory requirements to be eligible for DSH payments: 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 that exceeds 25 percent. Low-income utilization rate is defined as the sum of two fractions. The first fraction relates to revenue for patient services and is defined as total Medicaid revenue for patient services plus other payments for patient services from state and local governments divided by the total amount of hospital revenue for patient services. The second fraction relates to charity care and is defined as the total amount of hospital charges for inpatient hospital charity care minus any payments from state and local governments for this care divided by total hospital charges. Deemed DSH hospitals are required to receive Medicaid DSH payments.

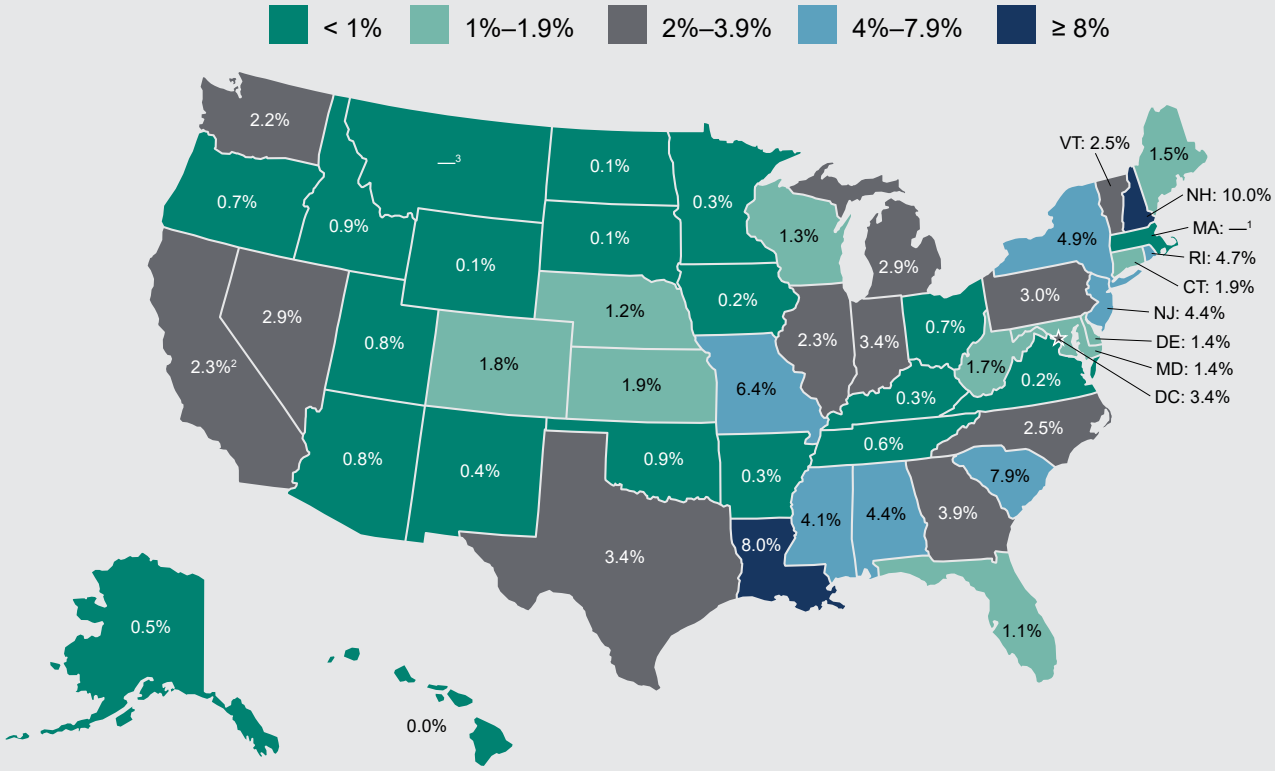
State DSH allotment. The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other regular Medicaid service expenditures. If a state does not spend the full amount of its 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.

State total DSH funding. The total amount of state and federal funds available for DSH payments within a state. Assuming a state is able to spend its full allotment in a given year, total DSH funding available to DSH hospitals is equal to the state's allotment divided by its federal medical assistance percentage.

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. For the definitions of Medicaid uncompensated care, see Box 3-3.

Between FY 2020 and FY 2024, Congress temporarily increased DSH allotments as part of the 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 Coronavirus Response Act (P.L. 116-127). At the time, Congress did not change federal DSH allotment policy. This statutory change 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 the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) so that the total available state and federal DSH funding remained the same as it would have been before the FMAP increase. The ARPA adjustments to DSH allotments were retroactive to the second quarter of FY 2020 and lasted until the first quarter of FY 2024.[10] For more on the effects that the FMAP has on DSH allotments, please refer to Chapter 1 of MACPAC's June 2023 report to Congress (MACPAC 2023b).

FIGURE 3-1. DSH Spending as a Share of Total Medicaid Benefit Spending by State, FY 2022



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] Montana reported no DSH spending in FY 2022. States typically have two years to report DSH spending after the close of the fiscal year.

Source: MACPAC, 2024, analysis of CMS-64 financial management report net expenditure data as of May 30, 2023.

In FY 2022, allotments to states for DSH payments totaled $14.9 billion.[11] State-specific DSH allotments that year ranged from less than $15 million in five states (Delaware, Hawaii, North Dakota, South Dakota, and Wyoming) to more than $1 billion in three states (California, New York, and Texas).

Total federal and state DSH spending was $20 billion in FY 2022 and accounted for 3 percent of total Medicaid benefit spending.[12,13] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 20 states to 10 percent in New Hampshire (Figure 3-1).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[14] As of the end of FY 2023, $1.9 billion (13 percent) in federal DSH allotments for FY 2021 were unspent.[15]

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 2021, over half of unspent DSH allotments were attributable to six states (Connecticut, Indiana, Louisiana, New Jersey, Pennsylvania, and Virginia). All of these states, excluding Indiana and Virginia, had FY 2021 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on 2021 Medicare cost reports, which suggests that these states may not be able to spend their full DSH allotments even if they have available state funds to provide the non-federal share.[16]

There are also regulatory or operational challenges to spend down DSH allotments in a timely manner when there are delays in Centers for Medicare & Medicaid Services (CMS) finalizing DSH allotments.[17] 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 what was projected.[18]

DSH payments to hospitals

In state plan rate year (SPRY) 2019, 41 percent of U.S. hospitals received DSH payments (Table 3-1).[19,20] 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 (54 percent) and teaching hospitals (63 percent) received DSH payments.

Medicaid DSH is also an important source of funding for rural hospitals. Almost half of all rural hospitals (46 percent) received more than $2 billion in DSH payments in SPRY 2019. Unlike Medicare DSH, Medicaid DSH payments can be used to support critical access hospitals, which receive a special payment designation from Medicare because they are small (fewer than 25 beds) and are often the only provider in their geographic areas.[21] For more information on Medicaid hospital payment policy for rural hospitals, refer to the MACPAC issue brief, *Rural Hospitals and Medicaid Payment Policy* (MAPCAC 2018).

The proportion of hospitals receiving DSH payments varies widely by state (Figure 3-2). In SPRY 2019, six states made DSH payments to fewer than 10 percent of the hospitals in their states (Arkansas, California, Illinois, Iowa, Maine, and North Dakota).[22] Conversely, one state, New York, made DSH payments to 95 percent of its hospitals.

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 2019, about 12 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just more than one-quarter (28 percent) of DSH hospitals but accounted for more than half (59 percent) of all DSH payments, receiving more than $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 6 states (Alabama, Alaska, Arkansas, Connecticut, North Dakota, and Utah) to 100 percent in 5 states (Delaware, Iowa, Illinois, Maine, and Maryland) and the District of Columbia.

TABLE 3-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2019

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as percentage of all hospitals in category	
Total	**2,464**	**5,940**	**41%**	**$17,224**
Hospital type				
Short-term (General and Specialty) hospitals	1,714	3,190	54	13,455
Critical Access hospital	535	1,358	39	438
Psychiatric hospital	139	625	22	2,933
Long-term hospital	9	347	3	8
Rehabilitation hospital	16	328	5	4
Children's hospital	51	92	55	386
Urban/Rural				
Urban	1,350	3,535	38	15,171
Rural	1,114	2,405	46	2,053
Hospital ownership				
For-profit	338	1,753	19	910
Non-profit	1,471	2,975	49	6,084
Public	655	1,212	54	10,229
Teaching status				
Non-teaching hospital	1,637	4,619	35	4,916
Low-teaching hospital	528	880	60	3,177
High-teaching hospital	299	441	68	9,130
Deemed DSH status				
Deemed	694	694	100	10,230
Not deemed	1,770	5,246	34	6,993

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 65 DSH hospitals that did not submit a fiscal year 2021 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 exclude 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. Data for DSH hospitals in Montana were estimated using Montana's SPRY 2018 as-filed DSH audit because SPRY 2019 was unavailable.

Source: MACPAC, 2024, analysis of FY 2021 Medicare cost reports and SPRY 2018–2019 as-filed Medicaid DSH audits.

FIGURE 3-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals by State, SPRY 2019

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. 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. Analysis also excludes Montana because its SPRY 2019 as-filed DSH audit was unavailable.

[1] None of the hospitals in Arkansas and Alaska that received DSH payments appear to meet the deemed DSH criteria according to MACPAC's analysis of available data.

Source: MACPAC, 2024, analysis of Medicare cost reports and SPRY 2019 as-filed Medicaid DSH audits.

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, 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., New Jersey) (Figure 3-2).

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) in FY 2018. These states directed a larger share of their SPRY 2018 DSH payments to publicly owned providers than states that fund DSH payments through general revenue or a provider tax. Conversely, in the 12 states that predominately used a provider tax to generate the non-federal share of DSH payments, DSH payments are distributed broadly, and these states did not appear to target their DSH payments to a particular class of hospital (MACPAC 2023g; GAO 2021a, 2014). More information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

TABLE 3-2. Uninsured Rates by Selected Characteristics, United States, 2021 and 2022

Characteristic	2021	2022	Percentage point change
All uninsured	**8.3%**	**7.9%**	**-0.4%***
Age group			
Younger than age 19	5.0	5.4	0.4
Age 19–64	11.6	10.8	-0.8*
Older than age 64	1.2	1.1	-0.1
Race and ethnicity			
White, non-Hispanic	5.2	4.9	-0.3*
Black, non-Hispanic	9.0	8.3	-0.7
Asian, non-Hispanic	6.2	5.9	-0.3
Hispanic (any race)	18.3	17.2	-1.1*
Income-to-poverty ratio			
Less than 100 percent	16.2	16.5	0.3
100–199 percent	13.2	12.7	-0.5
200–299 percent	11.0	9.9	-1.1*
300–399 percent	8.9	7.4	-1.5*
400 percent or more	3.3	3.1	-0.2
Medicaid expansion status in state of residence as of January 1, 2022			
Non-expansion	12.0	11.8	-0.2
Expansion	6.6	6.1	-0.5*

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, 2022.

* Indicates change is statistically different from zero at the 90 percent confidence level. MACPAC calculated significance using standard errors from Keisler-Starkey et al. 2023. This statistic includes only states that expanded Medicaid before January 1, 2022.

Source: MACPAC, 2024, analysis of Keisler-Starkey et al. 2023.

State DSH policies change frequently, often as a function of state budgets and financing decisions. 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 2019 also received DSH payments in SPRY 2018. However, the amount that hospitals receive can change considerably in subsequent reporting years. For example, 21 percent of the hospitals that received DSH payments in both SPRY 2018 and 2019 reported that their 2019 DSH payments changed by more than 50 percent.

Changes in the Number of Uninsured Individuals

In 2022, 25.9 million people (7.9 percent of the U.S. population) were uninsured, a statistically significant decrease from the number and share in 2021 (27.2 million and 8.3 percent, respectively) (Table 3-2) (Keisler-Starkey et al. 2023).

At the beginning of the PHE in 2020, Congress required states to maintain Medicaid coverage and eligibility standards to receive an enhanced FMAP. Beginning April 2023, Congress phased out this continuous coverage requirement, and states have resumed normal eligibility redeterminations.[23] Between February 2020 and March 2023, while this continuous coverage requirement was in effect, Medicaid and CHIP enrollment increased 32.5 percent, from 70.9 million to 93.9 million (CMS 2023a).

The uninsured rate in 2022 was highest for adults younger than age 65, individuals of Hispanic ethnicity, and individuals with incomes below the federal poverty level (Table 3-2). Between 2021 and 2022, the uninsured rate decreased significantly for adults younger than age 65, those who identify as Hispanic; those who identify as white, non-Hispanic; those with incomes between 200 and 399 percent of the federal poverty level; and those living in states that did expand Medicaid (Keisler-Starkey et al. 2023).

In 2022, 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 of the federal poverty level was nearly twice as high as the uninsured rate in states that expanded Medicaid (11.8 and 6.1 percent, respectively).[24] Missouri and Oklahoma both expanded Medicaid in calendar year 2021 and saw a decline in the uninsured rate between 2021 and 2022 (0.8 percentage points and 2.1 percentage points, respectively) (Table 3-2) (KFF 2023b).

As states continue Medicaid eligibility redeterminations in the coming year, Medicaid enrollment is expected to decline, and the number of uninsured individuals is likely to increase. By October 2023, more than 9 million Medicaid enrollees have been disenrolled due to the end of the continuous coverage requirement (KFF 2024). Some of those who were determined ineligible for Medicaid may now be eligible to receive coverage through the insurance exchanges. The Commission will continue to closely monitor the renewal process and how Medicaid redeterminations may affect Medicaid enrollment, the number of uninsured individuals, and associated levels of hospital uncompensated care.

Changes in the Amount of Hospital Uncompensated Care

DSH payments cover both unpaid costs of care for uninsured individuals and Medicaid shortfall. In states that have expanded Medicaid under the ACA, unpaid costs of care for uninsured individuals have declined substantially relative to pre-2014 levels. However, as the number of Medicaid enrollees has increased after Medicaid expansion, Medicaid shortfall has generally increased as well.

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

Data sources

American Hospital Association (AHA) annual survey. An annual survey of hospitals that provides aggregated national estimates of uncompensated care for community hospitals. The AHA survey has reported information about Medicaid shortfall in prior years but has not reported Medicaid shortfall information since 2020.

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 limited exceptions, such as those with no or low Medicare use). 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 2019, the latest year for which data are available to MACPAC.

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, copayments, or coinsurance.

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

Definitions of uncompensated care vary among data sources, complicating comparisons at the hospital level and our ability to fully understand the effects of uncompensated care on hospital finances (Box 3-3). The most recently available data on hospital uncompensated care for all hospitals comes from Medicare cost reports, which define uncompensated care as charity care and bad debt.[25] 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.

In our analysis of Medicaid DSH audits, we found that DSH payments were used to offset different types of uncompensated care in SPRY 2019 and that this practice 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 (73 percent) for DSH hospitals among expansion states compared with states that did not expand Medicaid (12 percent).

In the following sections, we review the most recent uncompensated care data available for all hospitals in FY 2021 as well as additional information about Medicaid shortfall reported for DSH hospitals in SPRY 2019. We also summarize the most recent available data on hospital margins.

Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $39.3 billion in charity care and bad debt in FY 2021, or about 3.6 percent of hospital operating expenses. This is a $1.4 billion increase from FY 2019 and a 0.4 percentage point decrease as a share of hospital operating expenses.[26]

Charity care and bad debt, as a share of hospital operating expenses, varied widely by state in FY 2021 (Figure 3-3). In the aggregate, hospitals in states that expanded Medicaid under the ACA before September 30, 2021, reported less than half the uncompensated care that was reported in non-expansion states (2.4 percent of hospital operating expenses in Medicaid expansion states vs. 6.6 percent in states that did not expand Medicaid).

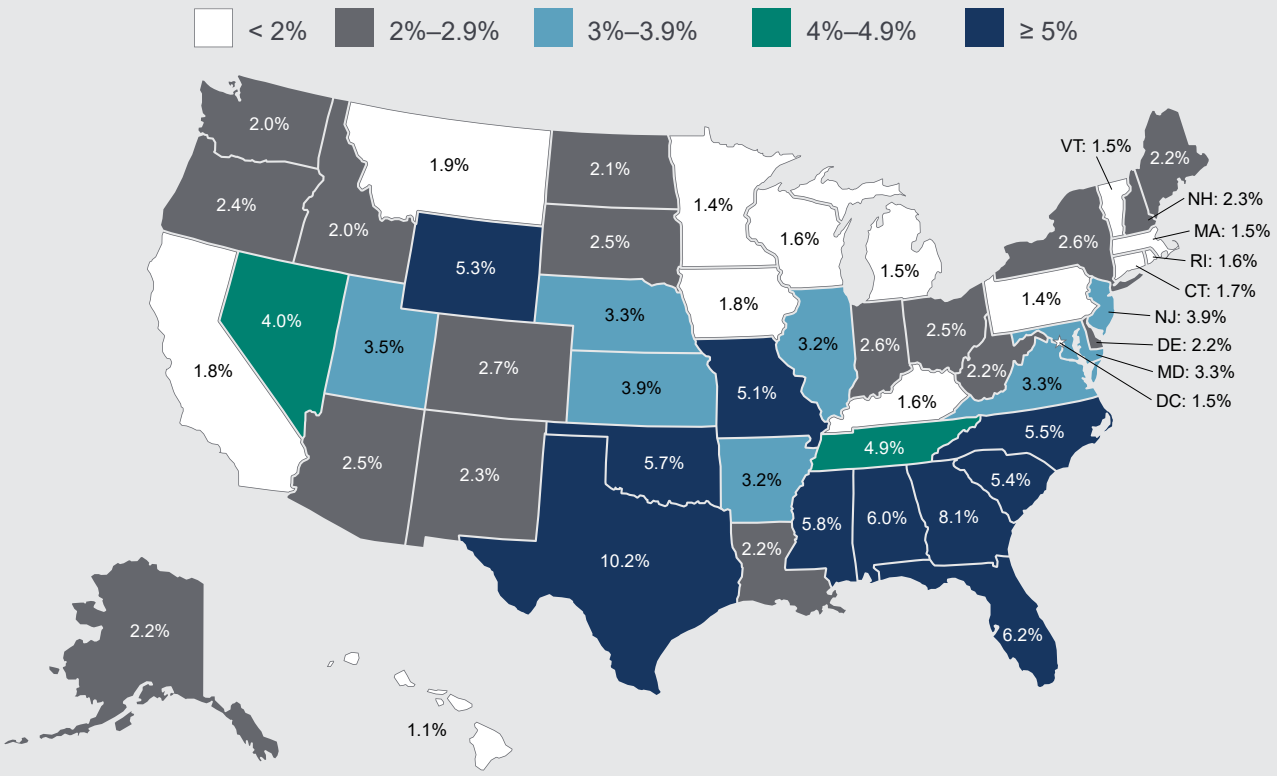
In FY 2021, about 57 percent of reported uncompensated care was for charity care for uninsured individuals ($22.5 billion), 12 percent was for charity care for insured individuals ($4.9 billion), and 31 percent was for bad debt expenses for both insured and uninsured individuals ($12.1 billion).[27]

Uncompensated care for insured individuals is not covered by Medicaid DSH and has been increasing in recent years. These costs occur when individuals are unable to pay their cost sharing for medical expenses (e.g., deductibles, coinsurance, and other forms of cost sharing). From 2016 to 2020, prices for medical care increased by 16 percent, more than double the rate of inflation (CBO 2022, HCCI 2022). Additionally, there has been growth in health insurance costs and the use of high-deductible health plans that may contribute to these uncompensated care costs for insured individuals. The share of workers in high-deductible health plans increased over the last 10 years: 20 percent in 2013 to 29 percent in 2023 (KFF 2023a).

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 (Box 3-3). The American Hospital Association (AHA) did not report 2021 Medicaid shortfall information collected in its most recent annual survey, but a prior survey for 2020 reported a total Medicaid shortfall of $24.8 billion (AHA 2022a). AHA reported the aggregate Medicaid payment-to-cost ratio was 88 percent in 2020, a ratio that has largely been unchanged in recent years (AHA 2022a, 2021, 2015).

FIGURE 3-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2021



Note: FY is fiscal year.

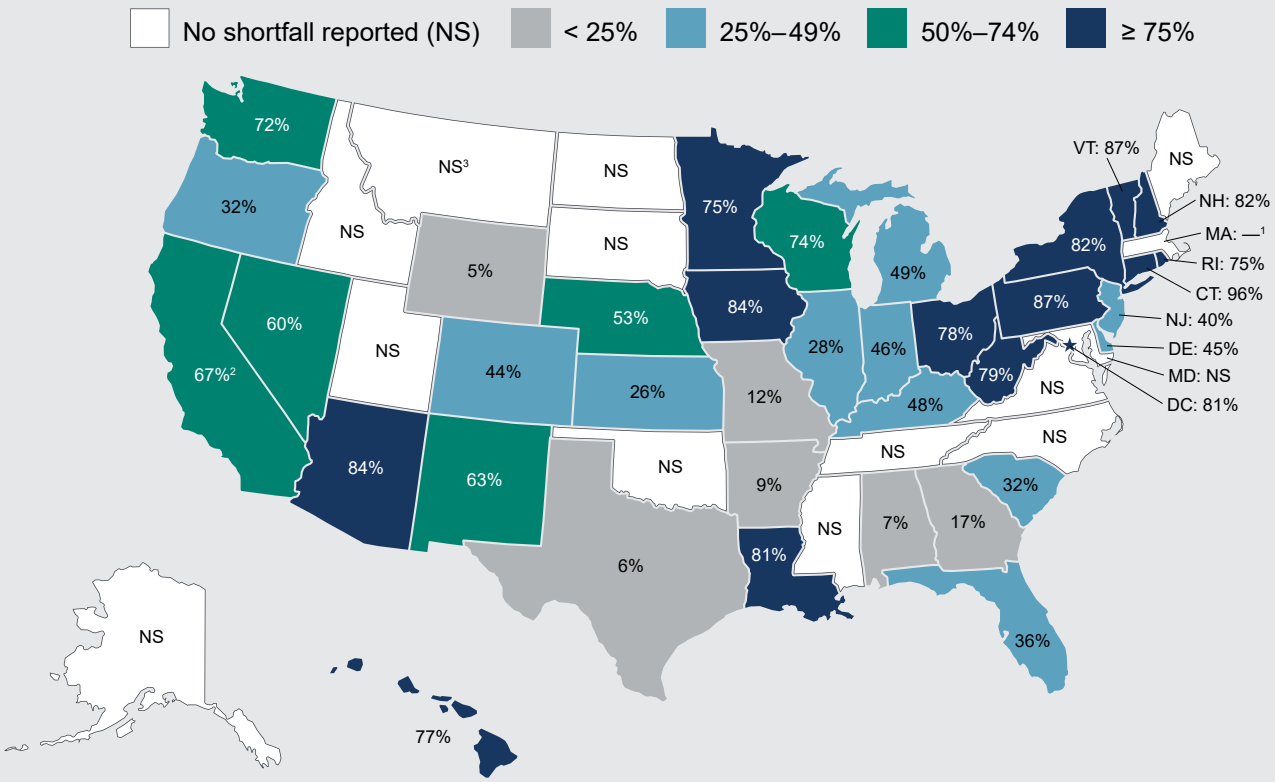
Source: MACPAC, 2024, analysis of FY 2021 Medicare cost reports.

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 (41 percent of U.S. hospitals in SPRY 2019). In SPRY 2019, DSH hospitals reported a total of $19.1 billion in Medicaid shortfall and an aggregate Medicaid payment-to-cost ratio of 86 percent before DSH payments.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 3-4). In SPRY 2019, 13 states reported no Medicaid shortfall for DSH hospitals, and 19 states and the District of Columbia 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. In SPRY 2019, 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 116 percent of Medicaid costs in the aggregate.[28] Nationwide, aggregate Medicaid payments to DSH hospitals were 96 percent of costs in SPRY 2019 (Figure 3-5).[29] Additional state-level data on base and supplemental payments for DSH hospitals are available in Appendix 3A.

FIGURE 3-4. Medicaid Shortfall as a Share of Total Uncompensated Care Costs by State, SPRY 2019



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 2019. A total of 2,312 disproportionate share hospitals (DSH) hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2021 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 and Massachusetts, 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.

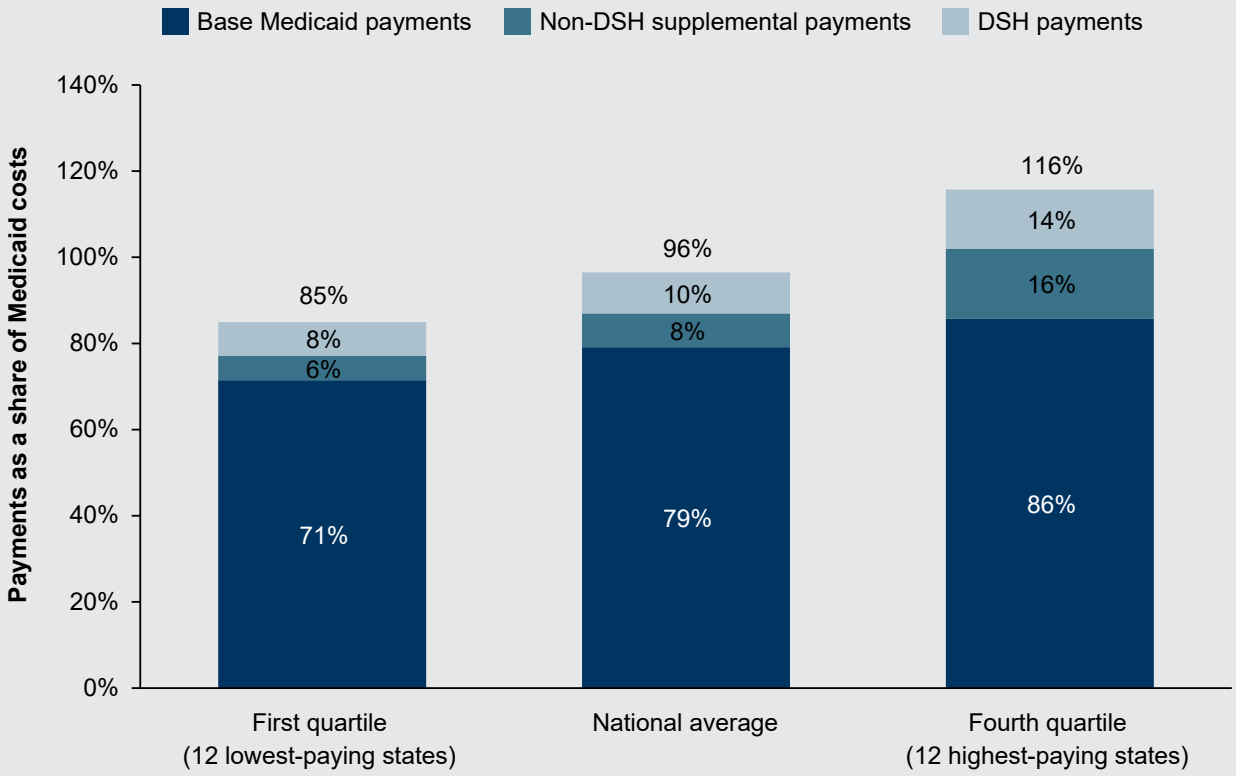
[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act (the Act) allows it to use all of its DSH funding for the state's safety-net care pool instead.

[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] Montana has not submitted a SPRY 2019 as-filed DSH audit. This analysis uses SPRY 2018 Montana DSH audit data.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 as-filed Medicaid DSH audits.

FIGURE 3-5. Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs by National Average and Selected Quartiles, SPRY 2019



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 2,312 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2021 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. This analysis also excludes some hospitals in California and Massachusetts, 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. This analysis uses SPRY 2018 Montana DSH audit data because Montana had not submitted a SPRY 2019 audit when this analysis was conducted. 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-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 fully account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers may not sum due to rounding.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 as-filed Medicaid DSH audits.

Aggregate data on Medicaid shortfall for DSH hospitals may not reflect the experience of all hospitals 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 North Carolina did not report a Medicaid shortfall in SPRY 2019, but 19 of the 80 hospitals that received DSH payments reported a Medicaid shortfall in that year.[30] Moreover, North Carolina finances DSH payments with provider taxes and intergovernmental transfers, and so net Medicaid payments to hospitals may be below costs after adding the full costs of these provider contributions to the non-federal share (MACPAC 2019).[31]

Hospital margins

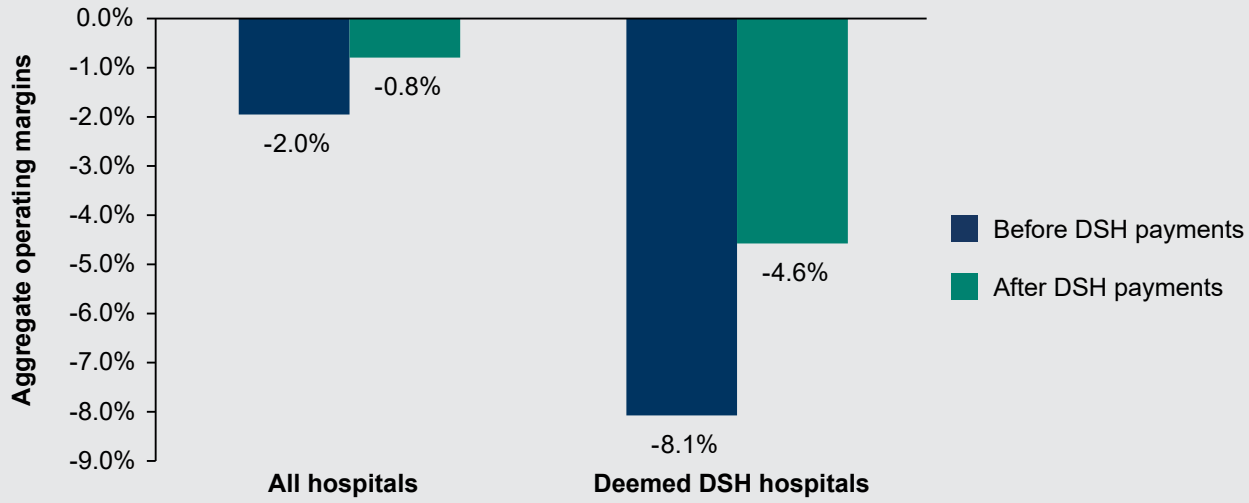
Changes in hospital uncompensated care costs may affect hospital margins. For example, deemed DSH hospitals report higher uncompensated care costs and lower operating and total margins than other hospital types in the aggregate. MACPAC estimates both total and operating margins using a combination of Medicaid DSH audit and Medicare cost report data. Operating margins only include 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 relief for hospitals. COVID-19 continued to have a large effect on hospital margins in FY 2021. 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 2021). Hospital costs have also increased as a result of workforce challenges exacerbated by the pandemic. During the early phase of the pandemic, hospitals also experienced declines in non-COVID-19 service use as a result of postponed or forgone 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 2021; Gallagher et al. 2021; Birkmeyer et al. 2020; Mehrotra et al. 2020a, 2020b, 2020c). While hospital discharges rebounded in 2021 when compared to 2020, discharges remained below prepandemic trends (McGough et al. 2023).

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 (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.[32] The Coronavirus Aid, Relief, and Economic Security 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 2021b, 2020a, 2020b). Since initial disbursements were based on Medicare fee-for-service (FFS) revenue 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). The U.S. Department of Health and Human Services 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 (HRSA 2023, GAO 2021b).[34]

FIGURE 3-6. Aggregate Hospital Operating Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2021



Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure profits (or losses) from patient care divided by net patient revenue. Operating margin before DSH payments in FY 2021 was estimated using state plan rate year (SPRY) 2019 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. This analysis uses Montana's SPRY 2018 DSH audit data because its 2019 audit was unavailable. For further discussion of this methodology and limitations, see Appendix 3B.

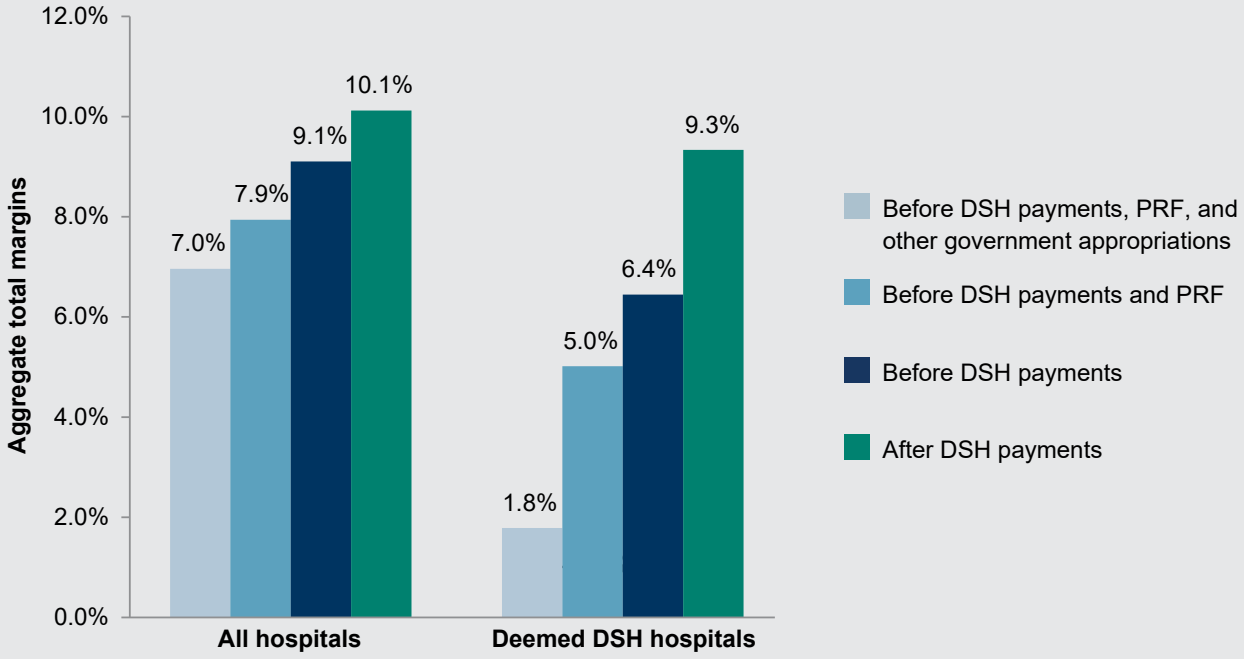
Source: MACPAC, 2024, analysis of FYs 2020–2021 Medicare cost reports and SPRY 2018-2019 as-filed Medicaid DSH audits.

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. Although 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).

Total and operating margins. In FY 2021, the aggregate operating margin was negative across all hospitals after counting DSH payments (-0.8 percent) (Figure 3-6). Deemed DSH hospitals reported even larger negative aggregate operating margins both before and after counting DSH payments (-8.1 percent and -4.6 percent, respectively).

The 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 10.1 percent in FY 2021, which was 2.9 percentage points higher than in FY 2020 (Figure 3-7). Before counting DSH payments, PHE-related federal spending, and other government appropriations, deemed DSH hospitals reported an aggregate total margin of 1.8 percent in FY 2021. After counting these payments and appropriations, deemed DSH hospitals reported an aggregate total margin of 9.3 percent, slightly less than the aggregate total margin for all hospitals (10.1 percent).

FIGURE 3-7. Aggregate Hospital Total Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2021



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 2021 were estimated using state plan rate year (SPRY) 2019 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. This analysis uses Montana's SPRY 2018 DSH audit data because its 2019 audit was unavailable. For further discussion of this methodology and limitations, see Appendix 3B.

Source: MACPAC, 2024, analysis of FY 2020–2021 Medicare cost reports and SPRY 2018–2019 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 3-4).

Using data from 2021 Medicare cost reports and the 2021 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2019, 92 percent provided at least one of the services included in MACPAC's definition of essential community services, 71 percent provided two or more of these services, and 56 percent provided three or more of these services. By contrast, among non-deemed hospitals, 38 percent provided three or more of these services.

BOX 3-4. Identifying Hospitals with High Levels of Uncompensated Care That Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations

MACPAC's authorizing statute requires that MACPAC provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act). Based on the types of services suggested in the statute and the limits of available data, we included the following services in our definition of essential community services in this report:

- burn services;
- dental services;
- graduate medical education;
- HIV/AIDS care;
- inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital);
- neonatal intensive care units;
- obstetrics and gynecology services;
- primary care services;
- substance use disorder services; and
- trauma services.

We also included deemed DSH hospitals that were designated as critical access hospitals because they may be the only hospital in their geographic areas. See Appendix 3B for further discussion of our methodology and its limitations.

DSH Allotment Reductions

At the time of this writing, DSH allotment reductions are currently scheduled to take effect March 9, 2024. However, because Congress has signaled an intention to further delay DSH allotment reductions, the analyses in this chapter assume that allotment reductions that were scheduled to take effect in FY 2024 and FY 2025 will be delayed (H.R. 5378, S. 3430). If this change takes effect, DSH allotments will be reduced by the following annual amounts beginning October 1, 2025:

- $8 billion in FY 2026; and
- $8 billion in FY 2027.

DSH allotment reductions are applied against the preliminary unreduced DSH allotments—that is, the amounts that states would have received without DSH allotment reductions (42 CFR 447.294).

BOX 3-5. Factors Used in Disproportionate Share Hospital Health Reform Reduction Methodology

The Disproportionate Share Hospital (DSH) Health Reform Reduction Methodology (DHRM), finalized in September 2019, is used by the Centers for Medicare & Medicaid Services to calculate how DSH allotment reductions will be distributed across states. As required by statute, the DHRM applies five factors when calculating state DSH allotment reductions:

Low-DSH factor. Allocates a smaller proportion of the total DSH allotment reductions to low-DSH states based on the size of these states' DSH expenditures relative to their total Medicaid expenditures. Low-DSH states are defined in statute as states with FY 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000. There are 17 low-DSH states, 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. Adjusts the high Medicaid and high uncompensated care factors that account 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.

Because 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. Under current law, DSH allotment reductions will amount to around half of unreduced DSH allotment amounts in FY 2026 (48.7 percent).[35]

DSH allotment reductions will be applied using the DSH Health Reform Reduction Methodology (DHRM). This methodology uses specific statutorily defined criteria, such as applying greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals (Box 3-5).

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.

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 2026, we estimated DSH allotment reduction factors based on data from CMS.

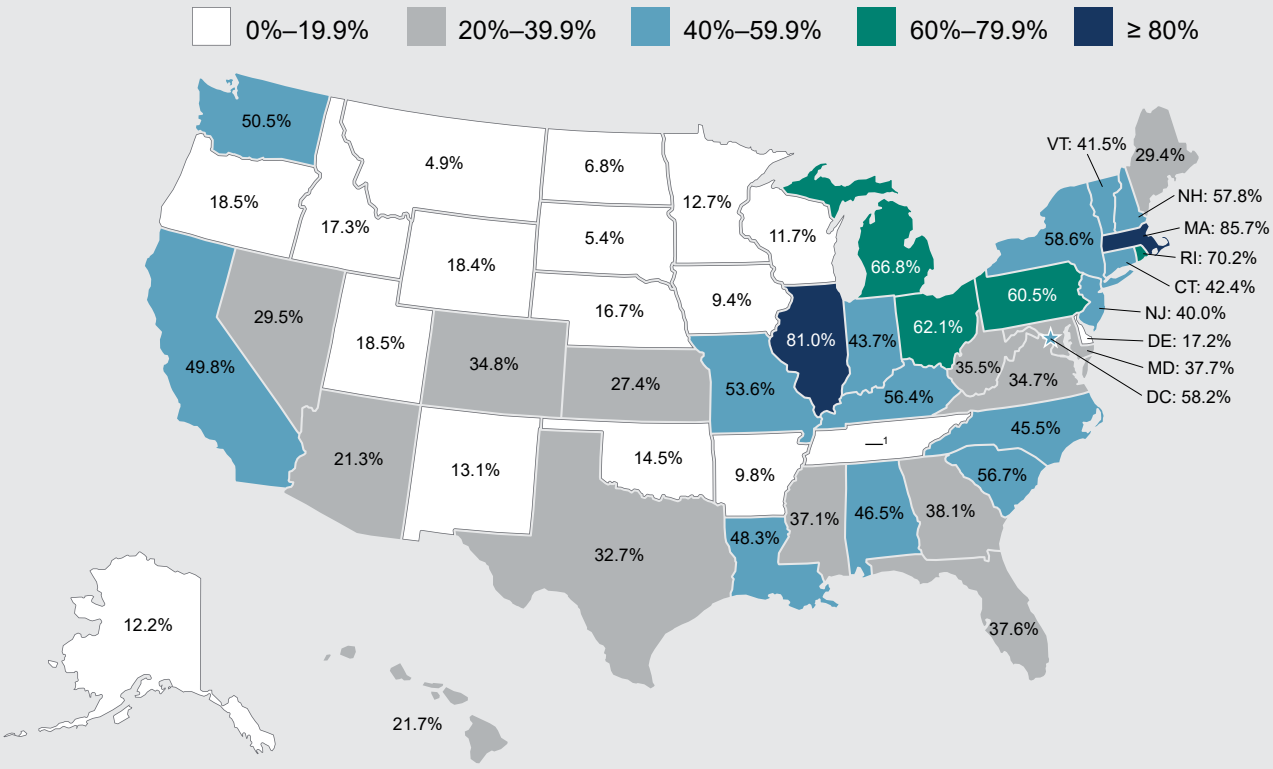
In FYs 2026 and 2027, DSH allotments will be reduced by $8 billion, which translates to a decrease of $14.2 billion in total DSH funding (state and federal amounts). The distribution of DSH allotment reductions among states is expected to be largely the same for these two years, assuming states do not 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 2026. Reductions will affect states differently, with estimated reductions ranging from 4.9 percent to 85.7 percent of unreduced allotment amounts (Figure 3-8). 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 federal DSH allotments for the 17 states that meet the low-DSH criteria (13.1 percent in the aggregate) is about one-quarter that of the other states (51.1 percent in the aggregate). Among states that do not meet the low-DSH criteria, the projected percentage reduction in federal DSH allotments is larger for states that expanded Medicaid as of January 1, 2022 (54.1 percent in the aggregate) than for states that did not expand Medicaid (39.6 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors is included in Appendix 3A.)

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 15 states are projected to have FY 2026 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2021. This means that these states could make DSH payments from their reduced FY 2026 allotment equal to the payments that they made from their FY 2021 allotment.[36]

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.[37] 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.[38]

FIGURE 3-8. Decrease in State DSH Allotments as a Percentage of Unreduced Allotments by State, FY 2026



Notes: DSH is disproportionate share hospital. FY is fiscal year. This analysis compares reduced allotments with unreduced allotments.

— 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). However, Tennessee receives a virtual DSH fund through its Section 1115 demonstration waiver that may be subject to reductions in FY 2026 if DSH allotment reductions take effect.

Source: MACPAC, 2024, analysis of preliminary unreduced and reduced allotment amounts using CMS 2023c and projected for FY 2026 using CBO 2023.

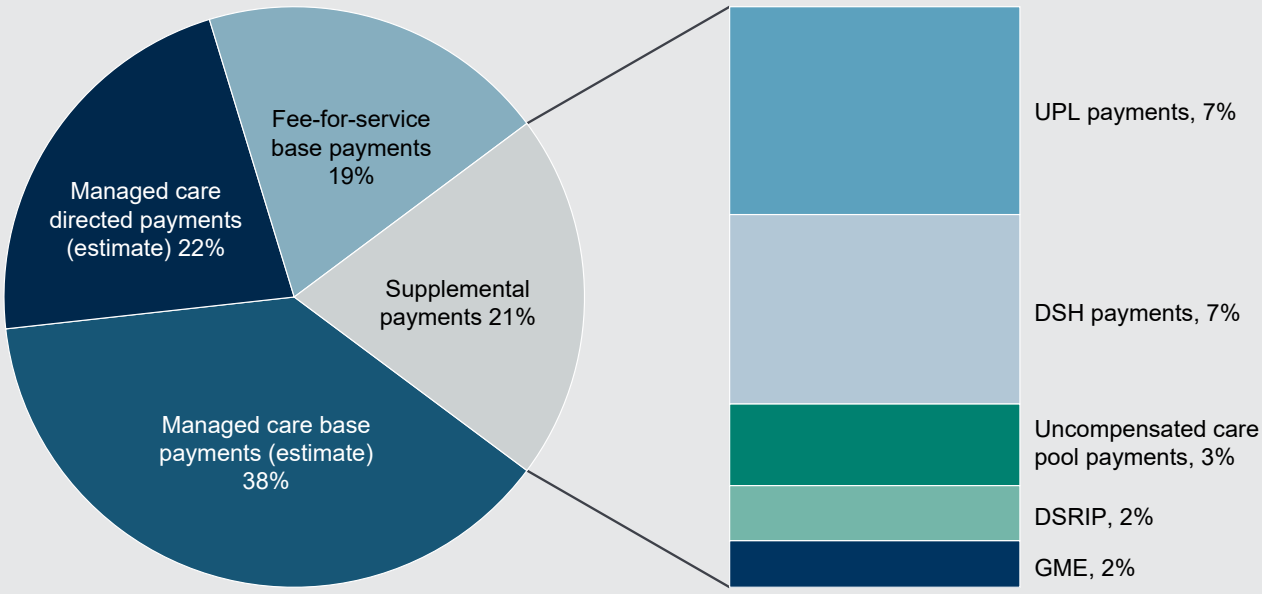
Relationship of DSH Allotments to the Statutorily Required Factors

As in our past reports, we find little meaningful relationship between FY 2024 DSH allotments and the factors that Congress asked MACPAC to consider:

- **Changes in number of uninsured individuals.** FY 2024 DSH allotments range from less than $100 per uninsured individual in 2 states to more than $1,000 per uninsured individual in 11 states and the District of Columbia. Nationally, the average FY 2024 DSH allotment per uninsured individual is $593.

- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2021 Medicare cost reports, FY 2024 federal DSH allotments range from less than 10 percent in five states to more than 80 percent in nine states and the District of Columbia. Nationally, these allotments are equal to 39.8 percent of hospital charity care and bad debt costs. At the state level, total FY 2024 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in 16 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 may not be able to spend their full DSH allotment.[39]
- **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.

FIGURE 3-9. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2021



Notes: FY is fiscal year. UPL is upper payment limit. DSH is disproportionate share hospital. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. Directed payment spending is estimated based on annual spending projected in the most recent rating period for preprints approved as of February 1, 2023.

Source: MACPAC, 2024, analysis of CMS-64 net expenditure data as of June 8, 2022, CMS-64 Schedule C waiver report data as of September 19, 2022, and directed payment preprints approved through February 2023.

Relationship Between DSH and Other Medicaid Supplemental Payments

In the Commission's view, DSH policy should be assessed in the context of other Medicaid payments to hospitals. In particular, many states make large non-DSH supplemental payments to hospitals. In recent years, states have begun making managed care directed payments, which are often used to make large increases in managed care payments to hospitals, similar to supplemental payments in FFS. These payment authorities are subject to different upper limits and different federal matching rates than DSH, which may explain why some states have begun substituting other types of Medicaid payments for DSH in recent years. Additional information about the different types of base and supplemental payments that hospitals can receive is provided in MACPAC's issue brief *Base and Supplemental Payments to Hospitals* (MACPAC 2023d).

In FY 2021, supplemental payments and managed care directed payments accounted for approximately 43 percent of payments to hospitals (Figure 3-9). DSH payment amounts were similar to upper payment limit (UPL) supplemental payments in FFS and smaller than managed care directed payments. Unlike DSH payments that pay for both Medicaid shortfall and unpaid costs of care for the uninsured, these other Medicaid payment authorities are intended only to pay for care provided to Medicaid patients.

UPL payments are lump-sum payments that are intended to fill in the difference between FFS base payments and the amount that Medicare would have paid for the same service. In the aggregate for each class of providers, FFS base and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles.[40] For context, Medicare payments to hospitals covered about 84 percent of costs in 2020, according to the AHA annual survey (AHA 2022).

Managed care directed payments are a newer policy option for states to direct managed care plans to pay providers according to specified rates or methods that CMS added in its 2016 managed care rule. Most directed payment spending within hospitals is attributable to arrangements requiring large uniform rate increases that are intended to offset low managed care base payment rates (similar to FFS supplemental payments).[41] There is currently no regulatory upper limit on the amount of payments states can make through directed payments, and projected spending on directed payments for hospital and non-hospital providers has grown rapidly in recent years, from $25.7 billion as of December 2020 to $69.3 billion as of February 2023 in states with available data (MACPAC 2023c).[42]

CMS recently proposed to cap managed care directed payments to hospitals at the average commercial rate, which is substantially higher than the Medicare payment rate limit used for UPL payments (CMS 2023b). For example, across five recent studies that the Congressional Budget Office reviewed, the average estimate of commercial insurers' hospital prices relative to Medicare's FFS rate was 223 percent (CBO 2022).

Commercial payment rates vary widely by state and hospital. According to the RAND Corporation's hospital transparency study, which used available 2018–2020 data from commercial insurers in all states, estimates of commercial payment rates relative to Medicare ranged from 147 percent in Hawaii to 322 percent in South Carolina (RAND 2023). On average, deemed DSH hospitals reported lower commercial payment rates relative to Medicare (232 percent) than other hospitals that do not serve a high share of Medicaid or low-income patients (264 percent). One reason that deemed DSH hospitals report lower commercial rates could be because they serve a smaller share of privately insured individuals and therefore have less leverage to negotiate higher commercial rates than other hospitals. This dynamic may also contribute to the increased financial challenges that deemed DSH hospitals face.

Increases in non-DSH supplemental payments and directed payments reduce a hospital's uncompensated care costs and thus reduce the amount of DSH payments that a hospital can receive. Because the surplus a hospital could receive from being paid the commercial rate for Medicaid-covered patients is often greater than a hospital's unpaid costs of care for uninsured individuals, some states have chosen to use directed payments instead of DSH payments to support large safety-net hospitals (Miller 2023).

In addition to different payment limits, non-DSH supplemental payments and directed payments are eligible for a higher FMAP in states that have expanded Medicaid under the ACA. Specifically, the portion of the payment that is attributable to the new adult group is matched at a 90 percent FMAP. For example, one state estimates that its managed care directed payment for inpatient hospital services would be matched at an average FMAP of 73 percent, which is about 7 percentage points higher than the state's regular FMAP of 66 percent (CMS 2023d).[43] In contrast, DSH payments are matched at a state's regular FMAP regardless of whether the state has expanded Medicaid.

Next Steps

The Commission is engaging in a long-term work plan to further examine all types of payments to hospitals using newly available data on non-DSH supplemental payments and directed payments. The Consolidated Appropriations Act, 2021 requires the U.S. Department of Health and Human Services to collect and report data on non-DSH supplemental payments beginning October 1, 2021, and these data were recently made available to MACPAC (MACPAC 2023a). In addition, CMS has begun collecting additional information on directed payment amounts on its standard application form (referred to as a preprint) and has begun posting approved preprints on its website (CMS 2023e).

MACPAC's review of these new data will be guided by MACPAC's provider payment framework, which is based on the statutory Medicaid payment goals of efficiency, economy, quality, and access (MACPAC 2015). Specifically, we aim to collect information on payment methods, payment amounts, and the characteristics of hospitals that receive Medicaid supplemental payments to assess the extent to which these payments are achieving their intended goals. We are also mindful of the limitations of available data, particularly the lack of provider-level data on contributions to the non-federal share, which reduce net payments that providers receive. We are concurrently examining policy approaches to improve transparency of Medicaid financing (MACPAC 2023e).

Endnotes

[1] This chapter includes findings for fiscal year (FY) 2021 Medicare cost report data, which includes the period from October 1, 2020, through September 30, 2021, and FY 2022, which covers October 1, 2021, through September 30, 2022. The first determination of a nationwide PHE due to COVID-19 was on January 31, 2020, midway through FY 2020. Thus, FY 2021 findings include the entirety of the PHE.

[2] These uninsured data are based on the Current Population Survey Annual Social and Economic Supplement, which is a different data source than the American Community Survey used in Table 3A-3.

[3] At the beginning of the PHE in 2020, Congress passed the Families First Coronavirus Response Act (P.L. 116-127), which required states to maintain Medicaid coverage and eligibility standards to receive an enhanced federal matching assistance percentage (FMAP) of 6.2 percentage points.

[4] The Medicare cost report and DSH audit data have two distinct definitions of uncompensated care costs. While some charity care and bad debt from Medicare cost reports may factor into hospital-specific DSH limits, it is not automatically eligible for inclusion in the DSH uncompensated care costs. For the definitions and data sources of uncompensated care costs, see Box 3-3.

[5] MACPAC calculates hospital margins two different ways, and both analyses are presented within this report. Operating margin 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, state and local subsidies, government appropriations, and other income, which can include any provider relief funding disbursed to support hospitals during the COVID-19 PHE.

[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 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. Since 2018, these Medicare uncompensated care payments have been distributed to hospitals based

on each Medicare DSH hospital's share of all Medicare DSH hospitals' uncompensated care costs. 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 enhancement to DSH allotments for the remainder of the COVID-19 PHE. The enhanced 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 until March 31, 2023. From April 1, 2023, to December 31, 2023, the Consolidated Appropriations Act, 2023 (P.L. 117-238) phased down the enhanced FMAP.

[10] The Consolidated Appropriations Act, 2023 (P.L. 117-238) phased down the enhanced FMAP beginning April 1, 2023, fully eliminating the increase after December 31, 2023. The FMAPs for the first quarter of FY 2024 received a 1.5 percentage point increase.

[11] This amount includes the ARPA increase to DSH allotments, which was made retroactive to FY 2020 and lasted through FY 2023. The Commission estimates that ARPA increased FY 2022 allotments from $13.4 billion to $14.9 billion.

[12] Total DSH spending in FY 2022 was $20.0 billion. Federal spending was $11.5 billion, and state spending was $8.5 billion.

[13] DSH spending in FY 2022 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.

[14] 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).

[15] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts ($1.5 billion in FY 2021) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

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

[17] 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 2022).

[18] Preliminary allotments are shared with states at the start of the fiscal year and published in the Federal Register during the fiscal year, while finalized allotments are not calculated for multiple years later. For example, preliminary FY 2019 allotments were published in the *Federal Register* in February 2019 and were finalized on March 2022 (CMS 2022, 2019).

[19] 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.

[20] At the time of drafting this report, Montana had not submitted its SPRY 2019 as-filed DSH audit to CMS. Therefore, we are relying on data from Montana's SPRY 2018 as-filed DSH audit in this report.

[21] The Balanced Budget Act of 1997 (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 several criteria, including be located in a rural area, and one of three isolation location requirements: (1) it must be 35 miles from another hospital (including a CAH), (2) it must 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, or (3) before 2006, it must be designated by the state as a necessary provider. However, a 2013 report found that 64 percent of CAHs did not meet either of the two distance-based location requirements and were CAHs due to being designated necessary providers before 2006 and thus grandfathered into the program (GAO 2013).

[22] California made DSH payments to 6 percent of hospitals as reported on its SPRY 2019 as-filed Medicaid DSH audit. However, California also makes additional payments to public hospitals through its Section 1115 demonstration waiver, which is financed with DSH funds.

[23] Enacted in December 2022, the Consolidated Appropriations Act, 2023 (CAA, P.L. 117-328) decoupled the continuous coverage requirement from the PHE and established an end date of March 31, 2023, for the requirement. The act phased down the enhanced FMAP rate and required states to initiate renewal redeterminations as early as February 2023.

[24] This statistic includes only states that expanded Medicaid before January 1, 2022.

[25] Medicare cost reports define bad debt as debt for non-Medicare beneficiaries and non-reimbursable bad debt for Medicare beneficiaries. The Medicare program reimburses providers for only 65 percent of beneficiary cost sharing that is not paid by the beneficiary or their supplemental insurance Medicare.

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

[27] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2021 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).

[28] 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 the state in which the Medicaid program operates.

[29] 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.

[30] Thirty-eight percent of hospitals in North Carolina are not included on the state's SPRY 2019 DSH audit because these hospitals did not receive DSH payments.

[31] The DSH audit data definition of Medicaid shortfall includes the Medicaid share of provider taxes as an allowable Medicaid cost. However, the definition does not include the full cost of provider taxes and does not include the costs of provider contributions through intergovernmental transfers.

[32] COVID-19 relief funding used to pay for care provided to uninsured individuals reduces the amount of unpaid costs of care for uninsured individuals reported on Medicaid DSH audits (CMS 2021).

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

[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 to calculate 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] Unreduced allotment amounts are the amounts that states would have received without DSH allotment reductions.

[36] For states to spend the same amount of DSH funding in FY 2026 as they spent in FY 2022, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[37] 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).

[38] 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 2023d).

[39] 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.

[40] Classes of providers are defined based on ownership (i.e., government, non-state government, and privately owned). States can use a variety of methods to estimate what Medicare would have paid, including a payment-based method (i.e., based on the hospital's aggregate Medicare payments relative to its charges) or a cost-based method (i.e., the hospital's costs according to Medicare cost principles). Additional information about rules for UPL supplemental payments is provided in MACPAC's issue brief Upper Payment Limit Supplemental Payments (MACPAC 2021a).

[41] Most directed payment arrangements are used to set minimum or maximum fee schedules for specific services (similar to base payment rate increases). States can also use directed payment authorities to require hospitals to participate in value-based payment models. However, these arrangements account for only 2 percent of directed payment spending among hospitals (MACPAC 2023c).

[42] Spending estimates are based on the most recently approved preprints with available spending data. Of the $69.3 billion in total directed payment spending approved for all provider types as of February 2023, $47.9 billion was targeted to hospitals.

[43] Analysis excludes the 6.2 percentage point increase in the FMAP added by ARPA during the PHE.

References

American Hospital Association (AHA). 2022a. *Underpayment by Medicare and Medicaid fact sheet*. Washington, DC: AHA. https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf.

American Hospital Association (AHA). 2022b. Exploring metropolitan anchor hospitals and the communities they serve. Washington, DC: AHA. https://www.aha.org/guidesreports/2022-10-21-exploring-metropolitan-anchorhospitals-and-communities-they-serve.

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

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

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

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

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023a. *June 2023 Medicaid and CHIP enrollment trends snapshot*. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2023-09/june-2023-medicaid-chip-enrollment-trend-snapshot.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023b. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Notice. *Federal Register* 88 (May 3): 28092–28252. https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08961.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023c. E-mail to MACPAC, October 4.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023d. Letter from Alexis Gibson to Todd Richards regarding "Missouri's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts." October 27, 2023. https://www.medicaid.gov/sites/default/files/2023-11/mo-fee-iph-renewal-20230701-20240630.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023e. Approved state directed payment preprints. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Medicaid program; final FY 2018, final FY 2019, preliminary FY 2020, and preliminary FY 2021 disproportionate share hospital allotments, and final FY 2018, final FY 2019, preliminary FY 2020, and preliminary FY 2021 institutions for mental diseases disproportionate share hospital limits. Notice. *Federal Register* 87 (March 16): 14858–14888. https://www.federalregister.gov/documents/2022/03/16/2022-05459/medicaid-program-final-fy-2018-final-fy-2019-preliminary-fy-2020-and-preliminary-fy-2021.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. *COVID-19 frequently asked questions (FAQs) for state Medicaid and Children's Health Insurance Program (CHIP) agencies*. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2021-01/covid-19-faqs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicaid program; final FY 2017 and preliminary FY 2019 disproportionate share hospital allotments, and final FY 2017 and preliminary FY 2019 institutions for mental diseases disproportionate share hospital limits. Notice. *Federal Register* 84 (February 11): 3169–3185. https://www.federalregister.gov/documents/2019/02/11/2019-01928/medicaid-program-final-fy-2017-and-preliminary-fy-2019-disproportionate-share-hospital-allotments.

Congressional Budget Office (CBO). 2023. *The budget and economic outlook: 2023 to 2033*. Washington, DC: CBO. https://www.cbo.gov/system/files/2023-02/51135-2023-02-Economic-Projections.xlsx.

Congressional Budget Office (CBO). 2022. *The prices that commercial health insurers and Medicare pay for hospitals' and physicians' services*. Washington, DC: CBO. https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf.

Congressional Research Service (CRS). 2023. *Medicaid disproportionate share hospital payments*. Washington, DC: CRS. https://crsreports.congress.gov/product/pdf/R/R42865.

Dickson, E., S. Purves, and C. Shields. 2022. To protect America's safety-net hospitals, establish a new federal designation. Health Affairs Forefront, October 3. https://www. healthaffairs.org/content/forefront/protect-america-s-safetynet-hospitals-establish-new-federal-designation.

Gallagher, K., J. Gerhart, K. Amin, et al. 2021. *Early 2021 data show no rebound in health care utilization*. Peterson-KFF Health System Tracker, August 17. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/.

Health Care Cost Institute (HCCI). 2022. *2020 Health care cost and utilization report*. Washington, DC: HCCI. https://healthcostinstitute.org/images//pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2023. Terms and conditions. https://www.hrsa.gov/provider-relief/compliance/terms-conditions.

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

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

Keisler-Starkey, K., L.N. Bunch, and R.A. Lindstrom. 2023. *Health insurance coverage in the United States: 2022.* Washington, DC: U.S. Census Bureau. https://www.census.gov/library/publications/2023/demo/p60-281.html.

KFF. 2024. *Medicaid enrollment and unwinding tracker.* San Francisco, CA: KFF. https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/.

KFF. 2023a. *2023 employer health benefits chart pack.* San Francisco, CA: KFF. https://www.kff.org/slideshow/2023-employer-health-benefits-chart-pack/.

KFF. 2023b. *Status of state Medicaid expansion decisions: Interactive map*. Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

Klemm, J.D. 2000. Medicaid spending: A brief history. *Health Care Financing Review* 22, no. 1: 105–112. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/00fallpg105.pdf.

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

McGough, M., K. Amin, and C. Cox. 2023. *How has healthcare utilization changed since the pandemic?* Peterson-KFF Health System Tracker, January 24th. https://www.healthsystemtracker.org/chart-collection/how-has-healthcare-utilization-changed-since-the-pandemic/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023a. *Hospital supplemental payment work plan*. September 2023. Washington, DC: MACPAC. https://www.macpac.gov/publication/hospital-supplemental-payment-work-plan/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023b. Chapter 1: Automatic Medicaid disproportionate share hospital allotments. In *Report to Congress on Medicaid and CHIP*. June 2023. Washington, DC: MACPAC. https://www.macpac.gov/publication/countercyclical-medicaid-disproportionate-share-hospital-allotments/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023c. *Directed payments in Medicaid managed care*. June 2023. Washington, DC: MACPAC. https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023d. *Medicaid base and supplemental payments to hospitals.* Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023e. Exhibit 24: Medicaid supplemental payments to hospital providers by state. In *MACStats*. December 2023. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-supplemental-payments-to-hospital-providers-by-state/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023f. Exhibit 18: Distribution of Medicaid benefit spending by eligibility group and service category. In *MACStats*. December 2023. Washington, DC: MACPAC. https://www.macpac.gov/publication/distribution-of-medicaid-benefit-spending-by-eligibility-group-and-service-category/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. Chapter 3: Annual analysis of disproportionate share hospital allotments to states. In *Report to Congress on Medicaid and CHIP*. March 2022. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-3-Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. *Upper payment limit supplemental payments.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *COVID relief funding for Medicaid providers.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/02/COVID-Relief-Funding-for-Medicaid-Providers.pdf.

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

Medicaid and CHIP Payments and Access Commission (MACPAC). 2020b. Letter from Melanie Bella to Seema Verma regarding "the decision to distribute the first wave of funding to health care providers under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-

136) based on institutions' Medicare fee-for-service revenues." April 10, 2020. https://www.macpac.gov/wp-content/uploads/2020/04/Letter-to-the-CMS-Administrator-on-CARES-Act-Fund-Distribution.pdf.

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

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *Rural hospitals and Medicaid payment policy.* Washington, DC: MACPAC. https://www.macpac.gov/publication/rural-hospitals-and-medicaid-payment-policy/.

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

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

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 7: A framework for evaluating Medicaid provider payment policy. In *Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/a-framework-for-evaluating-medicaid-provider-payment-policy/.

Medicare Payment Advisory Commission (MedPAC). 2022. Chapter 3: Supporting safety-net providers. In Report to Congress: Medicare and the health care delivery system. June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf.

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

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

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

Miller, A. 2023. *Special Medicaid funds help most states but prompt oversight concerns*. USA Today. https://www.usatoday.com/story/news/health/2023/04/09/special-medicaid-funds-oversight-concerns/11598000002/.

RAND. 2023. *Hospital price transparency study round 4*. Santa Monica, CA: RAND. https://www.rand.org/health-care/projects/price-transparency/hospital-pricing/round4.html.

U.S. Government Accountability Office (GAO). 2021a. Questionnaire data on states' methods for financing Medicaid payments in 2018, a supplement to GAO-21-98. E-mail to MACPAC, February 23.

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

U.S. Government Accountability Office (GAO). 2014. Medicaid financing: States' increased reliance on funds from health care providers and local governments warrants improved CMS data collection. Report no. GAO-14-627 [Reissued on March 13, 2015]. Washington, DC: GAO. http://www.gao.gov/products/GAO-14-627.

U.S. Government Accountability Office (GAO). 2013. *Most critical access hospitals would not meet the location requirements if required to re-enroll in Medicare*. Washington, DC: GAO. https://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf.

APPENDIX 3A: State-Level Data

TABLE 3A-1. State DSH allotments, FYs 2024 and 2025 (millions)

State	FY 2024		FY 2025	
	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,416.1**	**$15,643.2**	**$28,084.2**	**$16,024.3**
Alabama	**596.7**	436.3	**611.3**	447.0
Alaska	**58.3**	29.2	**59.8**	29.9
Arizona	**217.2**	144.0	**222.5**	147.5
Arkansas	**85.0**	61.2	**87.1**	62.7
California	**3,140.0**	1,570.0	**3,216.7**	1,608.4
Colorado	**264.9**	132.5	**271.4**	135.7
Connecticut	**572.9**	286.4	**586.9**	293.4
Delaware	**21.6**	12.9	**22.1**	13.2
District of Columbia	**124.3**	87.0	**127.3**	89.1
Florida	**492.2**	285.3	**504.2**	292.3
Georgia	**580.0**	382.2	**594.2**	391.5
Hawaii	**23.7**	13.9	**24.3**	14.2
Idaho	**33.5**	23.3	**34.3**	23.9
Illinois	**602.3**	307.7	**617.0**	315.2
Indiana	**463.3**	304.0	**474.6**	311.4
Iowa	**87.4**	56.0	**89.5**	57.4
Kansas	**96.4**	58.8	**98.7**	60.2
Kentucky	**286.7**	205.8	**293.8**	210.9
Louisiana	**1,440.1**	974.5	**1,475.3**	998.3
Maine	**238.6**	149.5	**244.4**	153.1
Maryland	**218.4**	109.2	**223.7**	111.9
Massachusetts	**873.6**	436.8	**895.0**	447.5
Michigan	**580.5**	377.0	**594.7**	386.2
Minnesota	**207.6**	106.9	**212.6**	109.5
Mississippi	**279.7**	216.2	**286.6**	221.4
Missouri	**1,019.6**	673.7	**1,044.6**	690.1
Montana	**25.3**	16.2	**25.9**	16.5
Nebraska	**68.9**	40.4	**70.5**	41.3

TABLE 3A-1. (continued)

State	FY 2024		FY 2025	
	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,416.1**	**$15,643.2**	**$28,084.2**	**$16,024.3**
Nevada	**108.4**	65.9	**111.1**	67.5
New Hampshire	**458.6**	229.3	**469.8**	234.9
New Jersey	**1,843.9**	921.9	**1,889.0**	944.5
New Mexico	**39.8**	28.9	**40.8**	29.6
New York	**4,600.8**	2,300.4	**4,713.2**	2,356.6
North Carolina	**636.5**	419.5	**652.1**	429.8
North Dakota	**25.4**	13.7	**26.0**	14.0
Ohio	**899.0**	578.0	**921.0**	592.2
Oklahoma	**76.2**	51.5	**78.1**	52.7
Oregon	**108.8**	64.5	**111.5**	66.1
Pennsylvania	**1,481.9**	802.0	**1,518.1**	821.6
Rhode Island	**168.8**	92.8	**172.9**	95.1
South Carolina	**669.1**	465.2	**685.4**	476.6
South Dakota	**28.7**	15.8	**29.4**	16.2
Tennessee[1]	**80.3**	53.1	**80.3**	53.1
Texas	**2,265.6**	1,362.8	**2,321.0**	1,396.1
Utah	**42.3**	27.9	**43.4**	28.6
Vermont	**56.6**	32.1	**58.0**	32.9
Virginia	**244.8**	125.4	**250.8**	128.4
Washington	**529.9**	264.9	**542.8**	271.4
West Virginia	**129.2**	95.8	**132.4**	98.1
Wisconsin	**222.0**	134.7	**227.5**	138.0
Wyoming	**0.6**	0.3	**0.7**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) 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). However, Tennessee receives a virtual DSH fund through its Section 1115 demonstration waiver that may be subject to reductions in FY 2026 if DSH allotment reductions take effect.

Sources: MACPAC, 2024, analysis of CMS MBES and CBO 2023a.

TABLE 3A-2. DSH Allotment Reductions by State, FY 2026 (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in total DSH funding
Total	**$28,707.0**	**$16,372.1**	**$14,177.9**	**$8,000.0**	**48.9%**
Alabama	**626.7**	458.2	**291.4**	213.1	46.5
Alaska	**61.3**	30.6	**7.5**	3.7	12.2
Arizona	**228.1**	151.2	**48.7**	32.3	21.3
Arkansas	**89.3**	64.3	**8.8**	6.3	9.8
California	**3,297.5**	1,648.8	**1,642.5**	821.3	49.8
Colorado	**278.2**	139.1	**96.8**	48.4	34.8
Connecticut	**601.6**	300.8	**255.1**	127.5	42.4
Delaware	**22.7**	13.6	**3.9**	2.3	17.2
District of Columbia	**130.5**	91.4	**75.9**	53.2	58.2
Florida	**516.9**	299.6	**194.2**	112.5	37.6
Georgia	**609.1**	401.4	**231.8**	152.7	38.1
Hawaii	**24.9**	14.6	**5.4**	3.2	21.7
Idaho	**35.2**	24.5	**6.1**	4.2	17.3
Illinois	**632.5**	323.2	**512.2**	261.7	81.0
Indiana	**486.5**	319.2	**212.6**	139.5	43.7
Iowa	**91.8**	58.8	**8.6**	5.5	9.4
Kansas	**101.2**	61.7	**27.7**	16.9	27.4
Kentucky	**301.1**	216.2	**169.7**	121.8	56.4
Louisiana	**1,512.3**	1,023.4	**729.8**	493.9	48.3
Maine	**250.6**	157.0	**73.6**	46.1	29.4
Maryland	**229.4**	114.7	**86.4**	43.2	37.7
Massachusetts	**917.4**	458.7	**786.3**	393.1	85.7
Michigan	**609.6**	395.9	**407.2**	264.4	66.8
Minnesota	**218.0**	112.2	**27.8**	14.3	12.7
Mississippi	**293.8**	227.0	**109.1**	84.3	37.1
Missouri	**1,070.8**	707.5	**573.5**	378.9	53.6
Montana	**26.5**	17.0	**1.3**	0.8	4.9
Nebraska	**72.3**	42.4	**12.1**	7.1	16.7

TABLE 3A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in total DSH funding
Total	**$28,707.0**	**$16,372.1**	**$14,177.9**	**$8,000.0**	**48.9%**
Nevada	**113.9**	69.2	**33.6**	20.4	29.5
New Hampshire	**481.6**	240.8	**278.2**	139.1	57.8
New Jersey	**1,936.4**	968.2	**775.1**	387.5	40.0
New Mexico	**41.8**	30.4	**5.5**	4.0	13.1
New York	**4,831.6**	2,415.8	**2,832.0**	1,416.0	58.6
North Carolina	**668.4**	440.6	**304.2**	200.5	45.5
North Dakota	**26.6**	14.3	**1.8**	1.0	6.8
Ohio	**944.1**	607.0	**586.1**	376.8	62.1
Oklahoma	**80.0**	54.1	**11.6**	7.9	14.5
Oregon	**114.3**	67.8	**21.1**	12.5	18.5
Pennsylvania	**1,556.3**	842.2	**941.4**	509.5	60.5
Rhode Island	**177.2**	97.5	**124.4**	68.5	70.2
South Carolina	**702.6**	488.5	**398.6**	277.2	56.7
South Dakota	**30.1**	16.6	**1.6**	0.9	5.4
Tennessee[1]	**–**	–	**–**	–	–
Texas	**2,379.3**	1,431.1	**778.0**	468.0	32.7
Utah	**44.5**	29.3	**8.2**	5.4	18.5
Vermont	**59.4**	33.7	**24.7**	14.0	41.5
Virginia	**257.1**	131.7	**89.1**	45.6	34.7
Washington	**556.5**	278.2	**281.3**	140.6	50.5
West Virginia	**135.7**	100.6	**48.2**	35.7	35.5
Wisconsin	**233.2**	141.4	**27.2**	16.5	11.7
Wyoming	**0.7**	0.3	**0.1**	0.1	18.4

Notes: FY is fiscal year. DSH is disproportionate share hospital. Under current law, federal DSH allotments will be reduced by $8 billion in FY 2026. For further discussion of methodology and limitations, see Appendix 3B.

– Dash indicates zero.

[1] Tennessee is not scheduled to have a DSH allotment in FY 2026 and is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act). However, Tennessee receives a virtual DSH fund through its Section 1115 demonstration waiver that may be subject to reductions in FY 2026 if DSH allotment reductions take effect.

Sources: MACPAC, 2024, analysis of CBO 2023a, CBO 2023b, CMS 2023.

TABLE 3A-3. Number of Uninsured Individuals and Uninsured Rate by State, 2021–2022

State	2021		2022		Difference in uninsured (2022–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**28,412**	**8.6%**	**26,529**	**8.0%**	**-1,883**	**-0.6%**
Alabama	489	9.9	437	8.8	-51	-1.1
Alaska	80	11.4	77	11.0	-3	-0.4
Arizona	766	10.7	749	10.3	-17	-0.4
Arkansas	273	9.2	252	8.4	-21	-0.8
California	2,713	7.0	2,492	6.5	-221	-0.5
Colorado	455	8.0	409	7.1	-47	-0.9
Connecticut	184	5.2	185	5.2	1	0.0
Delaware	57	5.7	57	5.6	0	-0.1
District of Columbia	24	3.7	19	2.9	-5	-0.8
Florida	2,598	12.1	2,448	11.2	-151	-0.9
Georgia	1,339	12.6	1,251	11.7	-88	-0.9
Hawaii	54	3.9	49	3.5	-6	-0.4
Idaho	166	8.8	157	8.2	-9	-0.6
Illinois	875	7.0	813	6.6	-62	-0.4
Indiana	504	7.5	469	7.0	-35	-0.5
Iowa	151	4.8	141	4.5	-10	-0.3
Kansas	264	9.2	247	8.6	-17	-0.6
Kentucky	251	5.7	247	5.6	-4	-0.1
Louisiana	345	7.6	312	6.9	-33	-0.7
Maine	78	5.7	90	6.6	12	0.9
Maryland	369	6.1	368	6.1	-1	0.0
Massachusetts	173	2.5	168	2.4	-5	-0.1
Michigan	495	5.0	451	4.5	-44	-0.5
Minnesota	252	4.5	254	4.5	3	0.0
Mississippi	343	11.9	312	10.8	-31	-1.1
Missouri	571	9.4	521	8.6	-50	-0.8
Montana	89	8.2	91	8.3	2	0.1
Nebraska	138	7.1	130	6.7	-8	-0.4
Nevada	362	11.6	349	11.1	-13	-0.5
New Hampshire	71	5.1	68	4.9	-3	-0.2

TABLE 3A-3. (continued)

State	2021		2022		Difference in uninsured (2022–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**28,412**	**8.6%**	**26,529**	**8.0%**	**-1,883**	**-0.6%**
New Jersey	657	7.2	627	6.8	-30	-0.4
New Mexico	207	10.0	170	8.2	-37	-1.8
New York	1,019	5.2	945	4.9	-74	-0.3
North Carolina	1,078	10.4	973	9.3	-105	-1.1
North Dakota	59	7.9	49	6.4	-11	-1.5
Ohio	758	6.5	683	5.9	-75	-0.6
Oklahoma	538	13.8	461	11.7	-77	-2.1
Oregon	255	6.1	252	6.0	-3	-0.1
Pennsylvania	702	5.5	681	5.3	-21	-0.2
Puerto Rico	185	5.7	161	5.1	-24	-0.6
Rhode Island	47	4.3	45	4.2	-2	-0.1
South Carolina	512	10.0	470	9.1	-41	-0.9
South Dakota	83	9.5	72	8.1	-12	-1.4
Tennessee	686	10.0	647	9.3	-39	-0.7
Texas	5,224	18.0	4,899	16.6	-325	-1.4
Utah	299	9.0	273	8.1	-26	-0.9
Vermont	23	3.7	25	3.9	1	0.2
Virginia	574	6.8	545	6.5	-29	-0.3
Washington	488	6.4	468	6.1	-20	-0.3
West Virginia	107	6.1	103	5.9	-4	-0.2
Wisconsin	312	5.4	303	5.2	-9	-0.2
Wyoming	69	12.2	66	11.5	-4	-0.7

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

Source: MACPAC, 2024, analysis of Census 2023.

TABLE 3A-4. State Levels of Uncompensated Care, FYs 2020–2021

State	Total hospital uncompensated care costs, 2020		Total hospital uncompensated care costs, 2021		Difference in total hospital uncompensated care costs, 2021-2020	
	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	**$40,565**	**3.9%**	**$39,309**	**3.6%**	**-$1,256**	**-0.4%**
Alabama	**799**	6.6	**779**	6.0	**-20**	-0.6
Alaska	**50**	2.6	**48**	2.2	**-2**	-0.3
Arizona	**442**	2.6	**496**	2.5	**54**	0.0
Arkansas	**262**	3.6	**253**	3.2	**-9**	-0.5
California	**2,474**	2.2	**2,393**	1.8	**-81**	-0.4
Colorado	**443**	2.7	**460**	2.7	**17**	0.0
Connecticut	**234**	1.7	**239**	1.7	**5**	-0.1
Delaware	**91**	2.6	**80**	2.2	**-11**	-0.5
District of Columbia	**64**	1.6	**60**	1.5	**-4**	-0.1
Florida	**3,729**	6.8	**3,703**	6.2	**-26**	-0.7
Georgia	**2,540**	9.0	**2,498**	8.1	**-42**	-0.9
Hawaii	**56**	1.6	**44**	1.1	**-12**	-0.5
Idaho	**180**	3.1	**132**	2.0	**-48**	-1.0
Illinois	**1,580**	3.8	**1,415**	3.2	**-165**	-0.6
Indiana	**800**	3.2	**684**	2.6	**-116**	-0.6
Iowa	**208**	2.0	**195**	1.8	**-13**	-0.3
Kansas	**415**	4.1	**426**	3.9	**11**	-0.2
Kentucky	**311**	2.0	**266**	1.6	**-45**	-0.4
Louisiana	**419**	2.7	**371**	2.2	**-48**	-0.5
Maine	**183**	2.8	**155**	2.2	**-27**	-0.6
Maryland	**627**	3.7	**208**	3.3	**-419**	-0.4
Massachusetts	**542**	1.7	**493**	1.5	**-48**	-0.2
Michigan	**606**	1.7	**552**	1.5	**-53**	-0.2
Minnesota	**327**	1.6	**298**	1.4	**-29**	-0.2
Mississippi	**574**	6.9	**519**	5.8	**-55**	-1.1
Missouri	**1,339**	6.1	**1,197**	5.1	**-142**	-0.9
Montana	**91**	2.0	**100**	1.9	**8**	0.0
Nebraska	**291**	4.1	**245**	3.3	**-45**	-0.9

TABLE 3A-4. (continued)

State	Total hospital uncompensated care costs, 2020		Total hospital uncompensated care costs, 2021		Difference in total hospital uncompensated care costs, 2021-2020	
	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	**$40,565**	**3.9%**	**$39,309**	**3.6%**	**-$1,256**	**-0.4%**
Nevada	**285**	4.3	**279**	4.0	**-5**	-0.4
New Hampshire	**164**	3.0	**135**	2.3	**-28**	-0.6
New Jersey	**1,055**	3.9	**1,124**	3.9	**68**	0.0
New Mexico	**144**	2.3	**144**	2.3	**1**	-0.1
New York	**2,257**	2.6	**2,350**	2.6	**93**	0.0
North Carolina	**1,899**	6.1	**1,862**	5.5	**-37**	-0.6
North Dakota	**104**	2.4	**101**	2.1	**-3**	-0.3
Ohio	**1,132**	2.7	**1,123**	2.5	**-9**	-0.2
Oklahoma	**767**	6.7	**700**	5.7	**-67**	-1.0
Oregon	**364**	2.7	**355**	2.4	**-9**	-0.2
Pennsylvania	**810**	1.7	**718**	1.4	**-92**	-0.3
Rhode Island	**73**	1.9	**63**	1.6	**-10**	-0.4
South Carolina	**871**	5.8	**877**	5.4	**6**	-0.4
South Dakota	**134**	2.7	**131**	2.5	**-3**	-0.3
Tennessee	**1,126**	5.4	**1,110**	4.9	**-16**	-0.4
Texas	**7,301**	10.7	**7,591**	10.2	**289**	-0.4
Utah	**336**	4.0	**328**	3.5	**-8**	-0.4
Vermont	**47**	1.6	**46**	1.5	**-1**	-0.1
Virginia	**809**	3.7	**790**	3.3	**-18**	-0.3
Washington	**519**	2.1	**512**	2.0	**-7**	-0.1
West Virginia	**194**	2.6	**177**	2.2	**-17**	-0.4
Wisconsin	**403**	1.7	**379**	1.6	**-24**	-0.2
Wyoming	**97**	5.2	**101**	5.3	**4**	0.2

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 as 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, 2024, analysis of Medicare cost reports for FYs 2020–2021.

TABLE 3A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria by State, FY 2019

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	**5,940**	**2,464**	**41%**	**694**	**12%**	**637**	**11%**
Alabama	114	76	67	4	4	1	1
Alaska	24	10	42	–	–	–	–
Arizona	119	40	34	38	32	30	25
Arkansas	106	3	3	–	–	–	–
California	404	25	6	22	5	19	5
Colorado	106	35	33	10	9	10	9
Connecticut	39	6	15	2	5	2	5
Delaware	14	2	14	2	14	2	14
District of Columbia	12	7	58	5	42	4	33
Florida	248	70	28	27	11	27	11
Georgia	164	125	76	21	13	18	11
Hawaii	26	12	46	2	8	2	8
Idaho	51	25	49	4	8	3	6
Illinois	203	14	7	14	7	12	6
Indiana	167	51	31	10	6	9	5
Iowa	124	10	8	9	7	9	7
Kansas	149	65	44	17	11	16	11
Kentucky	114	72	63	23	20	18	16
Louisiana	208	61	29	32	15	28	13
Maine	38	2	5	2	5	2	5
Maryland	59	10	17	10	17	9	15
Massachusetts	98	–	–	–	–	–	–
Michigan	160	106	66	11	7	11	7
Minnesota	139	36	26	10	7	9	6

TABLE 3A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,940**	**2,464**	**41%**	**694**	**12%**	**637**	**11%**
Mississippi	107	54	50	16	15	15	14
Missouri	137	98	72	17	12	17	12
Montana	66	7	11	4	6	4	6
Nebraska	98	23	23	9	9	9	9
Nevada	56	20	36	3	5	3	5
New Hampshire	30	26	87	3	10	3	10
New Jersey	95	75	79	25	26	24	25
New Mexico	55	10	18	6	11	6	11
New York	192	182	95	47	24	47	24
North Carolina	128	80	63	19	15	19	15
North Dakota	49	2	4	1	2	1	2
Ohio	229	157	69	14	6	14	6
Oklahoma	146	61	42	14	10	13	9
Oregon	63	20	32	9	14	9	14
Pennsylvania	220	159	72	36	16	32	15
Rhode Island	14	10	71	2	14	2	14
South Carolina	85	61	72	12	14	10	12
South Dakota	61	20	33	9	15	9	15
Tennessee	139	63	45	22	16	16	12
Texas	568	180	32	101	18	100	18
Utah	59	42	71	7	12	6	10
Vermont	16	13	81	3	19	3	19
Virginia	106	38	36	4	4	2	2
Washington	103	57	55	15	15	12	12

TABLE 3A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,940**	**2,464**	**41%**	**694**	**12%**	**637**	**11%**
West Virginia	59	43	73	6	10	5	8
Wisconsin	144	89	62	14	10	14	10
Wyoming	29	11	38	1	3	1	3

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 65 DSH hospitals that did not submit an FY 2021 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] None of the hospitals in Alaska and Arkansas that received DSH payments appeared to meet the deemed DSH criteria according to MACPAC's analysis of available data.

[2] 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.

[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.

[4] Because Montana did not submit a state plan rate year (SPRY) 2019 DSH audit, this analysis uses the state's SPRY 2018 DSH audit data.

Source: MACPAC, 2024, analysis of AHA 2023, Medicare cost reports for FY 2021, and SPRY 2018–2019 DSH audits.

TABLE 3A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals by State, SPRY 2019

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	**815,351**	**437,996**	**54%**	**141,418**	**17%**	**44,471**	**27,226**	**61%**	**12,362**	**28%**
Alabama	14,491	12,223	84	240	2	0	567	79	17	2
Alaska[1]	1,511	917	61	–	–	118	67	56	–	–
Arizona	15,501	7,580	49	7,397	48	1,044	668	64	665	64
Arkansas[1]	9,517	761	8	–	–	379	38	10	–	–
California[2]	72,507	4,791	7	3,280	5	4,916	451	9	310	6
Colorado	10,843	4,505	42	1,622	15	681	344	50	182	27
Connecticut	7,571	1,018	13	400	5	513	56	11	37	7
Delaware	2,666	354	13	354	13	156	37	24	37	24
District of Columbia	3,008	2,206	73	1,106	37	234	182	78	97	41
Florida	56,239	23,950	43	11,953	21	3,252	1,854	57	1,249	38
Georgia	22,384	18,785	84	5,283	24	1,255	1,116	89	483	38
Hawaii	2,694	2,307	86	268	10	181	168	93	48	26
Idaho	42,860	2,461	6	334	1	140	115	82	22	16
Illinois	30,026	2,740	9	2,740	9	1,655	210	13	210	13
Indiana	17,052	6,251	37	2,722	16	920	389	42	237	26
Iowa	7,517	2,707	36	2,666	35	349	225	65	223	64
Kansas	8,435	4,840	57	3,260	39	278	214	77	192	69
Kentucky	14,155	9,398	66	3,374	24	882	539	61	269	30
Louisiana	16,603	8,800	53	2,014	12	883	464	53	123	14
Maine	3,056	143	5	143	5	145	1	1	1	1
Maryland	12,376	2,101	17	2,101	17	805	70	9	70	9
Massachusetts[3]	18,817	–	–	–	–	1,411	–	–	–	–
Michigan	23,777	17,775	75	3,172	13	1,369	1,006	73	323	24
Minnesota	11,362	7,074	62	1,961	17	642	519	81	215	33

TABLE 3A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**815,351**	**437,996**	**54%**	**141,418**	**17%**	**44,471**	**27,226**	**61%**	**12,362**	**28%**
Mississippi	10,027	5,618	56	2,258	23	412	258	63	148	36
Missouri	18,725	13,538	72	2,366	13	950	552	58	148	16
Montana[4]	3,017	351	12	231	8	117	16	14	11	10
Nebraska	5,560	3,369	61	1,514	27	177	148	84	90	51
Nevada	7,391	4,386	59	1,222	17	524	387	74	165	31
New Hampshire	2,818	2,592	92	772	27	127	122	97	78	62
New Jersey	21,091	19,449	92	6,428	30	1,049	994	95	455	43
New Mexico	4,266	1,334	31	351	8	355	117	33	27	7
New York	45,849	44,962	98	10,059	22	3,509	3,452	98	1,004	29
North Carolina	22,506	19,378	86	5,920	26	1,239	1,144	92	416	34
North Dakota	2,496	133	5	25	1	85	0	0	0	0
Ohio	32,406	27,840	86	4,079	13	1,797	1,568	87	448	25
Oklahoma	11,171	6,903	62	1,162	10	486	318	65	43	9
Oregon	7,009	2,921	42	854	12	421	166	39	76	18
Pennsylvania	35,917	31,841	89	6,552	18	1,801	1,690	94	576	32
Rhode Island	2,865	2,145	75	882	31	166	147	88	97	58
South Carolina	12,540	11,135	89	3,250	26	604	580	96	283	47
South Dakota	2,738	1,928	70	1,519	55	88	85	97	79	90
Tennessee	18,179	13,594	75	5,971	33	1,006	884	88	524	52
Texas	68,311	40,072	59	21,754	32	3,733	2,967	79	2,044	55
Utah	5,519	4,668	85	1,044	19	235	221	94	76	32
Vermont	1,138	975	86	494	43	49	49	100	32	64
Virginia	16,555	9,887	60	1,295	8	831	593	71	120	14
Washington	12,062	8,863	73	1,448	12	856	635	74	132	15

TABLE 3A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**815,351**	**437,996**	**54%**	**141,418**	**17%**	**44,471**	**27,226**	**61%**	**12,362**	**28%**
West Virginia	5,847	5,163	88	1,052	18	337	323	96	124	37
Wisconsin	12,986	10,483	81	2,394	18	565	497	88	155	28
Wyoming	1,394	782	56	133	10	21	12	58	2	9

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Excludes 65 DSH hospitals that did not submit a fiscal year (FY) 2021 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of the methodology and limitations, see Appendix 3B.

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

[1] None of the hospitals in Alaska and Arkansas that received DSH payments appeared to meet the deemed DSH criteria according to MACPAC's analysis of available data.

[2] 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.

[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.

[4] Because Montana did not submit a SPRY 2019 DSH audit, this analysis uses the state's SPRY 2018 DSH audit data.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 DSH audits and Medicare cost reports for FYs 2019–2021.

TABLE 3A-7. Medicaid Payments to DSH Hospitals as a Share of Costs by State, SPRY 2019

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	**39%**	**79%**	**8%**	**10%**	**96%**	**70%**	**7%**	**8%**	**86%**
Alabama	67	73	25	23	**121**	57	20	18	**95**
Alaska[1]	38	103	0	2	**105**	99	0	2	**102**
Arizona	33	65	9	4	**78**	62	8	4	**74**
Arkansas[1]	2	75	24	20	**119**	70	22	19	**111**
California[1,2]	6	89	5	13	**107**	86	5	12	**104**
Colorado	33	71	23	9	**103**	67	22	8	**97**
Connecticut	8	70	7	9	**86**	69	7	9	**85**
Delaware	7	90	0	21	**111**	79	0	19	**98**
District of Columbia	25	71	3	25	**99**	66	3	23	**93**
Florida	27	76	12	3	**91**	63	10	3	**76**
Georgia	75	86	7	9	**103**	66	6	7	**78**
Hawaii	46	78	15	2	**95**	77	14	2	**93**
Idaho	49	99	2	4	**104**	86	2	3	**91**
Illinois	4	77	8	27	**113**	56	6	20	**82**
Indiana	31	92	0	14	**106**	85	0	13	**98**
Iowa	8	78	4	9	**91**	76	4	8	**88**
Kansas	42	88	4	7	**99**	72	4	6	**82**
Kentucky	58	96	0	7	**103**	93	0	6	**100**
Louisiana	27	68	1	35	**104**	64	1	32	**97**
Maryland	10	102	1	4	**108**	94	1	4	**99**
Michigan	63	93	4	5	**102**	91	4	4	**99**
Minnesota	22	85	4	1	**91**	82	4	1	**87**
Mississippi	50	85	19	15	**120**	71	16	13	**100**
Missouri	65	97	0	16	**114**	81	0	14	**95**

TABLE 3A-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	**39%**	**79%**	**8%**	**10%**	**96%**	**70%**	**7%**	**8%**	**86%**
Montana[1,3]	11	76	35	1	**112**	73	33	1	**106**
Nebraska	21	72	2	5	**80**	59	2	4	**65**
Nevada	36	74	13	6	**93**	68	12	5	**85**
New Hampshire	83	65	0	26	**91**	60	0	25	**85**
New Jersey	68	85	4	8	**97**	73	4	7	**84**
New Mexico	18	90	2	5	**98**	87	2	5	**94**
New York	84	72	3	12	**88**	68	3	12	**83**
North Carolina	58	72	35	5	**113**	57	28	4	**89**
North Dakota	2	104	7	1	**112**	93	6	1	**100**
Ohio	67	79	3	6	**89**	76	3	6	**85**
Oklahoma	39	77	31	3	**111**	62	25	2	**89**
Oregon	29	97	1	5	**103**	94	1	5	**100**
Pennsylvania	70	53	11	6	**70**	50	10	6	**66**
Rhode Island	71	87	1	13	**101**	83	1	13	**97**
South Carolina	64	85	5	16	**106**	70	4	13	**86**
South Dakota	31	119	2	1	**122**	90	2	0	**92**
Tennessee	42	85	18	2	**105**	72	15	2	**89**
Texas	29	85	12	16	**113**	62	9	12	**82**
Utah[1]	69	105	38	4	**148**	87	31	4	**121**
Vermont	81	75	0	5	**80**	72	0	5	**77**
Virginia	36	103	12	2	**117**	87	10	2	**99**
Washington	53	87	2	6	**95**	84	2	6	**91**

TABLE 3A-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	**39%**	**79%**	**8%**	**10%**	**96%**	**70%**	**7%**	**8%**	**86%**
West Virginia	68	72	14	3	**89**	70	13	3	**86**
Wisconsin	60	86	2	2	**89**	82	2	2	**85**
Wyoming	38	82	16	0	**98**	59	12	0	**71**

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 2,342 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2021 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 (the 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 fully account for provider contributions to the non-federal share; these contributions reduce the net payments providers receive. Numbers may not sum due to rounding.

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 percent of uncompensated care costs.

[3] Montana has not submitted a SPRY 2019 as-filed DSH audit. This analysis uses SPRY 2018 Montana DSH audit data.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 as-filed Medicaid DSH audits.

TABLE 3A-8. DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual by State, FY 2024

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per uninsured individual		FY 2024 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$27,419.0**	**$15,644.5**	**$1,039.9**	**$593.3**	**$358.4**	**$204.5**
Alabama	**596.7**	436.3	**1,364.7**	997.9	**418.6**	306.1
Alaska	**58.3**	29.2	**757.8**	379.0	**384.3**	192.2
Arizona	**217.2**	144.0	**290.1**	192.3	**123.5**	81.9
Arkansas	**85.0**	61.2	**337.3**	242.8	**91.3**	65.7
California	**3,140.0**	1,570.0	**1,260.1**	630.1	**352.9**	176.5
Colorado	**264.9**	132.5	**648.5**	324.3	**247.0**	123.5
Connecticut	**572.9**	286.4	**3,098.0**	1,549.0	**920.4**	460.2
Delaware	**21.6**	12.9	**380.5**	227.2	**120.7**	72.1
District of Columbia	**124.3**	87.0	**6,381.4**	4,467.0	**1,020.2**	714.1
Florida	**492.2**	285.3	**201.1**	116.6	**95.0**	55.1
Georgia	**580.0**	382.2	**463.6**	305.5	**213.4**	140.6
Hawaii	**23.7**	13.9	**486.0**	284.6	**89.6**	52.5
Idaho	**33.5**	23.3	**213.8**	149.1	**72.0**	50.2
Illinois	**602.3**	307.7	**740.6**	378.4	**225.4**	115.1
Indiana	**463.3**	304.0	**986.8**	647.6	**282.5**	185.4
Iowa	**87.4**	56.0	**620.6**	398.0	**130.1**	83.4
Kansas	**96.4**	58.8	**390.1**	237.9	**140.6**	85.8
Kentucky	**286.7**	205.8	**1,161.1**	833.4	**223.6**	160.5
Louisiana	**1,440.1**	974.5	**4,612.8**	3,121.5	**1,005.4**	680.3
Maine	**238.6**	149.5	**2,657.7**	1,665.0	**891.0**	558.2
Maryland	**218.4**	109.2	**592.9**	296.4	**199.6**	99.8
Massachusetts	**873.6**	436.8	**5,210.7**	2,605.3	**757.9**	379.0
Michigan	**580.5**	377.0	**1,285.8**	835.0	**244.0**	158.4
Minnesota	**207.6**	106.9	**815.8**	420.1	**205.2**	105.7
Mississippi	**279.7**	216.2	**897.8**	693.8	**295.4**	228.2
Missouri	**1,019.6**	673.7	**1,958.0**	1,293.7	**691.2**	456.7
Montana	**25.3**	16.2	**276.9**	177.0	**99.2**	63.4
Nebraska	**68.9**	40.4	**531.5**	311.4	**162.4**	95.2
Nevada	**108.4**	65.9	**311.0**	189.0	**135.7**	82.5
New Hampshire	**458.6**	229.3	**6,791.5**	3,395.8	**2,489.8**	1,244.9
New Jersey	**1,843.9**	921.9	**2,940.1**	1,470.1	**1,157.0**	578.5

TABLE 3A-8. (continued)

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per uninsured individual		FY 2024 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$27,419.0**	**$15,644.5**	**$1,039.9**	**$593.3**	**$358.4**	**$204.5**
New Mexico	**39.8**	28.9	**233.6**	169.6	**62.1**	45.1
New York	**4,600.8**	2,300.4	**4,869.6**	2,434.8	**1,026.3**	513.2
North Carolina	**636.5**	419.5	**654.1**	431.1	**245.7**	161.9
North Dakota	**25.4**	13.7	**521.6**	280.7	**167.3**	90.0
Ohio	**899.0**	578.0	**1,317.1**	846.9	**326.2**	209.7
Oklahoma	**76.2**	51.5	**165.4**	111.7	**63.4**	42.8
Oregon	**108.8**	64.5	**431.0**	255.6	**117.1**	69.5
Pennsylvania	**1,481.9**	802.0	**2,176.3**	1,177.8	**563.9**	305.2
Rhode Island	**168.8**	92.8	**3,719.0**	2,045.8	**881.7**	485.0
South Carolina	**669.1**	465.2	**1,422.1**	988.8	**501.5**	348.7
South Dakota	**28.7**	15.8	**400.8**	220.4	**145.9**	80.2
Tennessee	**83.2**	54.3	**128.6**	83.9	**46.3**	30.2
Texas	**2,265.6**	1,362.8	**462.5**	278.2	**277.2**	166.7
Utah	**42.3**	27.9	**155.3**	102.3	**63.4**	41.8
Vermont	**56.6**	32.1	**2,281.6**	1,294.8	**482.4**	273.8
Virginia	**244.8**	125.4	**449.1**	230.1	**147.0**	75.3
Washington	**529.9**	264.9	**1,133.3**	566.7	**373.7**	186.9
West Virginia	**129.2**	95.8	**1,253.7**	929.0	**251.4**	186.3
Wisconsin	**222.0**	134.7	**733.2**	444.8	**189.4**	114.9
Wyoming	**0.6**	0.3	**9.9**	4.9	**5.1**	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 3B.

Source: MACPAC, 2024, analysis of Census 2023 and the Centers for Medicare & Medicaid Services Medicaid Budget and Expenditure System.

TABLE 3A-9. FY 2024 DSH Allotment as a Percentage of Hospital Uncompensated Care Costs by State, FY 2021

State	FY 2024 federal DSH allotment (millions)	FY 2024 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021	FY 2024 DSH allotment (state and federal, millions)	FY 2024 total DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021
Total	**$15,644.5**	**39.8%**	**$27,419.0**	**69.8%**
Alabama	436.3	56.0	596.7	76.6
Alaska	29.2	60.4	58.3	120.8
Arizona	144.0	29.0	217.2	43.8
Arkansas	61.2	24.2	85.0	33.6
California	1,570.0	65.6	3,140.0	131.2
Colorado	132.5	28.8	264.9	57.5
Connecticut	286.4	119.8	572.9	239.7
Delaware	12.9	16.1	21.6	27.0
District of Columbia	87.0	144.5	124.3	206.5
Florida	285.3	7.7	492.2	13.3
Georgia	382.2	15.3	580.0	23.2
Hawaii	13.9	31.3	23.7	53.5
Idaho	23.3	17.7	33.5	25.4
Illinois	307.7	21.7	602.3	42.6
Indiana	304.0	44.4	463.3	67.7
Iowa	56.0	28.7	87.4	44.7
Kansas	58.8	13.8	96.4	22.6
Kentucky	205.8	77.4	286.7	107.9
Louisiana	974.5	262.9	1,440.1	388.5
Maine	149.5	96.2	238.6	153.5
Maryland	109.2	52.6	218.4	105.2
Massachusetts	436.8	88.6	873.6	177.2
Michigan	377.0	68.2	580.5	105.1
Minnesota	106.9	35.9	207.6	69.7
Mississippi	216.2	41.6	279.7	53.9
Missouri	673.7	56.3	1,019.6	85.2
Montana	16.2	16.2	25.3	25.4
Nebraska	40.4	16.4	68.9	28.1
Nevada	65.9	23.6	108.4	38.8
New Hampshire	229.3	169.2	458.6	338.5
New Jersey	921.9	82.0	1,843.9	164.1
New Mexico	28.9	20.0	39.8	27.6

TABLE 3A-9. (continued)

State	FY 2024 federal DSH allotment (millions)	FY 2024 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021	FY 2024 DSH allotment (state and federal, millions)	FY 2024 total DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021
Total	**$15,644.5**	**39.8%**	**$27,419.0**	**69.8%**
New York	2,300.4	97.9	4,600.8	195.8
North Carolina	419.5	22.5	636.5	34.2
North Dakota	13.7	13.5	25.4	25.0
Ohio	578.0	51.5	899.0	80.1
Oklahoma	51.5	7.4	76.2	10.9
Oregon	64.5	18.2	108.8	30.7
Pennsylvania	802.0	111.7	1,481.9	206.4
Rhode Island	92.8	147.6	168.8	268.3
South Carolina	465.2	53.0	669.1	76.2
South Dakota	15.8	12.1	28.7	21.9
Tennessee	54.3	4.9	83.2	7.5
Texas	1,362.8	18.0	2,265.6	29.8
Utah	27.9	8.5	42.3	12.9
Vermont	32.1	69.5	56.6	122.4
Virginia	125.4	15.9	244.8	31.0
Washington	264.9	51.8	529.9	103.5
West Virginia	95.8	54.1	129.2	73.0
Wisconsin	134.7	35.5	222.0	58.6
Wyoming	0.3	0.3	0.6	0.6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Uncompensated care is calculated using 2021 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. For further discussion of methodology and limitations, see Appendix 3B.

Source: MACPAC, 2024, analysis of Medicare cost reports for FYs 2020–2021 and the Centers for Medicare & Medicaid Services Medicaid Budget and Expenditure System.

TABLE 3A-10. DSH Allotment per Deemed DSH Providing at Least One Essential Community Service by State, FY 2024

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per deemed DSH hospital (millions)		FY 2024 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	**$27,419.0**	**$15,644.5**	**$39.5**	**$22.5**	**$45.2**	**$25.8**
Alabama	**596.7**	436.3	**149.2**	109.1	**596.7**	436.3
Alaska[1]	**58.3**	29.2	**–**	–	**–**	–
Arizona	**217.2**	144.0	**5.7**	3.8	**7.8**	5.1
Arkansas[1]	**85.0**	61.2	**–**	–	**–**	–
California[2]	**3,140.0**	1,570.0	**142.7**	71.4	**184.7**	92.4
Colorado	**264.9**	132.5	**26.5**	13.2	**29.4**	14.7
Connecticut	**572.9**	286.4	**286.4**	143.2	**286.4**	143.2
Delaware	**21.6**	12.9	**10.8**	6.5	**10.8**	6.5
District of Columbia	**124.3**	87.0	**24.9**	17.4	**31.1**	21.7
Florida	**492.2**	285.3	**18.2**	10.6	**18.2**	10.6
Georgia	**580.0**	382.2	**27.6**	18.2	**32.2**	21.2
Hawaii	**23.7**	13.9	**11.9**	6.9	**11.9**	6.9
Idaho	**33.5**	23.3	**8.4**	5.8	**11.2**	7.8
Illinois	**602.3**	307.7	**43.0**	22.0	**50.2**	25.6
Indiana	**463.3**	304.0	**46.3**	30.4	**51.5**	33.8
Iowa	**87.4**	56.0	**9.7**	6.2	**9.7**	6.2
Kansas	**96.4**	58.8	**5.7**	3.5	**6.0**	3.7
Kentucky	**286.7**	205.8	**12.5**	8.9	**20.5**	14.7
Louisiana	**1,440.1**	974.5	**45.0**	30.5	**68.6**	46.4
Maine	**238.6**	149.5	**119.3**	74.7	**119.3**	74.7
Maryland	**218.4**	109.2	**21.8**	10.9	**24.3**	12.1
Massachusetts[3]	**873.6**	436.8	**–**	–	**–**	–
Michigan	**580.5**	377.0	**52.8**	34.3	**52.8**	34.3
Minnesota	**207.6**	106.9	**20.8**	10.7	**23.1**	11.9

TABLE 3A-10. (continued)

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per deemed DSH hospital (millions)		FY 2024 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	**$27,419.0**	**$15,644.5**	**$39.5**	**$22.5**	**$45.2**	**$25.8**
Mississippi	**279.7**	216.2	**17.5**	13.5	**18.6**	14.4
Missouri	**1,019.6**	673.7	**60.0**	39.6	**60.0**	39.6
Montana	**25.3**	16.2	**6.3**	4.0	**6.3**	4.0
Nebraska	**68.9**	40.4	**7.7**	4.5	**11.5**	6.7
Nevada	**108.4**	65.9	**36.1**	22.0	**36.1**	22.0
New Hampshire	**458.6**	229.3	**152.9**	76.4	**152.9**	76.4
New Jersey	**1,843.9**	921.9	**73.8**	36.9	**76.8**	38.4
New Mexico	**39.8**	28.9	**6.6**	4.8	**6.6**	4.8
New York	**4,600.8**	2,300.4	**97.9**	48.9	**100.0**	50.0
North Carolina	**636.5**	419.5	**33.5**	22.1	**35.4**	23.3
North Dakota[4]	**25.4**	13.7	**25.4**	13.7	**–**	–
Ohio	**899.0**	578.0	**64.2**	41.3	**69.2**	44.5
Oklahoma	**76.2**	51.5	**5.4**	3.7	**5.9**	4.0
Oregon	**108.8**	64.5	**12.1**	7.2	**12.1**	7.2
Pennsylvania	**1,481.9**	802.0	**41.2**	22.3	**46.3**	25.1
Rhode Island	**168.8**	92.8	**84.4**	46.4	**84.4**	46.4
South Carolina	**669.1**	465.2	**55.8**	38.8	**66.9**	46.5
South Dakota	**28.7**	15.8	**3.2**	1.8	**4.8**	2.6
Tennessee	**83.2**	54.3	**3.8**	2.5	**5.2**	3.4
Texas	**2,265.6**	1,362.8	**22.4**	13.5	**22.7**	13.6
Utah	**42.3**	27.9	**6.0**	4.0	**7.1**	4.6
Vermont	**56.6**	32.1	**18.9**	10.7	**18.9**	10.7
Virginia	**244.8**	125.4	**61.2**	31.3	**122.4**	62.7
Washington	**529.9**	264.9	**35.3**	17.7	**66.2**	33.1

TABLE 3A-10. (continued)

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per deemed DSH hospital (millions)		FY 2024 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	**$27,419.0**	**$15,644.5**	**$39.5**	**$22.5**	**$45.2**	**$25.8**
West Virginia	**129.2**	95.8	**21.5**	16.0	**32.3**	23.9
Wisconsin	**222.0**	134.7	**15.9**	9.6	**15.9**	9.6
Wyoming	**0.6**	0.3	**0.6**	0.3	**0.6**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 65 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. For further discussion of methodology and limitations, see Appendix 3B.

– Dash indicates that the category is not applicable.

[1] None of the hospitals in Arkansas and Alaska that received DSH payments appear to meet the deemed DSH criteria according to MACPAC's analysis of available data.

[2] 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.

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

Source: MACPAC, 2024, analysis of AHA 2023, the Centers for Medicare and Medicaid Services Medicaid Budget and Expenditure System FY 2023, and state plan rate year 2018–2019 as-filed Medicaid DSH audits.

References

American Hospital Association (AHA). 2023. 2021 AHA annual survey data. Washington, DC: AHA. https://www.ahadata.com/aha-annual-survey-database.

Congressional Budget Office (CBO). 2023a. *The budget and economic outlook: 2023 to 2033*. Washington, DC: CBO. https://www.cbo.gov/system/files/2023-02/51135-2023-02-Economic-Projections.xlsx.

Congressional Budget Office (CBO). 2023b. *An update to the economic outlook: 2023 to 2025*. Washington, DC: CBO. https://www.cbo.gov/system/files/2023-07/51135-2023-07-Economic-Projections.xlsx.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. E-mail to MACPAC, October 4.

U.S. Census Bureau (Census), U.S. Department of Commerce. 2023. American Community Survey (ACS). Washington, DC: Census. https://www.census.gov/programs-surveys/acs.

APPENDIX 3B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. In the following sections, we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

Primary Data Sources

DSH audit data

We used the most recent available state plan rate year (SPRY) DSH audit reports to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types for all states. For all states except Montana, we used SPRY 2019 DSH audits. Since Montana had not submitted a SPRY 2019 DSH audit at the time these data were collected, we used its SPRY 2018 DSH audit and adjusted for inflation. 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, 2,464 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 (58 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-two 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. We excluded 65 DSH hospitals without matching 2021 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 1,464 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 quartile or below the lowest quartile. (Under this criterion, 404 hospitals were excluded from our analysis of fiscal year (FY) 2021 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 2019.

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, five DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions may have 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 2021 Medicare cost reports and the 2022 American Hospital Association annual survey (Table 3B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the American Hospital Association annual survey.

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

Data source	Service type
American Hospital Association annual survey	Burn services
	Dental services
	HIV/AIDS care
	Neonatal intensive care units
	Obstetrics and gynecology services
	Primary care services
	Substance use disorder services
	Trauma services
Medicare cost reports	Graduate medical education
	Inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital)

For this report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. For deemed DSH hospitals, we also included certain hospital types if they were the only hospital in their geographic 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 2026 were calculated using data provided to the Commission by CMS and the Congressional Budget Office. DSH allotments for FY 2026 were calculated by increasing FY 2024 DSH allotments by the Consumer Price Index projections for All Urban Consumers and allocating the $8 billion in reduction to each state using data provided to us by CMS (CBO 2023, CMS 2023).

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).

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. E-mail to MACPAC, October 4.

Congressional Budget Office (CBO). 2023. *The budget and economic outlook: 2023 to 2033*. Washington, DC: CBO. https://www.cbo.gov/system/files/2023-02/51135-2023-02-Economic-Projections.xlsx.