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Medicaid Disproportionate Share Hospital Payments

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Summary

The Medicaid statute requires states to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. This provision is intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely than others to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance.

As with most Medicaid expenditures, the federal government reimburses states for a portion of their Medicaid DSH expenditures based on each state's federal medical assistance percentage (FMAP). While most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. In FY2023, preliminary federal DSH allotments totaled $16.0 billion.

All states (with the exception of Tennessee) receive a Medicaid DSH allotment based on the prior year's DSH allotment increased by the percentage change in the consumer price index for all urban consumers (CPI-U). Since FY2020, the Medicaid DSH allotments have been recalculated to take into account the higher federal share of Medicaid DSH expenditures under the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase. FY2023 is the last year the Medicaid DSH allotment were recalculated even though the FFCRA FMAP increase will be in effect for the first fiscal quarter of FY2024.

Built on the premise that the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) insurance coverage provisions (including the ACA Medicaid expansion) would reduce the number of uninsured individuals, the ACA included a provision directing the Secretary of the Department of Health and Human Services (HHS) to make aggregate reductions in federal Medicaid DSH allotments for each year from FY2014 to FY2020. Since the initial enactment of the ACA, a number of laws have amended the ACA Medicaid DSH allotment reductions, and the reductions have yet to be implemented. Under current law, the Medicaid DSH allotment reductions are to be in effect for January 20, 2024, through FY2027.

Although states must follow some federal requirements in defining DSH hospitals and calculating DSH payments, for the most part, states are provided significant flexibility. One way the federal government restricts states' Medicaid DSH payments is that the federal statute limits the amount of DSH payments to institutions for mental disease and other mental health facilities.

In addition, there is a hospital-specific limit on the amount of Medicaid DSH payments each hospital can receive. The methodology for calculating this hospital-specific limit was amended in Section 203 of the Consolidated Appropriations Act, 2021 (P.L. 116-260). Some parts of Section 203 have not been fully implemented, including the exception for hospitals in the 97th percentile of all hospitals with respect to inpatient days made up by patients who are entitled to Medicare Part A benefits and Supplemental Security Income (SSI) benefits.

Since Medicaid DSH allotments were implemented in FY1993, total Medicaid DSH expenditures (i.e., including federal and state expenditures) have remained relatively stable. Over this same period of time, total Medicaid DSH expenditures as a percentage of total Medicaid medical assistance expenditures (i.e., including both federal and state expenditures but excluding expenditures for administrative activities) dropped from 13% in FY1993 to 2% in FY2022.

The future of Medicaid DSH payments is uncertain because Congress could extend application of or amend the Medicaid DSH reductions in the same way the reductions have been amended in the past, which includes eliminating the reductions for FY2014 through January 19, 2024, changing the reduction amounts, and extending the application of the reductions through FY2027.

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Introduction

Medicaid is a federal-state program providing medical assistance for low-income individuals.[1] Historically, Medicaid eligibility has generally been limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. Since 2014, states have had the option to cover nonelderly adults with income up to 133% of the federal poverty level under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion.

Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and territories choose to participate.[2] To participate in Medicaid, the federal government requires states to cover certain mandatory populations and benefits, but the federal government also allows states to cover optional populations and services. Due to this flexibility, there is substantial variation among the states in terms of factors such as Medicaid eligibility, covered benefits, and provider payment rates.

Medicaid is jointly financed by the federal government and the states. States incur Medicaid costs by making payments to service providers (e.g., for doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs.[3] The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP).[4] The FMAP varies by state and is inversely related to each state's per capita income. For FY2024, FMAP rates range from 50% (11 states) to 77% (Mississippi).[5]

For the most part, states establish their own payment rates for services rendered to Medicaid enrollees by Medicaid providers. Low Medicaid provider payment rates in many states and their impact on provider participation have been perennial policy concerns for the Medicaid program.[6] Some states rely on supplemental payments to offset low Medicaid payments for services or to support safety-net providers. Supplemental payments are Medicaid payments to providers that are separate from and in addition to the payments for services rendered to Medicaid enrollees.[7] Medicaid disproportionate share hospital (DSH) payments are the only type of supplemental payments that are mandatory for states.

[1] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

[2] The territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

[3] For an overview of Medicaid financing issues, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[4] For more information about the federal medical assistance percentage (FMAP), see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[5] Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2023 Through September 30, 2024," 87 *Federal Register* 74429, December 5, 2022.

[6] Stephen Zuckerman, Laura Skopec, and Joshua Aarons, "Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019," *Health Affairs*, vol. 40, no. 2 (February 2021); Kayla Holgash and Martha Heberlein, "Physician Acceptance Of New Medicaid Patients: What Matters and What Doesn't," *Health Affairs Blog*, April 2019; Sandra L. Decker, "In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," vol. 31, no. 8 (August 2012).

[7] For more information about Medicaid supplemental payments, see CRS Report R45432, *Medicaid Supplemental Payments*.

The Medicaid statute requires that states make DSH payments to hospitals treating large numbers of low-income patients.[8] This provision is intended to recognize the disadvantaged financial situation of such hospitals because low-income patients are more likely than others to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance.

While most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual federal DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. In FY2023, the preliminary federal DSH allotments to states totaled $16.0 billion.

This report provides an overview of Medicaid DSH, including how state DSH allotments are calculated and the exceptions to the DSH allotments calculation; how DSH hospitals are defined and how DSH payments to hospitals are calculated; trends in DSH spending; variation in states' DSH expenditures; and requirements outlining the basic requirements for state DSH reports and independently certified audits.

Background: Medicaid DSH

Medicaid DSH payments were established in the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981; P.L. 97-35) when the methodology for Medicaid payment rates to hospitals was amended.[9] Prior to OBRA 1981, state Medicaid programs were required to reimburse hospitals on a reasonable cost basis (as defined under Medicare) unless the state had approval to use an alternate payment method.[10] This law deleted the reasonable cost methodology and transferred the responsibility for determining Medicaid payment rates to the states.

A new provision required Medicaid hospital payment rates to take into account the situation of hospitals that serve a disproportionate number of "low-income patients with special needs."[11] This requirement established the Medicaid DSH payments.

The inclusion of this Medicaid DSH provision in OBRA 1981 recognized that hospitals serving a disproportionate share of low-income patients are particularly dependent on Medicaid payments because low-income patients are mostly Medicaid enrollees and uninsured individuals.[12] Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates are generally lower than the rates paid by Medicare and private insurance.

[8] The Medicare program also makes disproportionate share hospital (DSH) payments. Medicaid and Medicare DSH hospital payments are similar in that the major basis for designating hospitals to receive payments is the proportion of services provided to low-income patients. However, Medicaid and Medicare have different criteria for identifying DSH hospitals, and the programs have different calculations for determining DSH payment amounts.

[9] The DSH provision was included in a package of provisions referred to as the "Boren amendment" after its sponsor, Senator David Boren from Oklahoma.

[10] The HHS Secretary could approve an alternate system only if the Secretary determined that (1) a reasonable cost was paid (though the state could develop its own methods and standards for determining what was reasonable) and (2) the reasonable cost did not exceed the amount which would be determined reasonable under Medicare.

[11] §1902(a)(13)(A)(iv) of the Social Security Act.

[12] H. Rept. 97-208.

States Slow to Implement DSH Programs

While the requirement to make DSH payments was originally established in 1981, many states did not make DSH payments throughout the 1980s. As a result, other federal laws were enacted with provisions aimed at getting states to make DSH payments. For instance, a provision in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) was aimed at supporting state flexibility to make DSH payments. Also, the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) required states to submit a Medicaid state plan amendment describing their DSH policies and establishing certain minimum qualifying standards and payments.[13]

Sharp Increase in DSH Expenditures

DSH payments quickly became a significant portion of Medicaid spending in the early 1990s. DSH expenditures (including federal and state expenditures) grew from $1.0 billion in FY1990 to $17.4 billion in FY1992. As a percent of total Medicaid medical assistance expenditures (i.e., including federal and state spending and excluding expenditures for administrative activities), DSH expenditures grew from 1.3% of total Medicaid medical assistance expenditures in FY1990 to 15.0% in FY1992 (see **Table 1**).

Table 1. Total DSH Expenditures and Total DSH Expenditures as a Percentage of Total Medicaid Medical Assistance Expenditures

(FY1990 to FY1992)

	DSH Expenditures (in billions)	Percentage Increase	DSH Expenditures as a % of Medical Assistance Expenditures
FY1990	$1.0	—	1.3%
FY1991	$4.7	370.0%	5.2%
FY1992	$17.4	270.2%	15.0%

Source: Payments estimated by the Urban Institute.

Notes: Total DSH expenditures include both federal and state spending on DSH payments. Total Medicaid medical assistance expenditures include federal and state spending and exclude Medicaid spending on administrative activities.

DSH = Disproportionate share hospital.

The significant increase in DSH expenditures was not attributed to the laws enacted by Congress. Instead, the growth in Medicaid expenditures coincided with states' increased use of provider taxes and donations to help finance the state share of Medicaid expenditures.[14] DSH payments were a popular mechanism for returning provider taxes or donations to hospitals. Medicaid payments for regular inpatient rates were subject to federal upper payment limits, but DSH

[13] A Medicaid state plan is a contract between a state and the federal government describing how that state administers its Medicaid program, and a state is required to submit a state plan amendment when the state intends to change its Medicaid program.

[14] In the mid-1980s, states began using provider taxes along with provider donations to help finance Medicaid. Essentially, Medicaid providers would donate funds or agree to be taxed, and the revenue from these taxes and donations would be used to finance a portion of the state's share of Medicaid expenditures. Some states were using the provider tax and donation funds to draw down federal funds and increase Medicaid payment rates to the same providers that had paid taxes or donated funds. The providers were often fully reimbursed for the cost of their tax payment or donation. For more information about Medicaid provider taxes and donations, see CRS Report RS22843, *Medicaid Provider Taxes*.

payments were uncapped and did not need to be tied to specific Medicaid enrollees or services. As a result, states could increase DSH payments by any amount, tax away the state share of the increased DSH payments through provider taxes, and thus draw down unlimited federal funds.

Limits on DSH Payments

This dramatic growth in DSH expenditures again prompted congressional action. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) established ceilings on federal Medicaid DSH funding for each state.[15] Since FY1993, each state has had its own DSH limit, which is referred to as a *DSH allotment*.

DSH Allotments

While most federal Medicaid funding is provided on an open-ended basis, certain types of federal Medicaid funding, such as federal DSH funding, are capped. Each state receives an annual DSH allotment,[16] which is the maximum amount of federal matching funds a state is permitted to claim for Medicaid DSH payments.[17]

DSH Allotment Methodology

The original state DSH allotments provided in FY1993 were based on each state's FY1992 DSH payments. In FY1992, some states provided relatively more DSH payments to hospitals, and, as a result, these states locked in relatively higher Medicaid DSH allotments. Other states made relatively fewer DSH payments, and these states locked in relatively lower DSH allotments.

This disparity still remains to some extent in current DSH allotments because DSH allotments are not distributed according to a formula. However, over time, the disparity in DSH allotments was reduced by providing larger annual increases to DSH allotments for states that initially made fewer DSH payments and limiting the growth of DSH allotments for states that initially provided relatively more DSH payments.

DSH Allotment Reform

Since the state Medicaid DSH allotments are based off each state's FY1992 Medicaid DSH payments increased at varying rates over the years, the allotment amounts are not based on states' need for Medicaid DSH funding.

Over the years, there have been discussions about whether Medicaid DSH allotments should be restructured so that the state Medicaid DSH allotments are based off factors, such as the number of safety net hospitals in a state, number of uninsured individuals in a state, or the amount of hospital uncompensated care costs in the state.

Most recently, in 2019, there was some discussion of amending the allocation of Medicaid DSH allotment funding among the states. During the 116th Congress, the State Accountability, Flexibility, and Equity (SAFE) Hospitals Act (S. 18 and H.R. 3613) was introduced in the Senate and the House of Representatives, and these bills would have changed the methodology for allocating federal Medicaid DSH funding among the states based on the number of low-income residents in each state, among other things. In addition, Senate Finance Chairman Grassley stated that

[15] Also, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) restricted the use of provider donations in financing Medicaid to extremely limited situations and limited states' ability to draw down federal Medicaid matching funds with provider tax revenue.

[16] *State* is defined as the 50 states and the District of Columbia. DSH allotments are not provided for the five territories (i.e., America Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the Virgin Islands). (§1923(f)(9) of the Social Security Act).

[17] Each state's regular FMAP rate is used to determine the federal share of DSH payments.

he was considering options to amend the distribution of federal Medicaid DSH funding among states.[18] Medicaid DSH allotment reform was not implemented in 2019, but since then, the SAFE Hospitals Act has been reintroduced in the 117th Congress (H.R. 3613 and S. 2021) and the 118th Congress (S. 490 and S. 407).

The methodology for calculating states' annual DSH allotments has changed a number of times over the years. A history of the DSH allotment calculations is provided in **Appendix A**.

Currently, states' Medicaid DSH allotments are based on each state's prior year DSH allotment. Specifically, a state's DSH allotment is the higher of (1) a state's FY2004 DSH allotment or (2) the prior year's DSH allotment increased by the percentage change in the consumer price index for all urban consumers (CPI-U) for the prior fiscal year.[19] All states (with the exception of Tennessee) receive a Medicaid DSH allotment based on the prior year's DSH allotment increased by the percentage change in CPI-U.[20]

Since FY2020, the Medicaid DSH allotments have been recalculated to take into account the higher federal share of Medicaid DSH expenditures under the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase.[21] Division F, Section 6008, of the FFCRA provided a temporary FMAP rate increase of 6.2 percentage points beginning January 1, 2020, through March 31, 2023, and the FFCRA FMAP rate increase phases down from April 1, 2023, through December 31, 2023, when it ends.[22] During the period that states are receiving the FFCRA FMAP increase, the Medicaid DSH allotments are required to be recalculated to ensure that the total Medicaid DSH payments (including federal and state expenditures) a state can make in a fiscal year are equal to the Medicaid DSH payments a state could have made without the application of the FFCRA FMAP increase.[23]

The recalculation of Medicaid DSH allotments does not apply for the first fiscal year beginning after the end of the COVID-19 public health emergency period or any succeeding fiscal year.[24]

[18] Michelle M. Stein, "Grassley Is Considering Changes to Medicaid DSH Formula," Inside Health Policy, March 13, 2019; Susannah Luthi, "Congress Eyes Temporary Delay to DSH Cuts," Modern Healthcare, September 17, 2019.

[19] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) addressed the drop in DSH allotments for many states from FY2002 to FY2003 by providing a 16% increase in DSH allotments for states in FY2004. If a state's FY2004 DSH allotment is higher than the DSH allotment calculated under the pre-MMA calculation, then the state has received that higher DSH allotment amount since FY2004.

[20] Tennessee's Medicaid DSH allotment is provided through a special statutory authority under §1923(f)(6)(a) of the Social Security Act.

[21] §1923(f)(3) of the Social Security Act.

[22] The Families First Coronavirus Response Act (FFCRA; P.L. 116-127) increase is 5 percentage points from April 1, 2023, through June 30, 2023; 2.5 percentage points from July 1, 2023, through September 30, 2023; and 1.5 percentage points from October 1, 2023, through December 31, 2023. (FFCRA Section 6008 (42 U.S.C. §1396d note)).

[23] In recalculating the Medicaid DSH allotments for FY2020 and FY2023, CMS used the 6.2 percentage point FFCRA FMAP increase rather than a prorated FMAP rate for the FY2020 and FY2023 calculations, even though the 6.2 percentage point increase was not in effect for the full fiscal years in FY2020 and FY2023. This was done to ensure this provision applies to all States consistent with the statutory requirement, since states make Medicaid DSH payments at different times of the fiscal year. (HHS, CMS, "Medicaid Program; Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Disproportionate Share Hospital Allotments, and Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 88 *Federal Register* 23049, April 14, 2023.)

[24] The Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328) delinked the FFCRA FMAP increase from the COVID-19 public health emergency period and made December 31, 2023, the end date of the FFCRA FMAP increase. However, the CAA 2023 did not amend the end date of the requirement that the Medicaid DSH allotments be recalculated to correspond with the amended end date of the FFCRA FMAP increase.

The COVID-19 public health emergency period ended May 11, 2023.[25] FY2024 is the first fiscal year beginning after the end of the COVID-19 public health emergency period, so the Medicaid DSH allotments will not be recalculated for FY2024 even though the FFCRA FMAP increase will be in effect for the first fiscal quarter of FY2024.

Limits on DSH Expenditures

Each state's allotment can be no more than the greater of the prior year's allotment or 12% of its total Medicaid medical assistance expenditures (i.e., including federal and state spending and excluding expenditures for administrative activities) during the fiscal year.[26] This rule is referred to as the "12% limit."[27] This means the federal share of DSH expenditures cannot be more than 12% of each state's total Medicaid medical assistance expenditures.

In addition to the state-specific 12% limit, there is a national DSH target. Federal regulations specify that aggregate DSH payments, including federal and state expenditures for all states, should not be more than 12% of the total amount of Medicaid medical assistance expenditures for all 50 states and the District of Columbia.[28] This national target is not an absolute cap but a target.[29] The national DSH payment target is different from the 12% limit on state DSH allotments because the 12% national payment target restricts both federal and state spending while the 12% limit for allotments caps only federal spending.

States' DSH Allotments

Due to the state-specific 12% limit for state DSH allotments, the Centers for Medicare & Medicaid Services (CMS) must publish preliminary DSH allotments before the start of the fiscal year based on estimated Medicaid expenditures. Then, after the fiscal year has ended, CMS uses actual expenditure data to calculate final DSH allotments.

CMS calculates annual allotments and publishes them in the *Federal Register*. The most recent *Federal Register* notice included final DSH allotments for FY2020 and FY2021 and preliminary DSH allotments for FY2022 and FY2023.[30] The federal DSH allotments for FY2017 through FY2019 are shown in **Table 2**.

[25] Department of Health and Human Services, "COVID-19 Public Health Emergency (PHE)," https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html.

[26] §1923(f)(3)(B) of the Social Security Act.

[27] When DSH allotments were first implemented, a state with DSH expenditures greater than 12% of its total Medicaid medical assistance expenditures were classified as "high-DSH" states, and "high-DSH" states did not receive annual increases to their DSH allotment.

[28] 42 C.F.R. §447.297.

[29] This means if a state receives a federal DSH allotment equal to 12% of its total Medicaid medical assistance expenditures and the state uses all of its federal DSH allotment, then with the state matching funds, the state would provide DSH payments in excess of 12% of its total Medicaid medical assistance expenditures. As a result, the national DSH target could be surpassed. However, in FY2022, DSH payments were well below the national DSH target with total DSH payments (i.e., including federal and state expenditures) amounting to 2.3% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative services).

[30] HHS, CMS, "Medicaid Program; Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Disproportionate Share Hospital Allotments, and Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 88 *Federal Register* 23049, April 14, 2023.

Table 2. DSH Allotments for FY2020 Through FY2023

($ in millions)

State	FY2020 Final DSH Allotment	FY2021 Final DSH Allotment	FY2022 Preliminary DSH Allotment	FY2023 Preliminary DSH Allotment
Alabama	$390.6	$396.2	$409.3	$440.4
Alaska[a]	26.8	27.2	28.1	30.2
Arizona	128.9	130.8	135.1	145.5
Arkansas[a]	54.8	55.7	57.5	61.9
California	1,440.9	1,462.5	1,510.8	1,625.6
Colorado	121.6	123.4	127.5	137.2
Connecticut	262.9	266.8	275.6	296.6
Delaware[a]	11.7	11.9	12.3	13.2
District of Columbia	78.0	79.1	81.8	88.0
Florida	257.5	261.1	270.1	291.1
Georgia	343.2	348.5	360.1	387.9
Hawaii[b]	12.7	12.9	13.3	14.3
Idaho[a]	20.9	21.2	21.9	23.6
Illinois	282.5	286.2	295.6	318.8
Indiana	273.5	277.6	286.6	308.6
Iowa[a]	50.7	51.4	53.1	57.1
Kansas	53.3	54.0	55.8	60.1
Kentucky	184.2	186.9	192.9	207.7
Louisiana	876.2	888.7	917.3	987.9
Maine	134.7	136.8	141.2	152.1
Maryland	100.2	101.7	105.1	113.1
Massachusetts	400.9	406.9	420.3	452.3
Michigan	339.9	345.0	355.7	383.1
Minnesota[a]	98.2	99.6	102.8	110.6
Mississippi	192.7	195.4	201.8	217.2
Missouri	606.3	616.0	635.1	683.9
Montana[a]	14.5	14.7	15.2	16.4
Nebraska[a]	36.8	37.3	38.4	41.3
Nevada	59.3	60.3	62.3	67.1
New Hampshire	210.4	213.6	220.6	237.4
New Jersey	846.1	858.8	887.2	954.6
New Mexico[a]	25.9	26.2	27.1	29.1
New York	2,111.3	2,142.9	2,213.6	2,381.9

State	FY2020 Final DSH Allotment	FY2021 Final DSH Allotment	FY2022 Preliminary DSH Allotment	FY2023 Preliminary DSH Allotment
North Carolina	376.9	382.4	394.9	424.8
North Dakota[a]	12.6	12.7	13.1	14.1
Ohio	521.8	529.2	546.3	588.2
Oklahoma[a]	46.3	46.9	48.4	52.2
Oregon[a]	58.3	59.2	61.2	65.9
Pennsylvania	734.2	745.3	769.1	828.7
Rhode Island	84.9	86.0	88.7	95.6
South Carolina	416.6	422.8	436.7	470.0
South Dakota[a]	14.3	14.5	15.0	16.2
Tennessee[c]	58.1	58.1	58.1	58.1
Texas	1,232.1	1,248.9	1,292.0	1,392.2
Utah[a]	25.0	25.4	26.3	28.3
Vermont	29.3	29.7	30.6	33.0
Virginia	115.2	116.9	120.7	129.7
Washington	243.2	246.8	255.0	274.3
West Virginia	85.5	86.7	89.6	96.5
Wisconsin[a]	122.1	123.9	127.9	137.6
Wyoming[a]	0.3	0.3	0.3	0.3
Total (in millions of dollars)	$14,224.8	$14,433.3	$14,905.3	$16,041.5

Sources: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Medicaid Program; Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Disproportionate Share Hospital Allotments, and Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 88 *Federal Register* 23049, April 14, 2023.

Notes: DSH allotments are different from DSH payments. Allotments reflect the maximum amount of federal DSH funding available to states, and DSH payments are the amounts paid to hospitals. The Medicaid DSH allotments are adjusted for FY2020 through FY2023 to take into account the higher federal share of Medicaid DSH expenditures under the Families First Coronavirus Response Act (P.L. 116-127) federal medical assistance percentage increase.

a. These states are low DSH states. In the past, low DSH states received higher annual percentage increases to their DSH allotments than the non-low DSH states. Currently, low DSH and other states receive the same annual percentage increases to their DSH allotments.

b. Hawaii has a special statutory arrangement that specifies the DSH allotment for the state. Beginning in FY2013, Hawaii's DSH allotment is determined the same way the DSH allotments are determined for low DSH states.

c. Tennessee has a special statutory arrangement that specifies the DSH allotment for the state. Tennessee receives a Medicaid DSH allotment in the amount of $53.1 million for each fiscal year from FY2015 through FY2025. (§1923(f)(6)(a) of the Social Security Act.)

In February 2023, CMS published a proposed rule that includes a proposal to eliminate the requirement for CMS to publish the Medicaid DSH allotments in the *Federal Register*.[31] Instead, CMS would publish the information on Medicaid.gov and the Medicaid Budget and Expenditures System, which is the system state Medicaid agencies use to report Medicaid expenditures to CMS. As part of the proposed rule, CMS is proposing to remove the requirement that CMS post the Medicaid DSH allotments prior to April 1st each year, and instead, the requirement will be for CMS to post the information "as soon as practicable".

Exceptions for Certain States

While most states' DSH allotments are determined as described above, the DSH allotments for some states are determined by an alternative method. In the past, low DSH states received higher annual percentage increases to their DSH allotments, but currently low DSH states receive the same annual percentage increases to DSH allotments as other states. (See the textbox for more information about low DSH states.)

Low DSH States

Special rules for low DSH states were initially established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA; incorporated into the Consolidated Appropriations Act, 2001, P.L. 106-554).[32] Subsequently, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) amended the definition of low DSH state, and this definition continues to apply today.

A low DSH state is defined as a state with FY2000 DSH expenditures greater than 0% but less than 3% of its total Medicaid medical assistance expenditures for FY2000. States determined to be low DSH states in FY2004 continue to be low DSH states regardless of their DSH expenditures in years after FY2000.

States designated as low DSH states were provided greater annual increases to their DSH allotments to remove some of the inequities from the initial FY1993 state DSH allotments. However, increasing DSH allotments does not necessarily mean states will increase their DSH payments. The increased DSH allotments provide states with access to additional federal DSH funding if the states choose to use it.

The following sixteen states qualify as low DSH states: Alaska, Arkansas, Delaware, Idaho, Iowa, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Wisconsin, and Wyoming.

Each year, from FY2004 through FY2008, low DSH states received a 16% increase to their DSH allotments. For FY2009 and subsequent years, low DSH states receive DSH allotments equal to the prior year's allotment increased by the percentage change in the CPI-U for the previous fiscal year, which is the same adjustment that non-low DSH states receive.

In addition, Hawaii and Tennessee have special statutory arrangements for the determination of their respective DSH allotments. Both states received waivers from making Medicaid DSH payments (among other things), and these states did not receive DSH allotments from FY1998 to FY2006. Currently, Hawaii's annual DSH allotment increases in the same manner as low DSH states, and Tennessee receives a DSH allotment in the amount of $53.1 million for each fiscal year from FY2015 through FY2025. (See **Appendix A** for more information about the special statutory authorities for Hawaii and Tennessee.)

[31] CMS, "Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule," 88 *Federal Register* 11865, February 24, 2023, https://www.federalregister.gov/documents/2023/02/24/2023-03673/medicaid-program-disproportionate-share-hospital-third-party-payer-rule.

[32] BIPA defined extremely low DSH states as those for which FY1999 total DSH payments (federal and state shares) were greater than zero but less than 1% of the state's total Medicaid medical assistance expenditures (i.e., the federal and state share of Medicaid expenditures excluding administrative expenditures). (§1923(f)(5)(A) of the Social Security Act.)

DSH Allotment Reductions

The ACA was expected to reduce the number of uninsured individuals in the United States starting in 2014 through the health insurance coverage provisions (including the ACA Medicaid expansion). Built on the premise that with the ACA insurance coverage provisions reducing the number of uninsured individuals, there should be less need for Medicaid DSH payments, the ACA included a provision directing the Secretary of the Department of Health and Human Services (HHS) to make aggregate reductions in Medicaid DSH allotments equal to $500 million in FY2014, $600 million in FY2015, $600 million in FY2016, $1.8 billion in FY2017, $5.0 billion in FY2018, $5.6 billion in FY2019, and $4.0 billion in FY2020.[33]

Despite the assumption that reducing the uninsured would reduce the need for Medicaid DSH payments, the ACA was written so that, after the specific reductions for FY2014 through FY2020, DSH allotments would have returned to the amounts states would have received without the enactment of ACA. In other words, in FY2021, states' DSH allotments would have rebounded to their pre-ACA reduced level with the annual inflation adjustments for FY2014 to FY2021.

The ACA Medicaid DSH reductions have not yet been implemented, and a number of laws have amended the ACA Medicaid DSH reductions by eliminating the reductions for FY2014 through January 19, 2024, changing the reduction amounts, and extending the application of the reductions through FY2027. Under current law, the aggregate reductions to the Medicaid DSH allotments equal $8.0 billion for part of FY2024 (i.e., January 20, 2024, through September 31, 2024) and for each year from FY2025 through FY2027. In FY2028, DSH allotments are to rebound to the pre-ACA-reduced levels.[34]

DSH Payments

Medicaid state plans must include explanations for how DSH hospitals are defined and how DSH payments are calculated. There are federal requirements that states must follow in making these determinations, but for the most part, states are provided significant flexibility in defining DSH hospitals and calculating DSH payments.

Defining DSH Hospitals

The federal government provides states with the following three criteria for identifying DSH hospitals.

[33] §1923(f)(7) of the Social Security Act. For the same reason, the ACA also included reductions for Medicare DSH payments that went into effect in FY2014. For more information about the Medicare DSH reductions, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

[34] For more information about the ACA Medicaid DSH reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

- At a minimum, states must provide DSH payments to all hospitals with (1) a Medicaid inpatient utilization rate[35] in excess of one standard deviation[36] above the mean rate for the state or (2) a low-income utilization rate[37] of 25%.
- All DSH hospitals must retain at least two obstetricians with staff privileges willing to serve Medicaid patients.[38]
- A hospital *cannot* be identified as a DSH hospital if its Medicaid utilization rate is below 1%.

As long as states include all hospitals meeting the criteria, states can identify as many or as few hospitals as DSH hospitals. Because of the flexibility, there is a great deal of variation across the states in the proportion and types of hospitals designated as DSH hospitals. Some states target their DSH funds to a few hospitals, while other states provide DSH payments to all the hospitals in the state with Medicaid utilization rates above 1%.[39] In state plan rate year (SPRY) 2018,[40] five states made Medicaid DSH payments to less than 10% of the hospitals in the state, and one state provided Medicaid DSH payments to more than 90% of the hospitals in the state.[41]

Calculating DSH Payments

States are also provided a good deal of flexibility in terms of the formulas and methods they use to distribute DSH funds among DSH hospitals. The federal government provides minimum and maximum payment criteria, but otherwise federal law does not address the specific payment amounts states should provide to each DSH hospital.

[35] The formula for the Medicaid utilization rate is the number of days of care furnished to Medicaid beneficiaries during a given period divided by the total number of days of care provided during the period. (§1923(b)(2) of the Social Security Act.)

[36] The "standard deviation," as used for Medicaid DSH, is a statistical measure of the dispersion of hospitals' utilization rates around the average; the use of this measure identifies hospitals whose Medicaid utilization is unusually high.

[37] The formula for the low-income utilization rate is the sum of two fractions. The first fraction is total Medicaid revenue for services plus other payments from state and local governments divided by the total amount of hospital revenue for patient services. The second fraction is the total amount of hospital charges for inpatient hospital services minus the total amount of revenue from state and local governments divided by total hospital charges. (§1923(b)(3) of the Social Security Act.)

[38] There are exceptions to this rule for children's hospitals, hospitals that do not offer non-emergency obstetric services, and certain rural hospitals. (§1923(d) of the Social Security Act.)

[39] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, "Chapter 4. Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States," March 2023, https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf.

[40] Medicaid state plan rate year means the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding DSH payments as well as all other Medicaid payment rates. The period usually corresponds with the state's fiscal year or the federal fiscal year but can correspond to any 12-month period defined by the state as the Medicaid state plan rate year.

[41] MACPAC, *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, "Chapter 4. Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States," March 2023, https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf.

States must make minimum payments to DSH hospitals using one of three methodologies:[42]

- the Medicare DSH methodology,
- a formula providing Medicaid DSH payments that increase in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean, or
- a formula that varies DSH payments according to the type of hospitals.[43]

Hospital-Specific DSH Limits

DSH payments to individual hospitals are subject to a cap.[44] The hospital-specific limit was implemented through the Omnibus Reconciliation Act of 1993 (P.L. 103-66), because Congress had received reports that hospitals had been receiving Medicaid DSH payments that exceeded the hospitals' costs.[45]

This hospital-specific limit prohibits DSH payments from being greater than the cost of providing inpatient and outpatient hospital services to uninsured and Medicaid patients less payments received for those services.[46] The components for calculating the hospital-specific DSH limit have changed in recent years. The definition of the uninsured component was amended in 2014, and the definition of the Medicaid shortfall (i.e., the difference between costs and payments for Medicaid-eligible patients) was updated in 2020.

Definition of Uninsured

Under the hospital-specific DSH limit, uninsured is defined in the statute as individuals who "have no health insurance (or other source of third-party coverage) for the services furnished during the year."[47]

In 1994, CMS clarified that individuals who have no health insurance (or other third-party coverage) for the services provided during the year include those "who do not possess health insurance which applies to the service for which the individual sought treatment."[48] This interpretation remained in effect until January 19, 2009, when CMS defined *uninsured* as individuals who do not have a legally liable third-party payer for hospital services.[49]

Concerns were raised about the new definition of uninsured because this definition appeared to exclude from uncompensated care (for Medicaid DSH purposes) the costs of many services that were provided to individuals with creditable coverage but were outside the scope of such

[42] §1923(c) of the Social Security Act.

[43] If a state chooses to reimburse according to the type of hospital, the state must ensure that all hospitals of each type are treated equally and payments are reasonably related to the hospitals' Medicaid or low-income patient cost, volume, or proportion of Medicaid or low-income patients.

[44] §1923(g) of the Social Security Act.

[45] H.Rept. 103-111.

[46] In California, the hospital-specific cap for public hospitals is 175% of the unreimbursed costs. California's hospital-specific DSH cap for public hospitals was established in the Balanced Budget Act of 1997 (P.L. 105-33) and made permanent by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (which was included in the Consolidated Appropriations Act, 2000, P.L. 106-113).

[47] §1923(g)(1)(A) of the Social Security Act.

[48] State Medicaid Directors letter, "Summary of OBRA 93 DSH Limit Requirements," August 17, 1994.

[49] HHS, CMS, "Medicaid Program: Disproportionate Share Hospital Payments," 73 *Federal Register* 77904, December 19, 2008.

coverage. For instance, the definition excluded individuals who exhausted their insurance benefits and who reached lifetime insurance limits for certain services, as well as services not covered in a benefit package.

In response to these concerns, CMS issued a final rule on December 3, 2014, that changed the definition of uninsured for Medicaid DSH purposes to a service-specific definition. The definition requires a determination of whether, for each specific service furnished during the year, the individual has third-party coverage. As a result, the definition of uninsured includes services not within a covered benefit package and services beyond the annual and lifetime limits.[50]

Definition of Medicaid Shortfall

Medicaid shortfall, for the purposes of the hospital-specific Medicaid DSH limit, is the difference between the cost to the hospital of providing hospital services to Medicaid-eligible patients and the payments the hospital receives for those services. For this definition, the Medicaid payments include non-DSH supplemental payments.[51] The inclusion of payments for Medicaid-eligible patients with third-party coverage had been uncertain due to pending litigation until the enactment of the Consolidated Appropriations Act, 2021 (P.L. 116-260), in December 2020.

Third-Party Coverage Payments

For most Medicaid enrollees, Medicaid is the only source of coverage, but some Medicaid enrollees have third-party coverage, such as Medicare or private health insurance.[52] For Medicaid enrollees with third-party coverage, Medicaid is usually the payer of last resort, which means the third-party coverage must make payment for claims before Medicaid makes payments.[53] The inclusion of other third-party payments in the calculation of the Medicaid shortfall amount was the question of the pending litigation.

CMS had provided guidance to states, through a State Medicaid Directors Letter from 2002 and a frequently asked questions (FAQ) document from 2010, to include third-party payments (e.g., payments from Medicare or private health insurance), for Medicaid-eligible patients in the calculation of Medicaid shortfall.[54] However, after four appellate court decisions found that the change in policy required CMS to go through notice-and-comment rulemaking,[55] CMS withdrew the relevant FAQ guidance (i.e., questions 33 and 34), as of December 30, 2018.[56]

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[50] HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments - Uninsured Definition," 79 *Federal Register* 71679, December 3, 2014.

[51] 42 C.F.R. 422.304(d)(4).

[52] In 2017, MACPAC estimates that 27% of Medicaid enrollees had sources of third-party coverage: Medicare (17% of Medicaid enrollees), private health insurance (13%), Veterans and military health programs (3%), and Indian Health Service (1%). (MACPAC, *Report to Congress on Medicaid and CHIP*, Chapter 2: Treatment of Third-Party Payments in the Definition of Medicaid Shortfall, June 2019.)

[53] In the case of the Indian Health Service, Medicaid is not the payer of last resort, and Medicaid pays prior to Indian Health Service. (25 U.S.C. 1603).

[54] CMS, "Additional Information on DSH Reporting and Audit Requirements," January 2010; CMS, "Medicaid Disproportionate Share Hospital (DSH) Program - Supplemental Upper Payment Limit Payments and Payment for Prison Inmate Care," State Medicaid Director Letter, SMDL #02-013, August 16, 2002.

[55] Children's Health Care v. Ctrs. for Medicare & Medicaid Servs., 900 F.3d 1022, 1026–27 (8th Cir. 2018); Children's Hosp. of the King's Daughters, Inc. v. Azar, 896 F.3d 615, 623, (4th Cir. 2018); N.H. Hosp. Ass'n v. Azar, 887 F.3d 62, 74 (1st Cir. 2018); Tenn. Hosp. Ass'n v. Azar, 908 F.3d 1029, 1046 (8th Cir. 2018).

[56] CMS, "Additional Information on DSH Reporting and Audit Requirements," December 2018.

During that litigation, CMS issued a final rule clarifying that third-party payments should be included in the calculation for Medicaid shortfall.[57] This rule would have impacted hospital services after June 2, 2017.

Enforcement of this final rule was blocked by several federal district courts that found the rule to be contrary to the plain meaning of the statute.[58] However, CMS appealed these decisions.

In August 2019, the U.S. Court of Appeals for the District of Columbia Circuit reversed the lower court and reinstated the 2017 final rule clarifying that third-party payments should be included in calculation for the Medicaid shortfall.[59] In November 2019, the U.S. Court of Appeals for the Eighth Circuit also reversed the lower court and reinstated the 2017 final rule.[60]

If it had been decided that third-party payments could not be included in the calculation of the Medicaid shortfall, then hospitals would have been able to include the costs of the hospital services provided to Medicaid-eligible patients with third-party coverage but not the offsetting payments the hospital receives for those services. This would have meant the hospital could potentially receive double payment for these services (i.e., the payment from the third-party coverage and Medicaid DSH payment).

In June 2019, the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended Congress change the statutory definition of Medicaid shortfall "to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer."[61] This is the policy that was included in Section 203 of the Consolidated Appropriations Act, 2021. Section 203 changed the calculation for the Medicaid shortfall portion of the hospital-specific DSH limit to include only the cost of Medicaid payments for Medicaid enrollees for whom Medicaid is the primary payer. As a result, the calculation for the Medicaid shortfall excludes the cost of services provided to Medicaid enrollees with third party coverage (i.e., Medicare or private health insurance).

Section 203 included an exception for hospitals in the 97th percentile of all hospitals with respect to inpatient days made up by patients who were entitled to Medicare Part A benefits and Supplemental Security Income (SSI) benefits because these hospitals would be disproportionately impacted by the change in the calculation of the Medicaid shortfall portion of the hospital-specific DSH limit. For these hospitals, the Medicaid DSH hospital-specific limit is the higher of the value of the limit as calculated either under the old hospital-specific limit methodology (i.e., including Medicaid enrollees with third party coverage) or the new hospital-specific limit methodology (i.e., excluding Medicaid enrollees with third party coverage).

Section 203 had an effective date of October 1, 2021, but in December 2021, CMS released a State Medicaid Directors Letter indicating that there was not sufficient data available to identify the hospitals qualifying for the 97th percentile exception.[62] The letter stated that CMS would

[57] HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payment-Treatment of Third Party Payers in Calculating Uncompensated Care Costs," 82 *Federal Register* 16114, April 3, 2017.

[58] Missouri Hospital Ass'n v. Azar, No. 2:17-cv-04052 (W.D. Mo. Feb. 9, 2018); Children's Hosp. Ass'n of Texas v. Azar, 300 F. Supp. 3d 190 (D.D.C. Mar. 6, 2018); Baptist Mem'l Hosp.-Golden Triangle, Inc. v. Azar, No. 3:17-cv-491 (S.D. Miss. June 25, 2018).

[59] Children's Hosp. Ass'n of Texas v. Azar, No. 18-5135, (DC Cir. Aug. 13, 2019).

[60] Missouri Hospital Ass'n v. Azar, No. 18-1778, (8th Cir. Nov. 4, 2019).

[61] MACPAC, *Report to Congress on Medicaid and CHIP*, Chapter 2: Treatment of Third-Party Payments in the Definition of Medicaid Shortfall, June 2019.

[62] CMS, "RE: New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021," *State Medicaid Directors Letter*, SMD# 21-006, December 27, 2021, https://www.medicaid.gov/sites/default/files/2021-12/smd21006.pdf.

develop a data source to identify the hospitals for the 97th percentile exception, and CMS would release future rulemaking to address this exception. In February 2023, CMS released a proposed rule including a proposal for developing a data set to determine which hospitals meet the 97th percentile exception.[63] In addition, the proposed rule would amend the effective date for Section 203 to the state's first SPRY beginning on or after October 1, 2021.[64] This proposed rule has yet to be finalized, and according to the Unified Agenda, the final rule could be release in March 2024.[65]

Institutions for Mental Disease DSH Limits

Federal statute limits the amount of DSH payments to institutions for mental disease (IMDs) and other mental health facilities.[66] DSH payments to IMDs and other mental health facilities above the state-specific dollar limit are not eligible for federal matching funds.

Each state receives an IMD DSH limit that is the lesser of

- a state's FY1995 total IMD and other mental health facility DSH expenditures (i.e., including both state and federal spending) applicable to the state's FY1995 DSH allotment as reported on the Form CMS-64 as of January 1, 1997, or
- the amount equal to the product of the state's current year total DSH allotment and the applicable percentage, which is the lesser of 33% or the percent of FY1995 DSH expenditures that went to mental health facilities.

The IMD DSH limits fit within the state DSH allotments. In other words, when DSH payments to hospitals and IMDs and other mental health facilities are summed together, the total is required to be less than or equal to the state's DSH allotments in **Table 2**.

As with the DSH allotments, the IMD DSH limits are published in periodic *Federal Register* notices. In **Appendix B**, **Table B-1** includes each state's IMD DSH limit for FY2020 through FY2024.

DSH Expenditures

The implementation of the DSH allotments effectively controlled the significant growth of DSH expenditures from the early 1990s. As shown in **Figure 1**, total Medicaid DSH expenditures (i.e., including both federal and state expenditures) have remained relatively stable since the implementation of the federal DSH allotments in FY1993. In FY2022, DSH expenditures totaled $17.9 billion, and the federal share of those payments was $11.5 billion.[67]

[63] The data set would compile Medicare cost reports from the Healthcare Cost Report Information System, claims data from the Medicare Provider Analysis and Review files, and eligibility data from the Social Security Administration. (CMS, "Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule," 88 *Federal Register* 11865, February 24, 2023, https://www.federalregister.gov/documents/2023/02/24/2023-03673/medicaid-program-disproportionate-share-hospital-third-party-payer-rule.)

[64] For a state with a state plan rating year starting July 1st, the effective date for Section 203 would be July 1, 2022.

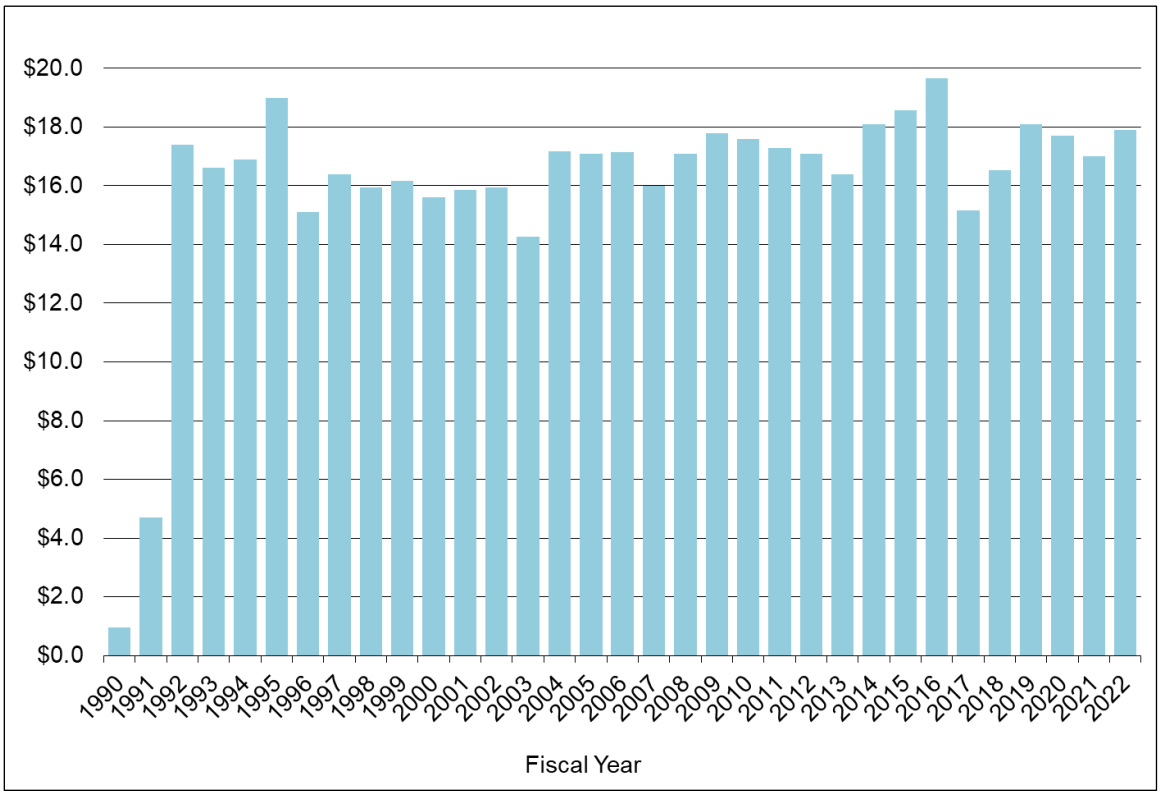
[65] Office of Management and Budget, "Disproportionate Share Hospital (DSH) Third Party Payer (CMS-2445)," *Unified Agenda*, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202304&RIN=0938-AV00.

[66] An *institution for mental diseases* is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services." (§1905(i) of the Social Security Act.) See also §1923(h) of the Social Security Act.

[67] Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System as of August 11, 2023.

Figure 1. Total Medicaid DSH Expenditures, FY1990-FY2022

($ in billions)



Sources: Payments estimated by the Urban Institute for FY1990-FY1992; data from CMS for FY1993-FY1996; CMS-64 data as reported by states to the Medicaid Budget and Expenditure System for FY1997-FY2022.

Notes: Total Medicaid DSH expenditures include both federal and state spending and payments to both hospitals and institutions for mental disease.

DSH expenditures are different from DSH allotments. DSH expenditures are the amounts paid to hospitals and mental health facilities, and DSH allotments reflect the maximum amount of federal DSH funding available to states.

The law establishing DSH allotments (i.e., Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. 102-234) specified a national DSH payment target equal to 12% of the total amount of Medicaid medical assistance spending (i.e., including federal and state expenditures and excluding expenditures for administrative activities) for all 50 states and the District of Columbia.[68] This is a target but not an absolute cap.

As mentioned earlier, the national DSH payment target is different from the state-specific 12% limit on state DSH allotments because the 12% national payment target restricts both federal and state spending while the 12% limit for allotments caps only federal spending. Under the national DSH payment target, aggregate DSH payments (including federal and state expenditures) should not be more than 12% of the total amount of Medicaid medical assistance expenditures for all 50 states and the District of Columbia. The federal statute limits state DSH allotments (i.e., the maximum amount of Medicaid DSH federal funds) to no more than 12% of each state's total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but

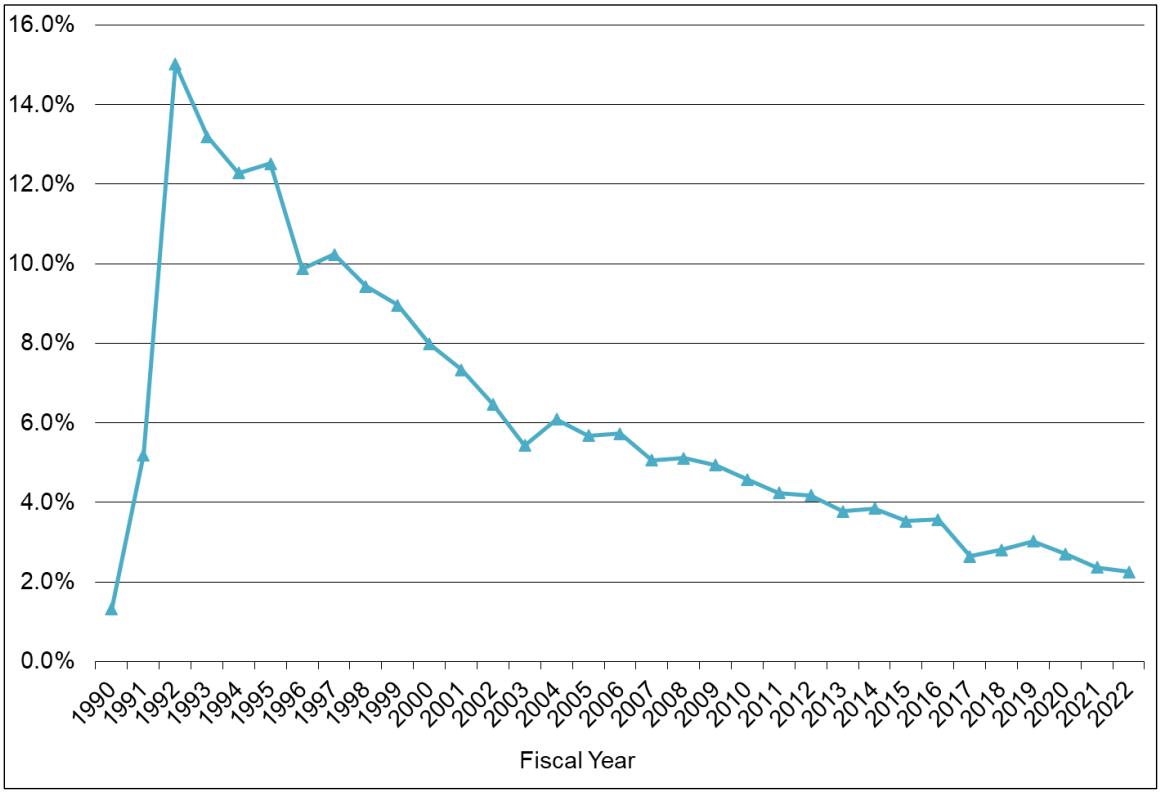
[68] 42 C.F.R. §447.297.

excluding administrative expenditures), which means the federal share of DSH expenditures cannot be more than 12% of each state's total Medicaid medical assistance expenditures.

This means if a state receives a federal DSH allotment equal to 12% of its total Medicaid medical assistance expenditures and the state uses all of its federal DSH allotment, then with the state matching funds, the state would provide DSH payments in excess of 12% of its total Medicaid medical assistance expenditures. As a result, it is possible that the national DSH target could be surpassed even if state DSH allotments are subject to the 12% limit. However, as shown in **Figure 2**, the implementation of DSH allotments effectively brought DSH payments under the 12% national target within a few years. DSH allotments were implemented in FY1993, and total DSH expenditures fell below 12% of total Medicaid medical assistance expenditures in FY1996. In FY2018, total DSH expenditures were 2.3% of the total Medicaid medical assistance expenditures.[69]

Figure 2. Total DSH Expenditures as a Percentage of Total Medicaid Medical Assistance Expenditures

(FY1990 to FY2022)



Sources: CRS calculation using DSH payment estimates from the Urban Institute for FY1990-FY1992; DSH payment data from Centers for Medicare & Medicaid Services (CMS) for FY1993-FY1996; DSH payment data for FY1997-FY2018 and medical assistance expenditure data for FY1990-FY2018 from Form CMS-64 data as reported by states to the Medicaid Budget and Expenditure System.

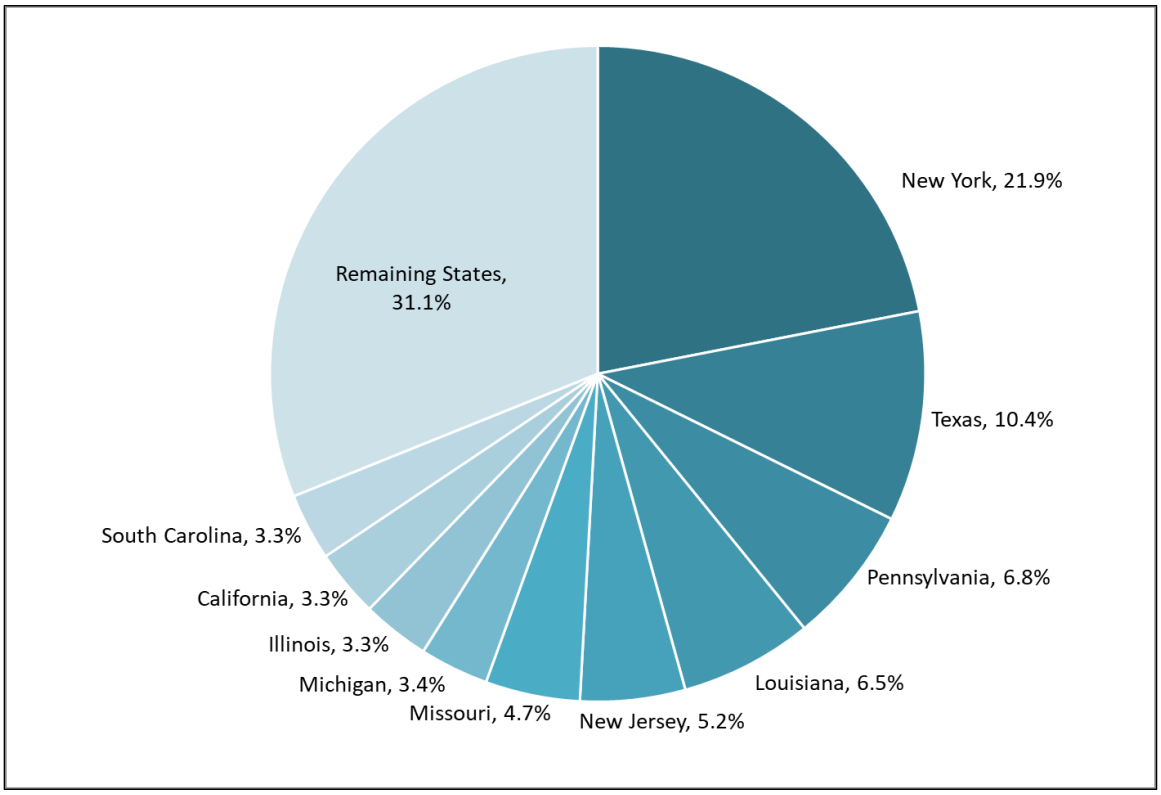
Notes: Total DSH expenditures and total Medicaid medical assistance expenditures (i.e., excluding expenditures for administrative activities) include both the federal and state expenditures.

[69] Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System as of August 11, 2023.

DSH expenditures are highly concentrated in a few states. As shown in **Figure 3**, 5 states (New York, Texas, Pennsylvania, Louisiana, and New Jersey) accounted for half of the FY2022 DSH expenditures, and 10 states accounted for 69% of all DSH expenditures. It makes sense that some of these states (New York, Texas, Pennsylvania, New Jersey, Michigan, Illinois, and California) accounted for a large portion of the total Medicaid DSH expenditures, because these states were among the top 10 highest spending states in terms of total medical assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities) for FY2022. By contrast, Louisiana, Missouri, and South Carolina ranked 17th, 22nd, and 29th (respectively) in terms of total medical assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities) for FY2022, but these states were among the top 10 highest spending states in terms of Medicaid DSH expenditures. This means Louisiana, Missouri, and South Carolina spent larger proportions of their Medicaid budgets on Medicaid DSH payments relative to most other states.

Figure 3. States' Share of Total Medicaid DSH Expenditures

(FY2022)



Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 data as reported by states to the Medicaid Budget and Expenditure System from FY2022.

Notes: The states included in the "remaining states" category had DSH expenditures that accounted for less than 3.3% of total DSH expenditures. In **Appendix C**, **Table C-1** shows state-by-state DSH spending.

State Variation

As mentioned previously, there is significant variation among the states in how each state DSH program is structured, and there is also variation from state to state with respect to DSH expenditures. Two distinct differences are (1) the percent of a state's total Medicaid medical

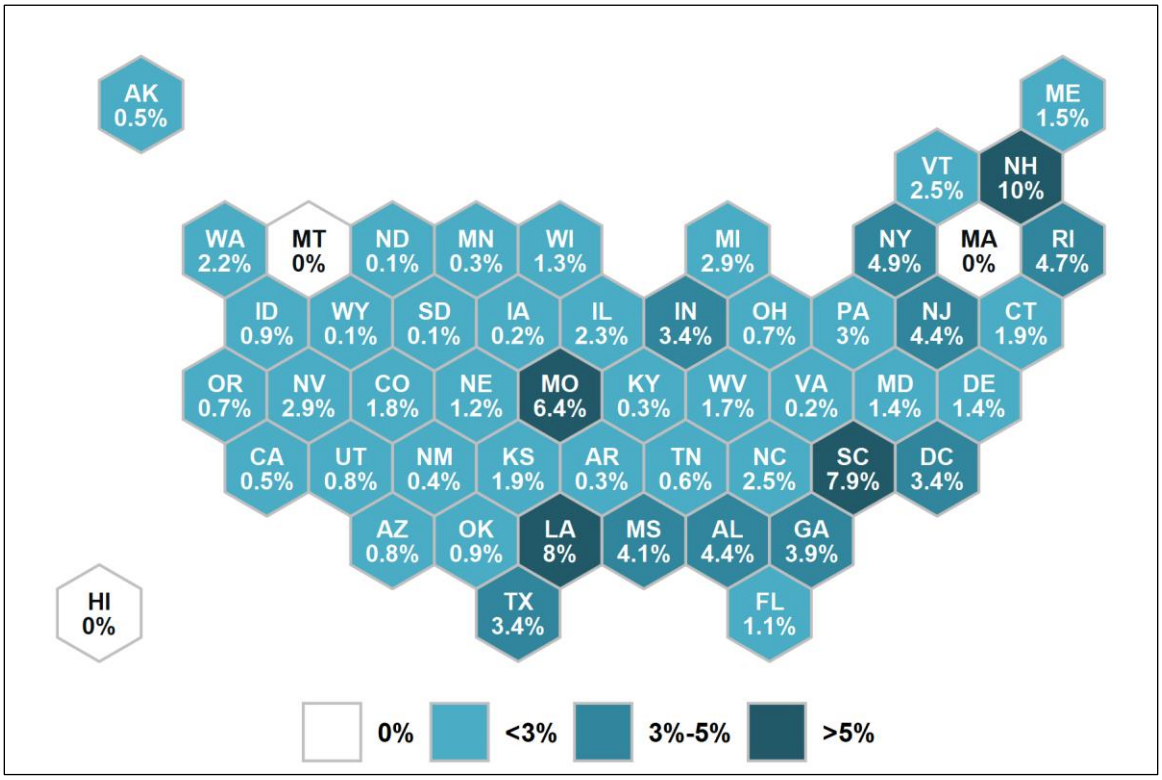
assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities) a state's DSH expenditures account for and (2) the proportion of DSH payments going to hospitals versus IMDs.

DSH as a Percentage of Total Medical Assistance Expenditures

Figure 4 shows FY2022 total DSH expenditures (i.e., including both federal and state expenditures) as a percentage of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities). DSH expenditures made in FY2018 ranged from 0.1% of total Medicaid medical assistance expenditures in North Dakota, South Dakota, and Wyoming to 10% in New Hampshire.

Figure 4. Total State DSH Expenditures as a Percentage of Total Medicaid Medical Assistance Expenditures

(FY2022)



Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 data as reported by states to the Medicaid Budget and Expenditure System for FY2022.

Notes: Total DSH expenditures and total Medicaid medical assistance expenditures (i.e., excluding expenditures for administrative activities) include both the federal and state share of expenditures. Hawaii and Montana did not have any Medicaid DSH expenditures in FY2022. Massachusetts does not have DSH expenditures because the state has a Section 1115 waiver allowing the state to use its DSH allotment to fund its uncompensated care pools. In **Appendix C**, **Table C-1** shows each state's total DSH expenditures and total Medicaid medical assistance expenditures for FY2022.

In FY2022, no states had DSH expenditures in excess of 12% of total Medicaid medical assistance expenditures,[70] which was the threshold used to determine *high* DSH states when DSH allotments were first implemented.[71] This is down from FY1993, when 21 states were considered high DSH states.

Hospital Versus IMD

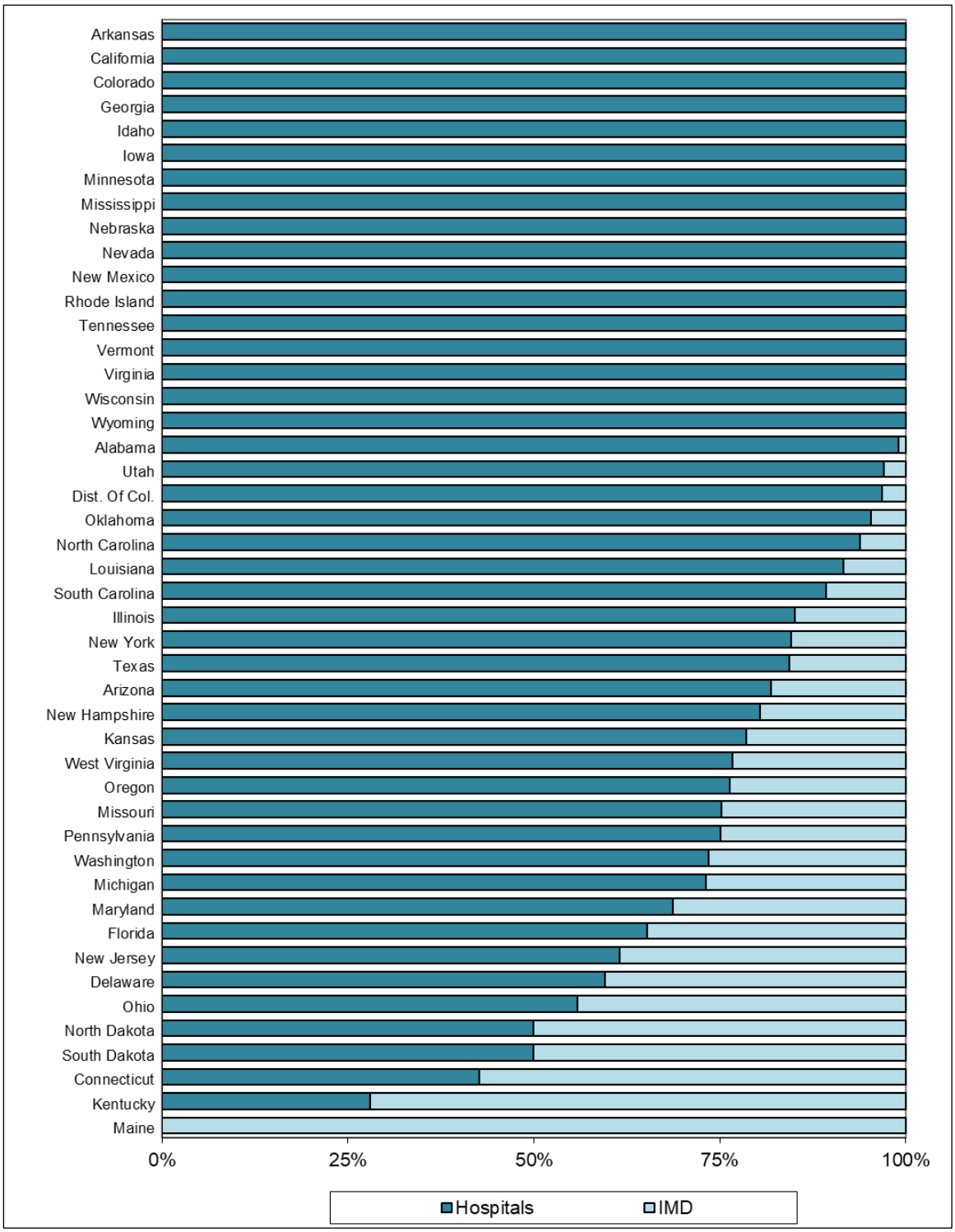
Nationally, 84% of DSH expenditures are allocated to hospitals, and the remaining 16% is distributed to IMDs and other mental health facilities. However, this distribution varies by state. As shown in **Figure 5**, in FY2022, most states targeted their DSH expenditures to hospitals, with 18 states allocating all of their DSH expenditures to hospitals.[72] Other states focused their DSH expenditures on IMDs and other mental health facilities. Maine made all of its DSH expenditures to IMDs and other mental health facilities.

[70] The 12% limit on DSH allotments caps the federal share of DSH expenditures to no more than 12% of a state's total Medicaid medical assistance expenditures. However, when the federal DSH allotment funds are matched with the state share of the Medicaid DSH payments, a state could provide DSH payments in excess of 12% of its total Medicaid medical assistance expenditures.

[71] When DSH allotments were first implemented, states with DSH expenditures greater than 12% of their total Medicaid medical assistance expenditures were classified as "high-DSH" states, and "high-DSH" states did not receive annual increases to their DSH allotment.

[72] The 18 states allocating all of their DSH expenditures to hospitals are Arkansas, California, Colorado, Georgia, Idaho, Indiana, Iowa, Minnesota, Mississippi, Nebraska, Nevada, New Mexico, Rhode Island, Tennessee, Vermont, Virginia, Wisconsin, and Wyoming.

Figure 5. Proportion of State DSH Expenditures Allocated to Hospitals and IMDs
(FY2022)



Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 data as reported by states to the Medicaid Budget and Expenditure System from FY2022.

Notes: IMD = Institutions for mental diseases and other mental health facilities.

Table C-1 shows each state's hospital and IMD DSH expenditures.

Hawaii and Montana did not have any Medicaid DSH expenditures in FY2022. Massachusetts does not have DSH expenditures because the state has a Section 1115 waiver allowing the state to use its DSH allotment to fund its uncompensated care pools.

Alaska and Indiana were excluded from this figure because both states had negative Medicaid DSH payments in FY2022 due to prior-year adjustments. Alaska had negative Medicaid DSH payments to hospitals, and Indiana has negative Medicaid DSH payments to IMDs and other mental health facilities.

State Reporting and Auditing Requirements

Since FY1993, each state has been required to provide quarterly reports with information about the aggregate DSH payments made to hospitals. Then, in 1997 and again in 2003, Congress enhanced the DSH reporting requirements in response to HHS Office of the Inspector General audits and Government Accountability Office reports detailing state violations in the DSH program.

The Balanced Budget Act of 1997 (BBA; P.L. 105-33) required states to provide an annual report to the Secretary of HHS describing the method used to target DSH funds and to calculate DSH payments. Then, in 2003, MMA mandated that beginning in state plan rate year (SPRY) 2005,[73] states were required to submit annual reports and independently certified audits.[74]

States' annual DSH reports must provide detailed information about each hospital receiving a DSH payment. For each hospital, the report must include the following information: the hospital-specific DSH limit, the Medicaid inpatient utilization rate, the low-income utilization rate, state-defined DSH qualification criteria, Medicaid basic payments, other supplemental payments, total Medicaid uncompensated care, total uninsured uncompensated care, federal Section 1011 payments,[75] and DSH payments.

The annual independent certified audits must verify that hospitals retain the DSH payment; DSH payments are made in accordance with the hospital-specific DSH limits; uncompensated care only includes inpatient and outpatient services; and the state separately documented and retains records of DSH payments (including the methodology for calculating each hospital's DSH payments).

The annual independent certified audits must be completed by the last day of the federal fiscal year ending three years from the end of the SPRY under audit. The annual DSH reports are due at the same time as the independent certified audits. If a state does not submit the independent certified audit by this deadline, the state could lose the federal DSH matching funds for the SPRYs subsequent to the date the audit is due.[76]

To ensure a period for developing and refining the reporting and auditing techniques, findings of state reports and audits for SPRY2005 to SPRY2010 were not to be given weight except to the

[73] Medicaid state plan rate year means the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding DSH payments as well as all other Medicaid payment rates. The period usually corresponds with the state's fiscal year or the federal fiscal year but can correspond to any 12-month period defined by the state as the Medicaid state plan rate year.

[74] §1923(j) of the Social Security Act.

[75] Under §1011 of MMA, hospitals, physicians, and ambulance service providers are eligible for §1011 payments for services furnished to the following types of patients: undocumented aliens; aliens who have been paroled into a United States port of entry for the purpose of receiving eligible services; and Mexican citizens permitted to enter the United States on a laser visa, issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act. (CMS, *Section 1011: Fact Sheet Federal Reimbursement of Emergency Health Services Furnished to Undocumented Alien.*)

[76] 42 C.F.R. 455.304(a).

extent that the findings draw into question the reasonableness of the state uncompensated care cost estimates used for calculations of prospective DSH payments. For SPRY2011 and after, audit findings demonstrating that DSH payments exceed the hospital-specific cost limit are regarded as discovery of overpayment to providers requiring the state to return the federal share of the overpayment to the federal government (unless the DSH payments are redistributed to other qualifying hospitals).[77]

Under the current reporting and independent audit requirements, CMS is not always able to identify when there has been a Medicaid DSH overpayment to a provider. The independent audit is able to report there is missing information that could have resulted in an overpayment without quantifying the amount of an overpayment. To determine the specific overpayment amount, CMS or the state has to do further review. As a result, CMS has proposed adding a new data element to the Medicaid DSH reporting requirements that provides a dollar estimate of any overpayments.[78]

Conclusion

Since DSH allotments were implemented in FY1993, nominal DSH payments have remained relatively stable. Total DSH expenditures have dropped as a percentage of total Medicaid medical assistance expenditures from 15.0% in FY1992 to 2.3% in FY2022.

All states (with the exception of Tennessee) receive a Medicaid DSH allotment based on the prior year's DSH allotment increased by the percentage change in CPI-U.

Since FY2020, the Medicaid DSH allotments have been recalculated to take into account the higher federal share of Medicaid DSH expenditures under the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase. FY2023 is the last year the Medicaid DSH allotment will be recalculated even though the FFCRA FMAP increase will be in effect for the first fiscal quarter of FY2024.

Medicaid DSH allotment reductions are slated to take effect on November 18, 2023, and continue through FY2027. If they take effect, DSH expenditures would likely continue to decline as a percentage of Medicaid medical assistance expenditures. The impact of these reductions will vary by state according to the uninsurance rate of each state, whether a state is a low DSH state, and how a state targets its DSH payments.

However, Congress could amend the Medicaid DSH reductions in the same way the reductions have been amended in the past, which includes eliminating the reductions for FY2014 through FY2022, changing the reduction amounts, and extending the application of the reductions through FY2027.[79]

In addition, there is uncertainty about which hospitals will meet 97th percentile exception for the change in how the Medicaid DSH hospital-specific limit is calculated. The final regulation specifying what data will be used to determine which hospitals are in the 97th percentile with respect to inpatient days made up by patients who were entitled to Medicare Part A benefits and Supplemental Security Income (SSI) benefit is not expected to be published until March 2024.

[77] HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments," 73 *Federal Register* 77904, December 19, 2008.

[78] CMS, "Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule," 88 *Federal Register* 11865, February 24, 2023, https://www.federalregister.gov/documents/2023/02/24/2023-03673/medicaid-program-disproportionate-share-hospital-third-party-payer-rule.

[79] For more information about the Medicaid DSH reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

Appendix A. A Chronology of State DSH Allotments Calculations

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) established ceilings on federal Medicaid DSH funding for each state. Since FY1993, each state has had its own DSH limit, which is referred to as *DSH allotments*. These allotments are calculated by the Centers for Medicare & Medicaid Services (CMS) and promulgated in the *Federal Register*. The methodology for calculating these allotments has changed a number of times over the years, and these different methodologies are described below.[80]

FY1993

The original state DSH allotments provided in FY1993 were based on each state's FY1992 DSH payments. This resulted in funding inequities because states that had been providing relatively more DSH payments to hospitals in FY1992 locked in higher Medicaid DSH allotments (and vice versa). As a result, the DSH allotment a state receives is not entirely based on the number of DSH hospitals in the state or the hospital services provided in DSH hospitals to low-income patients.

FY1994 to FY1997

The DSH allotments for FY1994 to FY1997 were based on each state's prior year DSH allotment. The annual growth for each state's DSH allotment depended on whether a state was classified as a "high-DSH" or "low-DSH" state. States with DSH expenditures greater than 12% of their total Medicaid medical assistance expenditures (i.e., federal and state Medicaid expenditures excluding expenditures for administrative activities) were classified as "high-DSH" states, and "high-DSH" states did not receive an increase to their DSH allotment. States with DSH expenditures less than 12% of their total Medicaid medical assistance expenditures were classified as "low-DSH" states, and the growth factor for the DSH allotment for "low-DSH" states was the projected percentage increase for each state's total Medicaid expenditures (i.e., including federal and state spending) for the current year. However, "low-DSH" states' DSH allotments could not exceed 12% of each state's total medical assistance expenditures.[81]

FY1998 to FY2000

Provisions included in the Balanced Budget Act of 1997 (BBA; P.L. 105-33) reduced Medicaid DSH expenditures by replacing the state DSH allotment calculations with *fixed* state DSH allotments specified in statute for FY1998 through FY2002.[82] The aggregate fixed allotments for FY1998 totaled $10.3 billion, which was a 50% decrease from the aggregate FY1997 DSH allotments. The aggregate allotments for FY1999 and FY2000 decreased to $10.0 billion and $9.3 billion respectively.

Adjustments for Specific States

A number of legislative adjustments were made to the BBA fixed DSH allotments. The Departments of Labor, Health and Human Services, and Education, and Related Agencies

[80] Tennessee and Hawaii have had special statutory arrangements for their federal DSH funding since FY2007.

[81] The definition of "low-DSH" state has changed over the years.

[82] §1923(f)(2) of the Social Security Act.

Appropriations Act, 1998 (P.L. 105-78) increased the FY1998 DSH allotments for Minnesota and Wyoming. The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105-277) increased the FY1999 DSH allotments for Minnesota, New Mexico, and Wyoming. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (included in the Consolidated Appropriations Act, 2000, P.L. 106-113) increased the FY2000, FY2001, and FY2002 DSH allotments for the District of Columbia, Minnesota, New Mexico, and Wyoming.

FY2001 and FY2002

The fixed state allotments were supposed to last through FY2002 with the aggregate DSH allotments slated to decrease in FY2001 and again in FY2002. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, which was incorporated into the Consolidated Appropriations Act, 2001, P.L. 106-554) eliminated the DSH reductions for FY2001 and FY2002 and provided states with increases to their DSH allotments. Specifically, the DSH allotments for those two years were determined by increasing each state's prior year DSH allotment by the percent change in the Consumer Price Index for all Urban Consumers (CPI-U) for the prior fiscal year. These state DSH allotments could not exceed 12% of a state's total medical assistance expenditures for the allotment year. This is referred to as the 12% rule.[83]

Extremely Low DSH States

BIPA also established a special rule for DSH allotments for "extremely low DSH states," which were defined as states with FY1999 DSH expenditures greater than 0% and less than 1% of total Medicaid medical assistance expenditures (i.e., federal and state Medicaid expenditures excluding expenditures for administrative activities).[84] The FY2001 DSH allotments for extremely low DSH states were increased to 1% of each state's FY2001 total medical assistance expenditures. Then, the FY2002 DSH allotments for extremely low DSH states were each state's FY2001 DSH allotment increased by the percentage change in CPI-U for FY2001, subject to the 12% rule.[85]

FY2003

For non-extremely low DSH states, FY2003 DSH allotments were each state's FY2002 fixed DSH allotment determined in BBA (i.e., not states' actual DSH allotment for FY2002 as provided by BIPA) increased by the percent change in CPI-U for FY2002, subject to the 12% rule. For most states, the FY2002 state DSH allotments provided by BBA were less than the actual state allotments states received in FY2002. As a result, in general, FY2003 DSH allotments were lower than the allotments states received in FY2002.[86] This was not the case for extremely low DSH states, which received FY2003 DSH allotments based on their actual FY2002 DSH allotment increased by percentage change in CPI-U for FY2002.[87]

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[83] HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments," 69 *Federal Register* 15850, March 26, 2004.

[84] Ten states were classified as extremely low DSH states for FY2001 and FY2002: Arkansas, Idaho, Iowa, Montana, Nebraska, North Dakota, South Dakota, Utah, Virginia, and Wisconsin.

[85] HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments," 69 *Federal Register* 15850, March 26, 2004.

[86] This is referred to as the "DSH dip."

[87] HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments," 69 *Federal Register* 15850, March 26, 2004.

FY2004

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) addressed the drop in DSH allotments for many states from FY2002 to FY2003 by exempting FY2002 DSH allotment amounts from the 12% rule and providing a 16% increase in DSH allotments for FY2004.

Low DSH States

MMA also discontinued the special arrangement for extremely low DSH states and instead established low DSH states—defined as those states in which total DSH payments for FY2000 were less than 3% of the state's total Medicaid medical assistance expenditures. For such states, FY2004 DSH allotments were each state's FY2003 DSH allotment increased by 16%.

After FY2004

State DSH allotments for years after FY2004 are set to be equal to each state's FY2004 DSH allotment, unless a state's allotment as determined by the calculation in place prior to MMA would equal or exceed the FY2004 allotment for that state. For any years in which a state's DSH allotments would be higher under the pre-MMA calculation, that state's DSH allotment will be equal to its DSH allotment from the prior fiscal year increased by the percentage change in the CPI-U for the prior fiscal year, subject to the 12% rule.[88]

Low DSH States

By statute, the definition of low DSH state is a state with FY2000 DSH expenditures greater than 0% but less than 3% of total Medicaid medical assistance expenditures for FY2000. So states determined to be low DSH states in FY2004 continue to be low DSH states regardless of the states' DSH expenditures in years after FY2000.

For FY2004 through FY2008, low DSH states received DSH allotments in each year equal to each state's prior year DSH allotment increased by 16%, subject to the 12% rule. For FY2009 forward, the allotment for low DSH states is equal to the prior year allotment amount increased by the percentage change in the CPI-U (subject to the 12% rule), which is the same DSH increase provided to non-low DSH states.

District of Columbia

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) increased the fixed DSH allotments for the District of Columbia for FY2000, FY2001, and FY2002 from $32 million to $49 million. This change was effective as of October 1, 2005. Increasing the District of Columbia's DSH allotments for FY2000 to FY2002 was done for the purposes of determining the District of Columbia's FY2006 DSH allotment. This change made the District of Columbia's DSH allotment for FY2006 $57.7 million, which was a $20.0 million increase over what the District of Columbia would have gotten without the change. The provision took effect on October 1, 2005, and applies to FY2006 and subsequent fiscal years.

[88] Ibid.

Hawaii and Tennessee

Tennessee and Hawaii operate their state Medicaid programs under Section 1115 research and demonstration waivers,[89] which allow the Secretary of Health and Human Services to waive various provisions of Medicaid law. Both states received waivers from making Medicaid DSH payments (among other things), and these states did not receive DSH allotments from FY1998 to FY2006.

Since FY2007, the Medicaid DSH allotments for Hawaii and Tennessee have been set by special statutory authority provided through multiple laws: the Tax Relief and Health Care Act of 2006 (P.L. 109-432); the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173); the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275); the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3); the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended); and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).

Hawaii

Hawaii's DSH allotment was set at $10 million for each of FY2007 through FY2011. Under the ACA, Hawaii's FY2012 DSH allotment was also set at $10.0 million, but the allotment was split into two periods. For the first quarter of FY2012 (i.e., October 1, 2011, to December 31, 2011), Hawaii's DSH allotment was $2.5 million. Then, for the remaining three quarters of FY2012, Hawaii's DSH allotment was $7.5 million. For FY2013 and subsequent years, Hawaii's annual DSH allotment increases in the same manner applicable to low DSH states.

Tennessee

The federal statute specified that Tennessee's DSH allotment for each year from FY2007 to FY2011 was the greater of $280.0 million or the federal share of the DSH payments reflected in TennCare for the demonstration year ending in 2006.[90] In accordance with this provision, Tennessee's DSH allotment was $305.4 million (i.e., the federal share of the DSH payments reflected in TennCare for the demonstration year ending in 2006) from FY2007 to FY2011. The statute further limited the amount of federal funds available to Tennessee for DSH payments to 30% of Tennessee's DSH allotment. Under this limit, the federal DSH funding available to Tennessee for each year from FY2007 to FY2011 was $91.6 million (i.e., 30% of $305.4 million).

For the first quarter of FY2012 (i.e., October 1, 2011, through December 31, 2011), Tennessee's DSH allotment was $76.4 million and was subject to the 30% limit.[91] For the last three fiscal quarters of FY2012, Tennessee received a DSH allotment of $47.2 million that was *not* subject to the 30% limit. In total, Tennessee had access to $70.1 million in federal DSH funding in FY2012.[92]

In FY2013, Tennessee had a DSH allotment of $53.1 million that was *not* subject to the 30% limit. After FY2013, the statute did not provide a federal DSH allotment to Tennessee, and Tennessee did not receive a Medicaid DSH allotment in FY2014. Then, MACRA provided a

[89] §1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.

[90] TennCare is the name of Tennessee's Medicaid program, which operates under a Section 1115 waiver.

[91] This amount is one-fourth of $305,451,928, which was the DSH allotment for Tennessee for each year from FY2007 to FY2011.

[92] $70,108,895 = $22,908,895 (i.e., 30% of $76,362,982) + $47,200,000.

Medicaid DSH allotment to Tennessee in the amount of $53.1 million for each fiscal year from FY2015 through FY2025.

FY2009 and FY2010

The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) temporarily increased states' DSH allotments for FY2009 and FY2010.[93] Specifically, ARRA provided states with a FY2009 DSH allotment that was 102.5% of the FY2009 allotment states would have received without ARRA. Then, states' FY2010 DSH allotments were 102.5% of each state's FY2009 DSH allotment as determined under ARRA. For both years, the ARRA DSH provisions were not applied to the DSH allotments for states that would have had a higher DSH allotment as determined without application of the ARRA DSH provisions. After FY2010, states' annual DSH allotments returned to being determined as they were prior to the enactment of ARRA.[94]

FY2020 through FY2024

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) temporarily increased states' Medicaid DSH allotments during the Coronavirus Disease 2019 (COVID-19) public health emergency period to take into account the higher federal share of Medicaid DSH expenditures under the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase.[95] Specifically, the HHS Secretary is required to recalculate states' DSH allotments to ensure that the total Medicaid DSH payments (including federal and state expenditures) a state can make in a fiscal year are equal to the Medicaid DSH payments a state could have made without the application of the FFCRA FMAP increase.[96]

The recalculation of Medicaid DSH allotments does not apply for the first fiscal year beginning after the end of the COVID-19 public health emergency period or any succeeding fiscal year.[97] The COVID-19 public health emergency period ended May 11, 2023.[98] FY2024 is the first fiscal year beginning after the end of the COVID-19 public health emergency period, so the Medicaid DSH allotments will not be recalculated for FY2024 even though the FFCRA FMAP increase will

[93] The ARRA increase to DSH allotments did not apply to the allotments for Hawaii and Tennessee.

[94] §5001(e) of ARRA specifies that the ARRA temporary increase to the FMAP does not apply to DSH payments.

[95] During the COVID-19 public health emergency period, the FFCRA provides a 6.2-percentage-point increase to the regular FMAP rates for all states, the District of Columbia, and the territories that meet certain conditions. The FFCRA FMAP increase began on January 1, 2020, and the FFCRA FMAP increase is set to phase out from April 1, 2023, through December 31, 2023. The FFCRA increase is 5 percentage points from April 1, 2023, through June 30, 2023; 2.5 percentage points from July 1, 2023, through September 30, 2023; and 1.5 percentage points from October 1, 2023, through December 31, 2023. (FFCRA Section 6008 (42 U.S.C. §1396d note)).

[96] In recalculating the Medicaid DSH allotments for FY2020 and FY2023, CMS used the 6.2 percentage point FFCRA FMAP increase rather than a prorated FMAP rate for the FY2020 and FY2023 calculations, even though the 6.2 percentage point increase was not in effect for the full fiscal years in FY2020 and FY2023. This was done to ensure this provision applies to all States consistent with the statutory requirement, since states make Medicaid DSH payments at different times of the fiscal year. (HHS, CMS, "Medicaid Program; Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Disproportionate Share Hospital Allotments, and Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 88 *Federal Register* 23049, April 14, 2023.)

[97] The Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328) delinked the FFCRA FMAP increase from the COVID-19 public health emergency period and made December 31, 2023 the end date of the FFCRA FMAP increase. However, the CAA 2023 did not amend the end date of the requirement of for the Medicaid DSH allotment to be recalculated to correspond with the new end date of the FFCRA FMAP increase.

[98] Department of Health and Human Services, "COVID-19 Public Health Emergency (PHE)," https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html.

be in effect for the first fiscal quarter of FY2024 (i.e., October 1, 2023 through December 31, 2023).

Appendix B. IMD DSH Limits

Under Sections 1923(h) of the Social Security Act, states cannot receive Medicaid federal matching funds for DSH payments to IMDs and other mental health facilities that are in excess of state-specific aggregate limits. The aggregate limit for each state is the lesser of a state's FY1995 DSH expenditures to IMDs and other mental health facilities or the amount equal to the product of a state's current year DSH allotment and the applicable percentage (i.e., the percentage of FY1995 DSH expenditures paid to IMDs and other mental health facilities with a maximum of 33%). **Table B-1** shows states' final IMD DSH limits for FY2020 and FY2021 and preliminary limits for FY2022 and FY2023.

Table B-1. States' IMD DSH Limits

(FY2020 through FY2023)

State	FY2020 Final	FY2021 Final	FY2022 Preliminary	FY2023 Preliminary
Alabama	$3,479,949	$3,507,104	$3,497,756	$3,500,427
Alaska	8,835,414	8,967,945	9,263,888	9,897,812
Arizona	21,703,569	21,700,721	21,700,721	21,572,584
Arkansas	635,980	634,423	637,619	635,079
California	874,426	874,426	874,426	874,426
Colorado	334,264	334,264	334,264	334,264
Connecticut	59,332,433	59,332,433	59,332,433	59,332,433
Delaware	3,868,001	3,926,810	4,056,531	4,359,254
District of Columbia	4,987,394	4,987,394	4,987,394	4,987,394
Florida	84,964,809	86,176,795	89,144,023	96,063,328
Georgia	0	0	0	0
Hawaii	0	0	0	0
Idaho	0	0	0	0
Illinois	50,372,623	51,105,771	51,222,001	50,247,451
Indiana	90,253,932	91,608,939	94,574,291	101,846,761
Iowa	0	0	0	0
Kansas	17,586,684	17,835,730	18,410,475	19,822,059
Kentucky	29,213,086	29,299,205	29,561,306	29,344,136
Louisiana	96,132,286	97,505,493	98,651,108	97,667,521
Maine	42,670,839	42,603,785	42,792,756	42,359,952
Maryland	33,073,663	33,569,767	34,677,570	37,313,065
Massachusetts	59,366,900	59,366,900	59,366,900	59,366,900
Michigan	112,161,346	113,840,630	117,375,563	126,426,094
Minnesota	2,954,554	2,954,554	2,981,366	2,996,086
Mississippi	0	0	0	0
Missouri	148,898,073	147,468,154	150,369,439	149,229,648

State	FY2020 Final	FY2021 Final	FY2022 Preliminary	FY2023 Preliminary
Montana	0	0	0	0
Nebraska	1,103,467	1,135,165	1,159,256	1,160,524
Nevada	0	0	0	0
New Hampshire	53,251,719	53,251,719	53,251,719	53,251,719
New Jersey	200,842,199	200,842,199	200,842,199	200,842,199
New Mexico	201,052	202,963	203,599	202,453
New York	340,010,000	340,010,000	340,010,000	340,010,000
North Carolina	124,370,665	126,177,553	130,300,836	140,193,269
North Dakota	556,019	579,248	591,011	570,846
Ohio	64,674,155	65,244,095	65,683,229	65,197,379
Oklahoma	2,363,940	2,428,423	2,438,897	2,407,801
Oregon	13,469,205	13,391,302	13,267,456	13,287,431
Pennsylvania	242,287,327	245,946,624	253,817,100	273,483,264
Rhode Island	1,418,318	1,445,654	1,464,596	1,442,536
South Carolina	55,426,706	55,376,253	55,462,744	55,340,215
South Dakota	479,479	484,438	487,518	472,868
Tennessee	0	0	0	0
Texas	196,247,369	198,938,494	195,984,107	193,263,730
Utah	695,239	688,977	682,528	673,837
Vermont	5,448,221	5,512,627	5,684,982	5,626,018
Virginia	4,366,891	4,366,891	4,366,891	4,417,397
Washington	80,244,295	81,447,959	84,135,742	90,530,058
West Virginia	15,324,948	15,334,392	15,275,842	15,151,187
Wisconsin	2,944,962	2,945,412	2,968,321	978,203
Wyoming	0	0	0	0
Total	**$2,277,426,401**	**$2,293,351,631**	**$2,321,890,403**	**$2,376,679,608**

Source: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), "Medicaid Program; Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Disproportionate Share Hospital Allotments, and Final FY 2020, Final FY 2021, Preliminary FY 2022, and Preliminary FY 2023 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 88 *Federal Register* 23049, April 14, 2023.

Notes: DSH = Disproportionate Share Hospital. IMD = Institutions for mental diseases.

Appendix C. State-by-State DSH Expenditures

There is significant variation from state to state with respect to DSH expenditures. Two distinct differences are (1) the proportion of DSH payments going to hospitals and IMDs and (2) total DSH payments as a percent of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities).

Nationally, 84% of Medicaid DSH expenditures were allocated to hospitals in FY2022, and the remaining 16% was distributed to IMDs and other mental health facilities. This distribution varies by state. As shown in **Table C-1**, in FY2022, most states targeted their DSH expenditures to hospitals, with 18 states allocating all of their DSH expenditures to hospitals. However, some states focused their DSH expenditures on IMDs and other mental health facilities. Two states (Alaska and Maine) used all of their DSH expenditures for IMDs and other mental health facilities.

Table C-1 also shows FY2022 total DSH expenditures (i.e., including both federal and state expenditures) as a percentage of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities). DSH expenditures made in FY2020 ranged from 0.1% of total Medicaid medical assistance expenditures in North Dakota, South Dakota, and Wyoming to 10% in New Hampshire.

Table C-1. DSH Expenditures by Type and DSH Expenditures as a Percentage of Medical Assistance Expenditures, FY2022

($ in millions)

State	DSH Expenditures			Total Medical Assistance	DSH Payments as a Percentage of Medical Assistance Expenditures
	Hospital	IMD	Total		
Alabama	$308.8	$3.2	$312.0	$7,166.5	4.4%
Alaska[a]	-$0.5	$11.5	11.0	$2,435.5	0.5%
Arizona	$127.2	$28.5	155.6	$20,257.9	0.8%
Arkansas	$26.6	$0.0	26.6	$8,533.1	0.3%
California	$595.7	$0.1	595.8	$117,884.6	0.5%
Colorado	$210.1	$0.0	210.1	$11,873.7	1.8%
Connecticut[a]	$79.1	$105.6	184.7	$9,671.7	1.9%
Delaware	$25.3	$17.3	42.7	$3,136.9	1.4%
District of Columbia	$121.4	$3.8	125.2	$3,647.7	3.4%
Florida	$239.8	$128.2	368.0	$32,667.5	1.1%
Georgia	$564.2	$0.0	564.2	$14,339.6	3.9%
Hawaii	$0.0	$0.0	0.0	$2,990.0	0.0%
Idaho	$27.8	$0.0	27.8	$3,195.3	0.9%
Illinois	$507.9	$89.4	597.3	$25,956.0	2.3%
Indiana[b]	$619.4	-$41.2	578.1	$16,850.9	3.4%
Iowa	$10.0	$0.0	10.0	$6,614.1	0.2%

State	DSH Expenditures			Total Medical Assistance	DSH Payments as a Percentage of Medical Assistance Expenditures
	Hospital	IMD	Total		
Kansas	$65.5	$18.1	83.6	$4,301.3	1.9%
Kentucky	$13.6	$35.6	49.2	$14,590.5	0.3%
Louisiana	$1,074.4	$97.8	1,172.2	$14,674.0	8.0%
Maine	$0.0	$58.5	58.5	$3,785.8	1.5%
Maryland	$136.2	$61.6	197.8	$14,343.5	1.4%
Massachusetts[c]	$0.0	$0.0	0.0	$20,864.8	0.0%
Michigan	$445.2	$163.4	608.6	$21,023.3	2.9%
Minnesota	$49.9	$0.4	50.3	$16,158.8	0.3%
Mississippi	$245.7	$0.0	245.7	$5,943.7	4.1%
Missouri	$628.0	$207.2	835.2	$13,013.1	6.4%
Montana[b]	$0.0	$0.0	0.0	$2,343.6	0.1%
Nebraska	$39.9	$0.0	39.9	$3,295.9	1.2%
Nevada	$144.9	$0.0	144.9	$5,052.7	2.9%
New Hampshire	$197.1	$48.4	245.5	$2,460.9	10.0%
New Jersey	$570.8	$357.4	928.2	$20,872.6	4.4%
New Mexico	$33.6	$0.0	33.6	$8,258.0	0.4%
New York	$3,321.2	$605.0	3,926.2	$80,518.4	4.9%
North Carolina	$434.4	$27.5	462.0	$18,403.7	2.5%
North Dakota	$0.5	$1.2	1.8	$1,524.1	0.1%
Ohio	$117.6	$93.4	211.0	$30,024.8	0.7%
Oklahoma	$61.7	$3.3	64.9	$7,523.2	0.9%
Oregon	$68.2	$21.1	89.3	$13,083.2	0.7%
Pennsylvania	$919.6	$304.6	1,224.2	$41,178.3	3.0%
Rhode Island	$160.0	$0.0	160.0	$3,392.6	4.7%
South Carolina	$529.7	$62.5	592.2	$7,544.3	7.9%
South Dakota	$0.9	$0.8	1.7	$1,246.3	0.1%
Tennessee	$71.9	$0.0	71.9	$11,264.6	0.6%
Texas	$1,565.9	$289.2	1,855.1	$54,941.9	3.4%
Utah	$33.7	$0.9	34.7	$4,211.5	0.8%
Vermont	$46.4	$0.0	46.4	$1,884.4	2.5%
Virginia	$42.3	$0.0	42.3	$17,823.7	0.2%
Washington	$277.0	$100.1	377.1	$17,140.7	2.2%
West Virginia	$69.0	$21.2	90.2	$5,183.9	1.7%
Wisconsin	$143.1	$0.0	143.1	$11,429.1	1.3%

Wyoming	$0.5	$0.0	0.5	$668.4	0.1%
Total	**$14,971.3**	**$2,925.7**	**$17,897.0**	**$787,190.5**	**2.3%**

Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 Data as reported by states to the Medicaid Budget and Expenditure System for FY2022.

Notes: Medicaid medical assistance expenditures exclude administrative expenditures.

DSH = Disproportionate share hospital. IMD = Institutions for mental diseases.

a. Alaska and Indiana had negative expenditures due to prior period adjustments.

b. Hawaii and Montana did not have any Medicaid DSH expenditures in FY2022.

c. Massachusetts does not have DSH expenditures because the state has a Section 1115 waiver allowing it to use its DSH allotment to fund its uncompensated care pools.

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