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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 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 FY2015, federal DSH allotments totaled \$11.9 billion.

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 ACA, five laws have amended the DSH reductions. Under current law, the Medicaid DSH reductions are to be in effect for FY2018 through FY2025.

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 for institutions for mental disease and other mental health facilities.

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% to 4%.

This report provides an overview of Medicaid DSH. It includes a description of the rules delineating how state DSH allotments are calculated and the exceptions to the rules, how DSH hospitals are defined, and how DSH payments are calculated. The DSH expenditures section shows the trends in DSH spending and explains variation in states' DSH expenditures. Finally, the basic requirements for state DSH reports and independently certified audits are also outlined.

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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. However, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) included the ACA Medicaid expansion, which expands Medicaid eligibility to individuals under the age of 65 with income up to 133% of the federal poverty level (FPL; effectively 138% of FPL) at state option.

Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and territories² choose to participate. In order 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 FY2016, FMAP rates range from 50% (13 states) to 74% (Mississippi).

The Medicaid statute requires that states make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients.⁵ This provision is intended to recognize the disadvantaged financial situation of such hospitals because low-income patients are more likely 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 FY2015, the federal DSH allotments to states totaled \$11.9 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'

¹ For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

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*, by Alison Mitchell.

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

⁵ The Medicare program also makes 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.

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.⁶ 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.⁷ 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.”⁸ 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.⁹ 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.

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 amendment¹⁰ describing their DSH policies and establishing certain minimum qualifying standards and payments.

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),

⁶ The DSH provision was included in a package of provisions referred to as the “Boren amendment” after its sponsor, Senator David Boren from Oklahoma.

⁷ The Secretary of the Department of Health and Human Services (HHS) 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.

⁸ §1902(a)(13)(A)(iv) of the Social Security Act.

⁹ Conf. Rept. 97-208.

¹⁰ 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.

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)	Percent 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.¹¹ 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 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.¹² Since FY1993, each state has had its own DSH limit, which is referred to as a “DSH allotment.”

¹¹ 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 borrowing funds from Medicaid providers in order 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*, by Alison Mitchell.

¹² 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.

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 state¹³ receives an annual DSH allotment, which is the maximum amount of federal matching funds a state is permitted to claim for Medicaid DSH payments.¹⁴

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 based on the number of DSH hospitals in a state or the amount of hospital services these hospitals provide to low-income patients. 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.

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 allotment¹⁵ 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. Louisiana had been the only state that continued to receive its FY2004 DSH allotment; however, FY2015 was the first year for which Louisiana will receive a Medicaid DSH allotment based on the prior year's DSH allotment increased by the percentage change in CPI-U.¹⁶

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.¹⁷ This rule is referred to as the "12% limit."¹⁸ This means the federal share of DSH expenditures cannot be more than 12% of each state's total Medicaid medical assistance expenditures.

¹³ State is defined as the 50 states and the District of Columbia. DSH allotments are not provided for the five territories (i.e., American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the Virgin Islands). (§1923(f)(9) of the Social Security Act).

¹⁴ Each state's regular FMAP rate is used to determine the federal share of DSH payments.

¹⁵ 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.

¹⁶ HHS, "Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 81 *Federal Register* 5448, February 2, 2016.

¹⁷ §1923(f)(3)(B) of the Social Security Act.

¹⁸ 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.

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.¹⁹ This national limit is not an absolute cap but a target.²⁰ The national DSH payment limit is different from the 12% limit on state DSH allotments because the 12% national payment limit restricts both federal and state spending while the 12% limit for allotments caps only federal spending.

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 FY2013 and preliminary DSH allotments for FY2015.²¹ The federal DSH allotments for FY2012 through FY2015 are shown in **Table 2**.

Table 2. DSH Allotments for FY2012 Through FY2015

(\$ in millions)

State	FY2012	FY2013	FY2014	FY2015
	DSH Allotment	DSH Allotment	Preliminary DSH Allotment	Preliminary DSH Allotment
Alabama	\$315.5	\$323.1	\$327.9	\$333.2
Alaska ^a	20.9	21.4	21.7	22.1
Arizona	103.9	106.4	108.0	109.7
Arkansas ^a	44.3	45.3	46.0	46.7
California	1,124.8	1,151.8	1,169.1	1,187.8
Colorado	94.9	97.2	98.6	100.2
Connecticut	205.2	210.1	213.3	216.7
Delaware ^a	9.3	9.5	9.7	9.8
District of Columbia	62.8	64.4	65.3	66.4
Florida	205.2	210.1	213.3	216.7
Georgia	275.8	282.4	286.6	291.2
Hawaii ^b	10.0	10.2	10.4	10.6
Idaho ^a	16.9	17.3	17.5	17.8

¹⁹ 42 C.F.R. §447.297.

²⁰ 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 FY2015, DSH payments were well below the national DSH target with total DSH payments (i.e., including federal and state expenditures) amounting to 3.5% of total Medicaid medical assistance expenditures (i.e., including federal and state expenditures but excluding administrative services).

²¹ HHS, "Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits," 81 *Federal Register* 5448, February 2, 2016.

State	FY2012	FY2013	FY2014	FY2015
	DSH Allotment	DSH Allotment	Preliminary DSH Allotment	Preliminary DSH Allotment
Illinois	220.6	225.9	229.3	233.0
Indiana	219.3	224.6	228.0	231.6
Iowa ^a	40.4	41.4	42.0	42.7
Kansas	42.3	43.3	44.0	44.7
Kentucky	148.8	152.4	154.6	157.1
Louisiana	732.0	732.0	732.0	743.7
Maine	107.7	110.3	112.0	113.8
Maryland	78.2	80.1	81.3	82.6
Massachusetts	313.0	320.5	325.3	330.5
Michigan	271.9	278.4	282.6	287.1
Minnesota ^a	76.6	78.5	79.7	80.9
Mississippi	156.5	160.2	162.6	165.2
Missouri	486.1	497.8	505.2	513.3
Montana ^a	11.6	11.9	12.1	12.3
Nebraska ^a	29.0	29.7	30.2	30.7
Nevada	47.5	48.6	49.3	50.1
New Hampshire	164.3	168.2	170.7	173.5
New Jersey	660.5	676.4	686.5	697.5
New Mexico ^a	20.9	21.4	21.7	22.1
New York	1,648.1	1,687.7	1,713.0	1,740.4
North Carolina	302.7	310.0	314.6	319.6
North Dakota ^a	9.8	10.0	10.2	10.3
Ohio	416.8	426.9	433.3	440.2
Oklahoma ^a	37.2	38.0	38.6	39.2
Oregon ^a	46.4	47.6	48.3	49.0
Pennsylvania	575.9	589.7	598.6	608.1
Rhode Island	66.7	68.3	69.3	70.4
South Carolina	336.0	344.1	349.3	354.9
South Dakota ^a	11.3	11.6	11.8	12.0
Tennessee ^c	123.6	53.1	0.0	53.1
Texas	981.2	1,004.7	1,019.8	1,036.1
Utah ^a	20.1	20.6	20.9	21.3
Vermont	23.1	23.6	24.0	24.4
Virginia	89.9	92.1	93.4	94.9
Washington	189.8	194.4	197.3	200.5

State	FY2012	FY2013	FY2014	FY2015
	DSH Allotment	DSH Allotment	Preliminary DSH Allotment	Preliminary DSH Allotment
West Virginia	69.3	70.9	72.0	73.1
Wisconsin ^a	97.0	99.3	100.8	102.4
Wyoming ^a	0.2	0.2	0.2	0.2
Total (in billions of dollars)	\$11,362.1	\$11,543.8	\$11,652.0	\$11,891.6

Sources: Department of Health and Human Services (HHS), “Medicaid Program: Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FY2012, and Preliminary FY2013 Disproportionate Share Hospital Allotments and Limits,” 78 *Federal Register* 45217, July 26, 2013; HHS, “Medicaid Program; Preliminary Disproportionate Share Hospital Allotments (DSH) for Fiscal Year (FY) 2014 and the Preliminary Institutions for Mental Disease Disproportionate Share Hospital Limits for FY 2014,” 79 *Federal Register* 11436, February 28, 2014; HHS, “Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits,” 81 *Federal Register* 5448, February 2, 2016.

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.

- 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.
- 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.
- Tennessee has a special statutory arrangement that specifies the DSH allotment for the state. The statute limited Tennessee’s Medicaid DSH payments to \$91.6 million in FY2011, \$70.1 million in FY2012, and \$53.1 million in FY2013. After FY2013, the statute did not provide a federal DSH allotment to Tennessee until the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) provided a Medicaid DSH allotment to Tennessee in the amount of \$53.1 million for each fiscal year from FY2015 through FY2025.

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. Also, Hawaii and Tennessee have special statutory arrangements for the determination of their respective DSH allotments.

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 of 2001, P.L. 106-554).²² 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.

²² 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.)

Under the MMA definition, 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 (i.e., including federal and state expenditures and excluding expenditures for administrative activities) 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 in order to remove some of the inequities from the initial FY1993 state DSH allotments, which were based on states' DSH expenditures in FY1992. 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.

Sixteen states qualified as low DSH states under the MMA definition, and they continue to be defined as low DSH states. These states are 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 to increase their DSH allotments relative to other states.²³

For FY2009 and subsequent years, low DSH states receive DSH allotments equal to the prior year's allotment increased by the percent change in CPI-U for the previous fiscal year, which is the same adjustment that non-low DSH states receive.

Hawaii and Tennessee

Tennessee and Hawaii operate their state Medicaid programs under Section 1115 research and demonstration waivers,²⁴ which allow the Secretary of Health and Human Services (HHS) 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. However, since FY2007, these two states received DSH allotments by special statutory authority provided through multiple laws.²⁵ **Table 3** shows the federal DSH funding available to Hawaii and Tennessee from FY2007 to FY2015.

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 will increase in the same manner applicable to low DSH states. Currently, all states, including low DSH states, receive

²³ §1923(f)(5)(B) of the Social Security Act.

²⁴ §1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.

²⁵ These laws include 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), and the Patient Protection and Affordable Care Act (P.L. 111-148 as amended).

DSH allotments equal to the prior year's allotment increased by the percent change in CPI-U for the previous fiscal year.

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 TennCare²⁶ for the demonstration year ending in 2006. 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 million²⁷ and was subject to the 30% limit. 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 million²⁸ in federal DSH funding in FY2012.

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, the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) provided a Medicaid DSH allotment to Tennessee in the amount of \$53.1 million for each fiscal year from FY2015 through FY2025.

²⁶ TennCare is the name of Tennessee's Medicaid program, which operates under a §1115 waiver.

²⁷ This amount is one-fourth of \$305,451,928, which was the DSH allotment for Tennessee for each year from FY2007 to FY2011.

²⁸ \$70,108,895 = \$22,908,895 (i.e., 30% of \$76,362,982) + \$47,200,000.

Table 3. Federal DSH Funding Available to Tennessee and Hawaii
FY2007 to FY2015

Fiscal Year	Hawaii	Tennessee
FY2007	\$10,000,000	\$91,635,578
FY2008	\$10,000,000	\$91,635,578
FY2009	\$10,000,000	\$91,635,578
FY2010	\$10,000,000	\$91,635,578
FY2011	\$10,000,000	\$91,635,578
FY2012	\$10,000,000	\$70,108,895
FY2013	\$10,240,000	\$53,100,000
FY2014	\$10,393,600 ^a	\$0
FY2015	\$10,559,898 ^a	\$53,100,000

Sources: Section 1923(f)(6) of the Social Security Act; Centers for Medicare & Medicaid Services, “Medicaid Program; Final FY2009 and Preliminary FY2011 Disproportionate Share Hospital Allotments, and Final FY2009 and Preliminary FY2011 Institutions for Mental Diseases Disproportionate Share Hospital Limits,” 76 *Federal Register* 148, January 3, 2011; Centers for Medicare & Medicaid Services, “Medicaid Program; Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FYs 2010, 2011, and Preliminary FY2012 Disproportionate Share Hospital Allotments and Limits,” 77 *Federal Register* 43301, July 24, 2012; HHS, “Medicaid Program: Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FY2012, and Preliminary FY2013 Disproportionate Share Hospital Allotments and Limits,” 78 *Federal Register* 45217, July 26, 2013; HHS, “Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits,” 81 *Federal Register* 5448, February 2, 2016.

Notes: This chart does not provide DSH allotments for Hawaii and Tennessee but the federal DSH funding available to Hawaii and Tennessee. For Hawaii, the DSH allotment and the federal DSH funding available is the same. However, Tennessee’s allotment for FY2007 to FY2011 is \$305,451,928, but the federal DSH funding available to Tennessee is limited to 30% of the DSH allotment ($\$305,451,928 * 0.30 = \$91,635,578$). Tennessee’s DSH funding for FY2012 is the combination of \$22,908,895 (30% of \$76,362,982) for the first fiscal quarter and \$47,200,000 for the last three fiscal quarters.

CPI-U = Consumer Price Index for all Urban consumers.

a. This is the preliminary allotment for Hawaii.

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 (including the ACA Medicaid expansion) 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 FY2020.²⁹

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,

²⁹ §1923(f)(7) of the Social Security Act.

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.

Since the ACA, a number of laws have amended the ACA Medicaid DSH reductions by eliminating the reductions for FY2014 through FY2017, changing the reduction amounts, and extending the reductions through FY2025. Under current law, the aggregate reductions to the Medicaid DSH allotments equal \$2.0 billion in FY2018, \$3.0 billion in FY2019, \$4.0 billion in FY2020, \$5.0 billion in FY2021, \$6.0 billion in FY2022, \$7.0 billion in FY2023, \$8.0 billion in FY2024, and \$8.0 billion in FY2025. In FY2026, DSH allotments are to rebound to the pre-ACA-reduced levels.³⁰

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.

- At a minimum, states must provide DSH payments to all hospitals with (1) a Medicaid inpatient utilization rate³¹ in excess of one standard deviation³² above the mean rate for the state or (2) a low-income utilization rate³³ of 25%.
- All DSH hospitals must retain at least two obstetricians with staff privileges willing to serve Medicaid patients.³⁴
- 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

³⁰ For more information about the ACA Medicaid DSH reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*, by Alison Mitchell.

³¹ 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.)

³² The “standard deviation” 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.

³³ 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.)

³⁴ 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.)

in the state with Medicaid utilization rates above 1%.³⁵ In state plan rate year³⁶ (SPRY) 2011, Medicaid DSH payments were made to less than 20% of the hospitals in 10 states, and 11 states provided Medicaid DSH payments to more than 80% of the hospitals in the state.³⁷

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.

States must make minimum payments to DSH hospitals using one of three methodologies:³⁸

- 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.³⁹

DSH payments to individual hospitals are subject to a cap.⁴⁰ This hospital-specific limit prohibits DSH payments from being greater than 100% of the cost of providing inpatient and outpatient services to Medicaid and uninsured patients less payments received from Medicaid and uninsured patients.⁴¹

The 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.”⁴² In the past, CMS has provided conflicting guidance regarding this definition; in December 2014, CMS issued a final rule to address this issue.⁴³

³⁵ Courtney Burke, “Health Reform: Uncompensated Care Costs and Reductions In Medicaid DSH Payments,” *Health Affairs Blog*, October 15, 2010.

³⁶ 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.

³⁷ Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, February 2016.

³⁸ §1923(c) of the Social Security Act.

³⁹ 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.

⁴⁰ §1923(g) of the Social Security Act.

⁴¹ 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 of 2000, P.L. 106-113).

⁴² §1923(g)(1)(A) of the Social Security Act.

⁴³ HHS, CMS, “Medicaid Program; Disproportionate Share Hospital Payments - Uninsured Definition,” 79 *Federal Register* 71679, December 3, 2014.)

The hospital-specific limit was implemented through the Omnibus Reconciliation Act of 1993 (P.L. 103-66), and, following the passage of the law, CMS did not issue a rule. However, CMS did issue a State Medicaid Director Letter delineating the agency’s interpretation of the statute, which stated 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.”⁴⁴

This interpretation remained in effect until January 19, 2009, which was the effective date for the 2008 DSH final rule implementing the DSH auditing and reporting requirements (these requirements are discussed later in the report in the section titled “State Reporting and Auditing Requirements”).⁴⁵ In promulgating the 2008 DSH final rule, CMS defined “uninsured” as individuals who do not have a legally liable third party payer for hospital services.⁴⁶ The 2008 DSH final rule relied on the existing regulatory definition of creditable coverage developed to implement the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). The definition of uninsured from the 2008 final rule superseded the guidance from the 1994 State Medicaid Director Letter.

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 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 includes services not within a covered benefit package and services beyond the annual and lifetime limits.⁴⁷

Institutions for Mental Disease DSH Limits

Federal statute limits the amount of DSH payments for institutions for mental disease (IMDs) and other mental health facilities.⁴⁸ 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

⁴⁴ State Medicaid Directors letter, August 17, 1994.

⁴⁵ The reporting requirements originally established in the Balanced Budget Act of 1997 (P.L. 105-33) were extended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173).

⁴⁶ HHS, CMS, “Medicaid Program: Disproportionate Share Hospital Payments,” 73 *Federal Register* 77904, December 19, 2008.

⁴⁷ HHS, CMS, “Medicaid Program; Disproportionate Share Hospital Payments - Uninsured Definition,” 79 *Federal Register* 71679, December 3, 2014.

⁴⁸ 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.

- 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.

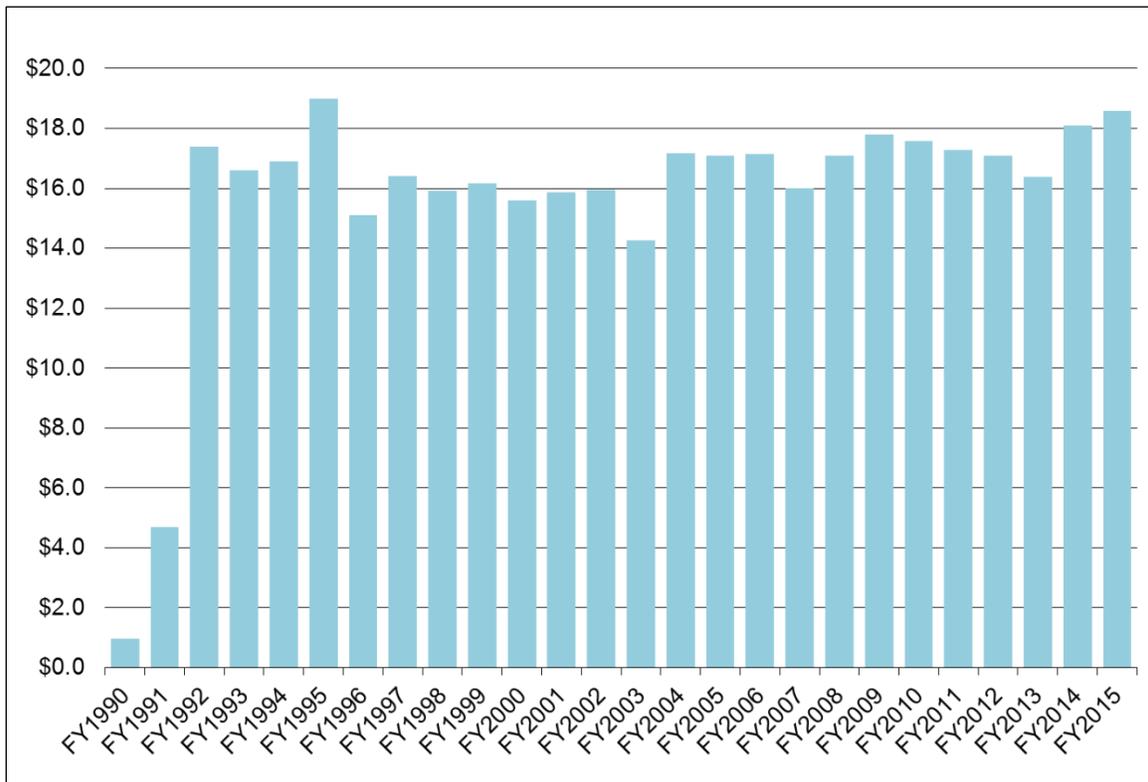
The IMD DSH limits fit within the state DSH allotments. In other words, when DSH payments to hospitals and IMDs and other mental health facilities are summed together, the total is required to be less than or equal to the state’s DSH allotments in **Table 2**.

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 FY2013 through FY2015.

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 FY2015, DSH expenditures totaled \$18.6 billion, and the federal share of those payments was \$10.6 billion.⁴⁹

Figure 1. Total Medicaid DSH Expenditures, FY1990-FY2015
(\$ in billions)



Sources: Payments estimated by the Urban Institute for FY1990-FY1992; data from CMS for FY1993-FY1996; CMS-64 data for FY1997-FY2015.

⁴⁹ Form CMS-64 Data as of March 31, 2016.

Notes: Total Medicaid DSH expenditures include both federal and state spending and payments to both hospitals and institutions for mental disease. Data for FY2015 is preliminary.

DSH expenditures are different from DSH allotments. DSH expenditures are the amounts paid to hospitals, 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 limit 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.⁵⁰ This is a target but not an absolute cap.

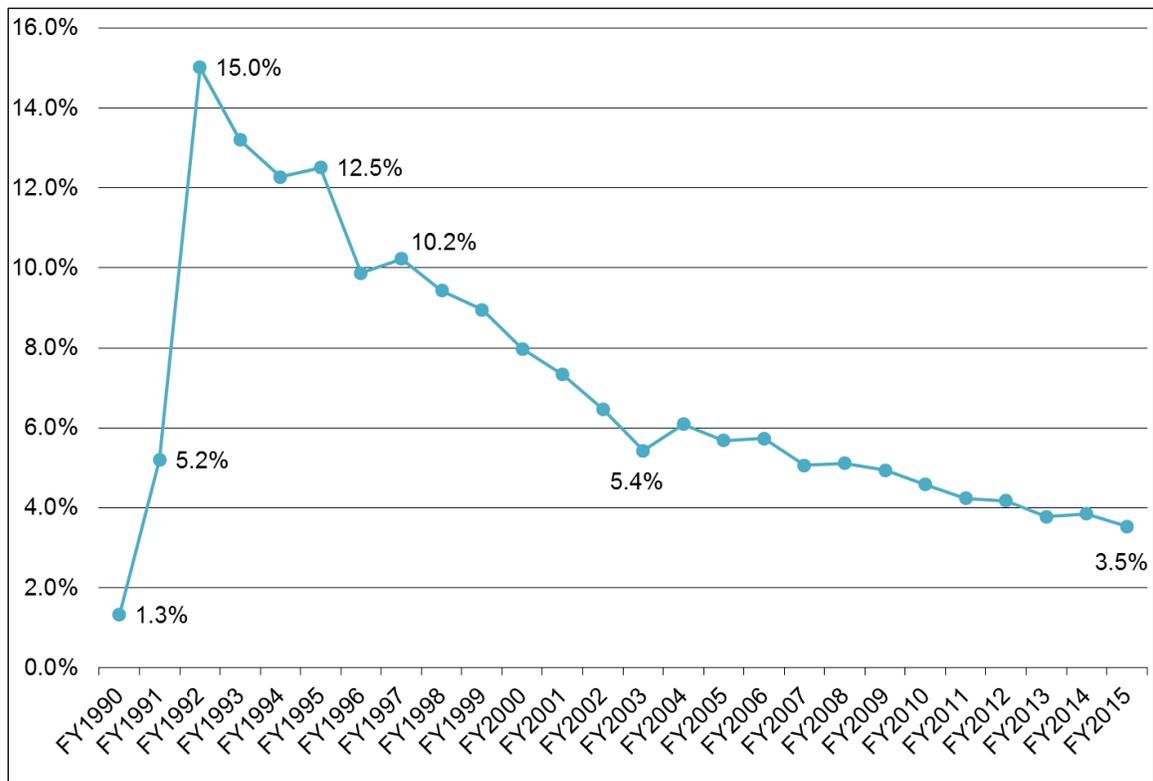
As mentioned earlier, the national DSH payment limit is different from the state-specific 12% limit on state DSH allotments because the 12% national payment limit restricts both federal and state spending while the 12% limit for allotments caps only federal spending. The national DSH payment target states that 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 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 FY2015, total DSH expenditures were 3.5% of the total Medicaid medical assistance expenditures.⁵¹

⁵⁰ 42 C.F.R. §447.297.

⁵¹ Form CMS-64 Data as of March 31, 2016.

Figure 2. Total DSH Expenditures as a Percentage of Total Medicaid Medical Assistance Expenditures
FY1990 to FY2015

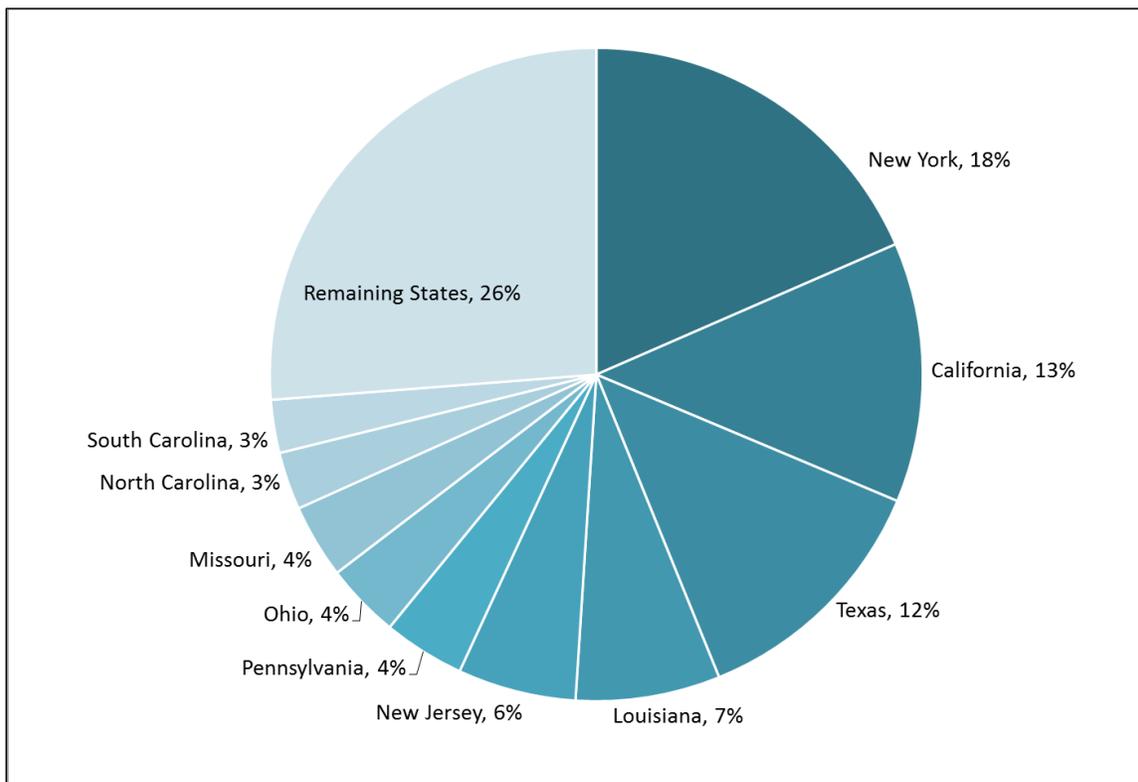


Sources: CRS calculation using DSH payment estimates from the Urban Institute for FY1990-FY1992; DSH payment data from Centers for Medicare & Medicaid Services (CMS) for FY1993-FY1996; DSH payment data for FY1997-FY2015 and medical assistance expenditure data for FY1990-FY2015 from Form CMS-64 data.

Notes: Total DSH expenditures and total Medicaid medical assistance expenditures (i.e., excluding expenditures for administrative activities) include both the federal and state expenditures. Data for FY2015 is preliminary.

DSH expenditures are highly concentrated in a few states. As shown in **Figure 3**, 4 states (New York, California, Texas, and Louisiana) accounted for half of the FY2015 DSH expenditures, and 10 states accounted for almost three-quarters of all DSH expenditures. It makes sense that some of these states (New York, California, Texas, New Jersey, Pennsylvania, and Ohio) 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 FY2015. On the other hand, Louisiana, Missouri, North Carolina, and South Carolina ranked 24th, 16th, 11th, and 27th (respectively) in terms of total medical assistance expenditures (i.e., including federal and state expenditures and excluding expenditures for administrative activities) for FY2015, but these states were among the top 10 highest spending states in terms of Medicaid DSH expenditures. This means Louisiana, Missouri, North Carolina, 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
FY2015



Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 data from FY2015 as of March 31, 2016.

Notes: The states included in the "remaining states" category had DSH expenditures that accounted for less than 3% of total DSH expenditures. In **Appendix C, Table C-1** shows state-by-state DSH spending.

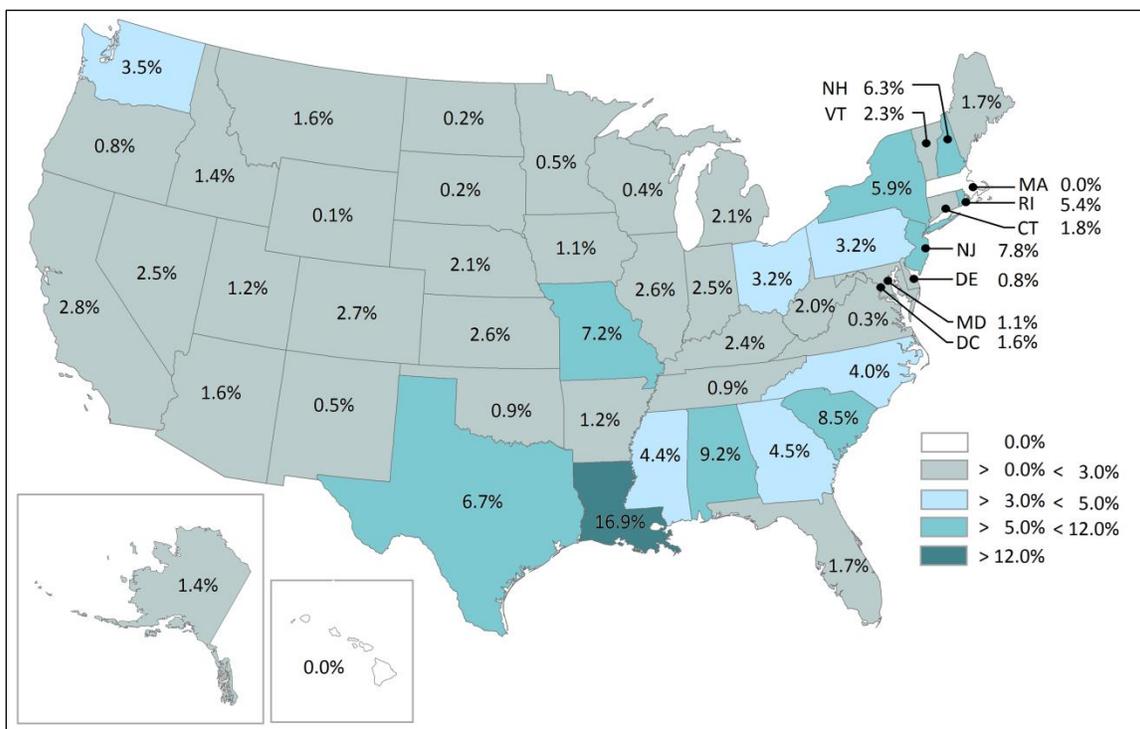
State Variation

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 FY2015 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 FY2015 ranged from 0.1% of total Medicaid medical assistance expenditures in Wyoming to 16.9% in Louisiana.

**Figure 4. Total State DSH Expenditures as a Percentage of Total Medicaid Medical Assistance Expenditures
FY2015**



Source: CRS calculation using Centers for Medicare & Medicaid Services’ Form CMS-64 data for FY2011-FY2015 as of March 31, 2016.

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.

Massachusetts and Hawaii do not have DSH expenditures because these states have Section 1115 waivers allowing each 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.

In FY2015, one state (Louisiana) had DSH expenditures in excess of 12% of total Medicaid medical assistance expenditures,⁵² which was the threshold used to determine “high” DSH states when DSH allotments were first implemented.⁵³ 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. This distribution varies by state. As shown

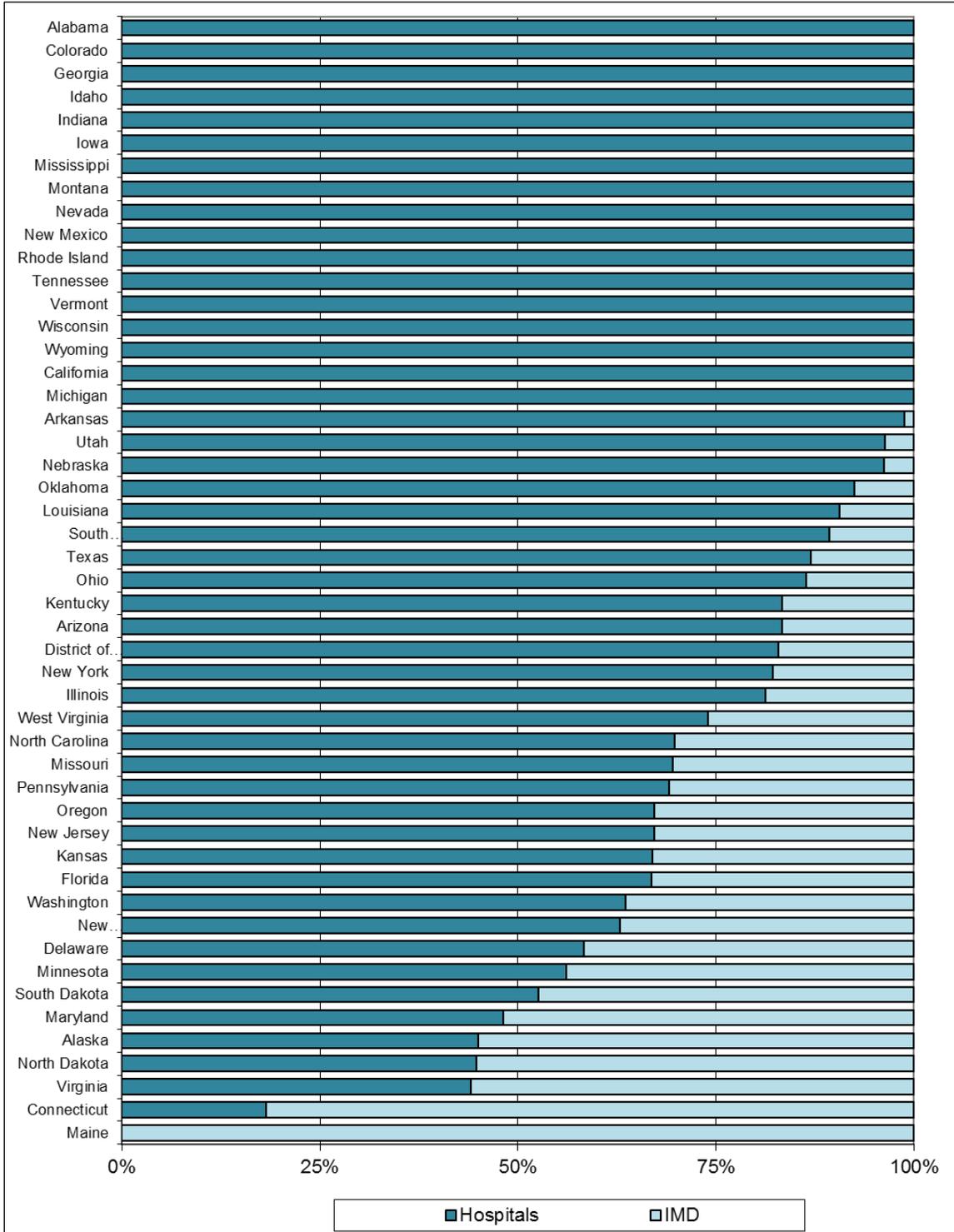
⁵² The 12% limit on DSH allotments caps the federal share of DSH expenditures to no more than 12% of a state’s total Medicaid medical assistance expenditures. However, when the federal DSH allotment funds are matched with the state share of the Medicaid DSH payments, a state could provide DSH payments in excess of 12% of its total Medicaid medical assistance expenditures.

⁵³ 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.

in **Figure 5**, in FY2015, most states targeted their DSH expenditures to hospitals, with 15 states⁵⁴ allocating all of their DSH expenditures to hospitals. Other states focused their DSH expenditures on IMDs and other mental health facilities. One state (Maine) made all of its DSH expenditures to IMDs and other mental health facilities.

⁵⁴ The fifteen states allocating all of their DSH expenditures to hospitals are Alabama, Colorado, Georgia, Idaho, Indiana, Iowa, Mississippi, Montana, Nevada, New Mexico, Rhode Island, Tennessee, Vermont, Wisconsin, and Wyoming.

**Figure 5. Proportion of State DSH Expenditures Allocated to Hospitals and IMDs
FY2015**



Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 data from FY2015 as of March 31, 2016.

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

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

California and Michigan made small DSH payments to IMDs. Specifically, California had DSH payments to IMDs in the amount of \$26, 766, and Michigan had DSH payments to IMDs in the amount of \$82,888.

Massachusetts and Hawaii do not have DSH expenditures because these states have Section 1115 waivers allowing each state to use its DSH allotment to fund its uncompensated care pools.

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 year⁵⁵ (SPRY) 2005, states were required to submit annual reports and independently certified audits.⁵⁶

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,⁵⁷ 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.⁵⁸

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 extent that the findings draw into question the reasonableness of the state uncompensated care

⁵⁵ 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.

⁵⁶ §1923(j) of the Social Security Act.

⁵⁷ 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.*)

⁵⁸ 42 CFR 455.304(a).

cost estimates used for calculations of prospective DSH payments. For SPY2011 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).⁵⁹

Conclusion

Since DSH allotments were implemented in FY1993, 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 3.5% in FY2015.

Over the next few years, DSH expenditures are to continue to decline as a percentage of Medicaid medical assistance expenditures due to the DSH reductions. 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.

Currently, the DSH reductions are slated to end in FY2025 with state DSH allotments returning to the level states would have received without the DSH reduction for FY2026 and subsequent years. However, the future of Medicaid DSH payments is uncertain because Congress may decide to change the DSH reductions again. Also, as states build experience with the ACA Medicaid expansion, the role of DSH in Medicaid may be revisited and modified by Congress.

⁵⁹ HHS, CMS, “Medicaid Program; Disproportionate Share Hospital Payments,” 73 *Federal Register* 77904, December 19, 2008.

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.⁶⁰

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.⁶¹

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 FY2002.⁶² 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

⁶⁰ Tennessee and Hawaii have had special statutory arrangements for their federal DSH funding since FY2007.

⁶¹ The definition of “low-DSH” state has changed over the years.

⁶² §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 of 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.⁶³

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).⁶⁴ 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.⁶⁵

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 FY2002.⁶⁶ 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 FY2002.⁶⁷

⁶³ HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments," 69 *Federal Register* 15850, March 26, 2004.

⁶⁴ 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.

⁶⁵ HHS, CMS, "Medicaid Program; Disproportionate Share Hospital Payments," 69 *Federal Register* 15850, March 26, 2004.

⁶⁶ This is referred to as the "DSH dip."

⁶⁷ 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 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.⁶⁸

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.

⁶⁸ Ibid.

FY2009 and FY2010

The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) temporarily increased states' DSH allotments for FY2009 and FY2010.⁶⁹ 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.⁷⁰

⁶⁹ The ARRA increase to DSH allotments did not apply to the allotments for Hawaii and Tennessee.

⁷⁰ §5001(e) of ARRA specifies that the ARRA temporary increase to the FMAP does not apply to DSH payments.

Appendix B. IMD DSH Limits

Under Sections 1923(h) of the Social Security Act, states cannot collect 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 FY2013 and preliminary limits for FY2014 and FY2015.

Table B-1. States' IMD DSH Limits
FY2013 through FY2015

State	FY2013 Final	FY2014 Preliminary	FY2015 Preliminary
Alabama	\$3,050,798	\$3,032,546	\$3,071,276
Alaska	7,062,870	7,168,813	7,283,514
Arizona	18,702,314	19,143,675	19,493,917
Arkansas	574,939	574,365	580,756
California	777,960	777,960	777,960
Colorado	297,388	297,388	303,395
Connecticut	52,786,863	52,786,863	52,786,863
Delaware	3,139,053	3,186,139	3,237,117
District of Columbia	4,581,595	4,581,595	4,581,595
Florida	69,346,847	70,387,050	71,513,243
Georgia	0	0	0
Hawaii	0	0	0
Idaho	0	0	0
Illinois	44,704,138	44,704,138	45,383,641
Indiana	74,114,444	75,226,160	76,429,779
Iowa	0	0	0
Kansas	14,302,787	14,517,329	14,749,607
Kentucky	26,416,088	26,146,498	26,187,685
Louisiana	80,310,122	80,310,122	81,595,084
Maine	36,407,095	36,953,201	37,544,452
Maryland	26,438,486	26,835,063	27,264,424
Massachusetts	52,817,527	52,817,527	52,817,527
Michigan	91,884,573	93,262,842	94,755,047
Minnesota	2,628,607	2,628,607	2,628,607
Mississippi	0	0	0
Missouri	127,179,885	128,547,634	131,490,365

State	FY2013 Final	FY2014 Preliminary	FY2015 Preliminary
Montana	0	0	0
Nebraska	1,010,002	991,526	964,899
Nevada	0	0	0
New Hampshire	47,376,974	47,376,974	47,376,974
New Jersey	178,685,231	178,685,231	178,685,231
New Mexico	175,981	176,312	177,458
New York	302,500,000	302,500,000	302,500,000
North Carolina	102,286,600	103,820,899	105,482,034
North Dakota	516,677	494,239	494,239
Ohio	59,404,548	58,881,324	58,526,280
Oklahoma	2,094,879	2,095,533	2,039,234
Oregon	12,472,447	12,612,273	12,796,044
Pennsylvania	194,604,591	197,523,660	200,684,038
Rhode Island	1,229,129	1,201,554	1,198,917
South Carolina	50,763,367	50,864,274	50,914,727
South Dakota	422,155	402,245	387,971
Tennessee	0	0	0
Texas	173,460,560	171,676,227	169,804,140
Utah	650,565	657,388	659,444
Vermont	5,083,555	5,148,868	5,098,976
Virginia	3,885,134	3,885,134	3,885,134
Washington	64,145,834	65,108,022	66,149,750
West Virginia	13,606,227	13,426,800	13,475,907
Wisconsin	2,683,527	2,652,982	2,617,495
Wyoming	0	0	0
Total	\$1,954,582,362	\$1,964,066,980	\$1,978,394,746

Source: Department of Health and Human Services (HHS), “Medicaid Program; Preliminary Disproportionate Share Hospital Allotments (DSH) for Fiscal Year (FY) 2014 and the Preliminary Institutions for Mental Disease Disproportionate Share Hospital Limits for FY 2014,” 79 *Federal Register* 11436, February 28, 2014; HHS, “Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits,” 81 *Federal Register* 5448, February 2, 2016.

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 are allocated to hospitals, and the remaining 16% is distributed to IMDs and other mental health facilities. This distribution varies by state. As shown in **Table C-1**, in FY2015, most states targeted their DSH expenditures to hospitals with 15 states allocating all of their DSH expenditures to hospitals. However, some states focused their DSH expenditures on IMDs and other mental health facilities. One state (Maine) used all of its DSH expenditures for IMDs and other mental health facilities.

Table C-1 also shows FY2015 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 FY2015 ranged from 0.1% of total Medicaid medical assistance expenditures in Wyoming to 16.9% in Louisiana.

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

FY2015
(\$ in millions)

State	DSH Expenditures			Total Medical Assistance	DSH Payments as a Percentage of Medical Assistance Expenditures
	Hospital	IMD	Total		
Alabama	\$482.9	\$0.0	\$482.9	\$5,264.8	9.2%
Alaska	9.0	10.9	19.9	1,405.4	1.4%
Arizona	142.6	28.5	171.1	10,617.7	1.6%
Arkansas	64.0	0.8	64.9	5,469.5	1.2%
California ^a	2,390.1	0.0	2,390.1	84,983.4	2.8%
Colorado	196.5	0.0	196.5	7,302.7	2.7%
Connecticut	23.5	105.6	129.0	7,183.4	1.8%
Delaware	8.4	6.0	14.4	1,860.1	0.8%
District of Columbia	30.6	6.3	36.9	2,369.9	1.6%
Florida	239.7	119.1	358.8	21,320.5	1.7%
Georgia	435.0	0.0	435.0	9,664.8	4.5%
Hawaii ^b	0.0	0.0	0.0	1,958.0	0.0%
Idaho	24.2	0.0	24.2	1,715.4	1.4%
Illinois	359.5	82.7	442.2	16,938.5	2.6%
Indiana	232.1	0.0	232.1	9,249.8	2.5%
Iowa	47.1	0.0	47.1	4,476.3	1.1%

State	DSH Expenditures			Total Medical Assistance	DSH Payments as a Percentage of Medical Assistance Expenditures
	Hospital	IMD	Total		
Kansas	52.9	26.0	78.9	3,010.9	2.6%
Kentucky	188.9	37.7	226.6	9,423.5	2.4%
Louisiana	1,203.5	125.6	1,329.1	7,863.2	16.9%
Maine	0.0	42.1	42.1	2,477.4	1.7%
Maryland	52.0	56.0	108.0	9,410.2	1.1%
Massachusetts ^b	0.0	0.0	0.0	15,378.2	0.0%
Michigan	336.5	0.1	336.6	15,867.4	2.1%
Minnesota	32.0	25.1	57.0	10,704.5	0.5%
Mississippi	224.5	0.0	224.5	5,136.3	4.4%
Missouri	473.6	207.2	680.9	9,518.5	7.2%
Montana	18.6	0.0	18.6	1,132.4	1.6%
Nebraska	37.0	1.4	38.4	1,846.4	2.1%
Nevada	78.0	0.0	78.0	3,105.6	2.5%
New Hampshire	68.3	40.4	108.7	1,716.2	6.3%
New Jersey	731.8	357.4	1,089.1	14,049.4	7.8%
New Mexico	22.7	0.0	22.7	4,920.3	0.5%
New York	2,820.3	610.8	3,431.2	57,897.0	5.9%
North Carolina	371.0	160.3	531.3	13,212.7	4.0%
North Dakota	0.4	0.5	0.9	533.6	0.2%
Ohio	593.5	93.4	686.9	21,423.0	3.2%
Oklahoma	40.2	3.3	43.5	4,703.0	0.9%
Oregon	40.8	19.9	60.7	8,027.1	0.8%
Pennsylvania	519.2	231.8	751.0	23,223.6	3.2%
Rhode Island	140.5	0.0	140.5	2,584.8	5.4%
South Carolina	435.5	52.3	487.9	5,767.7	8.5%
South Dakota	0.8	0.8	1.6	805.7	0.2%
Tennessee	81.7	0.0	81.7	9,094.1	0.9%
Texas	2,026.5	303.5	2,330.0	34,691.3	6.7%
Utah	24.5	0.9	25.4	2,148.0	1.2%
Vermont	37.4	0.0	37.4	1,632.6	2.3%
Virginia	9.1	11.6	20.7	8,032.8	0.3%
Washington	230.4	132.2	362.6	10,494.1	3.5%
West Virginia	53.7	18.9	72.6	3,646.5	2.0%
Wisconsin	31.4	0.0	31.4	7,893.5	0.4%

State	DSH Expenditures			Total Medical Assistance	DSH Payments as a Percentage of Medical Assistance Expenditures
	Hospital	IMD	Total		
Wyoming	0.5	0.0	0.5	559.0	0.1%
Total	\$15,663.2	\$2,919.1	\$18,582.3	\$523,710.8	3.5%

Source: CRS calculation using Centers for Medicare & Medicaid Services' Form CMS-64 Data for FY2015 as of March 31, 2016.

Notes: Medicaid medical assistance expenditures exclude administrative expenditures.

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

- a. California made small DSH payments to IMDs. Specifically, California had DSH payments to IMDs in the amount of \$26, 766 in FY2015.
- b. Massachusetts and Hawaii do not have DSH expenditures because these states have Section 1115 waivers allowing each state to use its DSH allotment to fund its uncompensated care pools.

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