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Medicaid Disproportionate Share Hospital (DSH) Reductions

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. (See CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.)

Whereas 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 FY2019, federal DSH allotments totaled $12.6 billion.

DSH Allotment Reduction Amounts

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) has reduced the number of uninsured individuals in the United States through the health insurance coverage provisions (including the ACA Medicaid expansion). Built on the premise that with fewer 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.

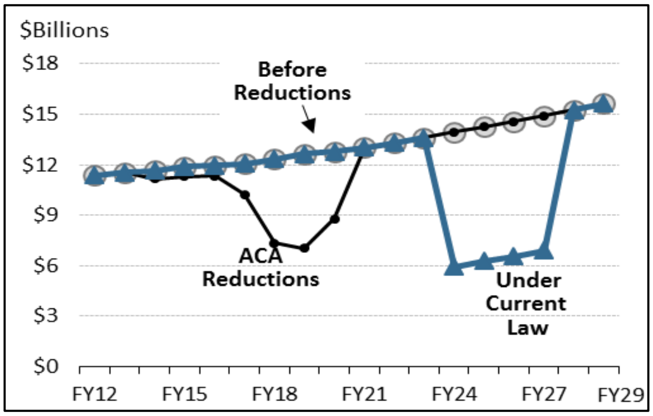
Despite the assumption that decreasing the number of uninsured individuals would reduce the need for Medicaid DSH payments, the ACA was written so that, after the specific reductions for FY2014 through FY2020, DSH allotments would have returned to the amounts that states would have received without the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

The Medicaid DSH reductions have been amended by a number of laws since the ACA. The specific laws that have amended the Medicaid DSH reductions are

- the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96);
- the American Taxpayer Relief Act of 2012 (P.L. 112-240);
- the Bipartisan Budget Act of 2013 (P.L. 113-67);
- the Protecting Access to Medicare Act of 2014 (P.L. 113-93);
- the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10);
- the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123);
- the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59);
- the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69);
- the Further Consolidated Appropriations Act, 2020 (P.L. 116-94);
- the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136);
- the Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-159);
- the Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215); and
- the Consolidated Appropriations Act, 2021 (P.L. 116-260).

Under current law, the Medicaid DSH reductions are to occur from FY2024 through FY2027 (see **Figure 1**). The aggregate reductions to the Medicaid DSH allotments equal $8.0 billion for each of those years.

Figure 1. Total DSH Allotments Before the Reductions, with the ACA Reductions, and Under Current Law



Source: CRS calculation using Consumer Price Index for All Urban Consumers estimates from Congressional Budget Office, *An Overview of the Economic Outlook: 2021 to 2031*, February 2021.

Figure 1 shows estimates of aggregate DSH allotments for FY2012 through FY2029 before the ACA reductions, with the ACA reductions, and under current law. The ACA reductions totaled $18.1 billion, and under current law the DSH allotment reductions total $32.0 billion.

Under current law, the aggregate reductions relative to the Medicaid DSH allotments before reductions will be an estimated 57% reduction in FY2024 phasing down to an estimated 54% reduction in FY2027. In FY2028, DSH allotments will rebound to the pre-reduced levels, with annual inflation adjustments for FY2024 to FY2027.

Statutory Requirements for Reductions to State DSH Allotments

Although the aggregate DSH reduction amounts are specified in statute, the HHS Secretary is responsible for determining how to distribute the aggregate DSH reductions among the states using some broad statutory guidelines. The Secretary is required to impose *larger* percentage DSH reductions on states that (1) have the lowest percentage of uninsured individuals (determined by the Census Bureau's data, audited hospital cost reports, and other information) during the most recent fiscal year with available data or (2) do *not* target their DSH payments to hospitals with high volumes of Medicaid patients and high levels of uncompensated care (excluding bad debt).

The statute also requires the Secretary to impose *smaller* percentage reductions on low DSH states (i.e., states with total Medicaid DSH payments for FY2000 between 0% and 3% of total Medicaid medical assistance expenditures).

The last specification provided in statute requires the Secretary to take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under a Section 1115 waiver as of July 31, 2009.

Although the statute provides the Secretary with flexibility regarding how to allocate the DSH reductions among the states, in general, states with the lowest percentage of uninsured individuals can be expected to receive relatively larger percentage DSH reductions. In addition, states that do not target their DSH payments to hospitals with the most Medicaid patients and highest levels of uncompensated care can be expected to receive relatively larger percentage DSH reductions. Also, low DSH states should receive relatively smaller percentage DSH reductions. As a result, a non-low DSH state with a low percentage of uninsured individuals that does not target its DSH payments can be expected to receive a relatively larger percentage reduction and a low DSH state with a high percentage of uninsured individuals that targets its DSH payments should receive a relatively smaller percentage DSH reduction.

The magnitude of the Medicaid DSH reductions is such that most states are expected to have DSH allotment reductions. Tennessee is the only state that is not subject to the Medicaid DSH reductions due to the special statutory authority for Tennessee's Medicaid DSH allotment.

Methodology for Allocating DSH Reductions

On September 25, 2019, the Centers for Medicare & Medicaid Services (CMS) released a final rule regarding the methodology for allocating the Medicaid DSH reductions. The methodology begins by splitting the aggregate DSH reduction amount for each year into two separate amounts: one DSH reduction amount for low DSH states and another reduction amount for non-low DSH states.

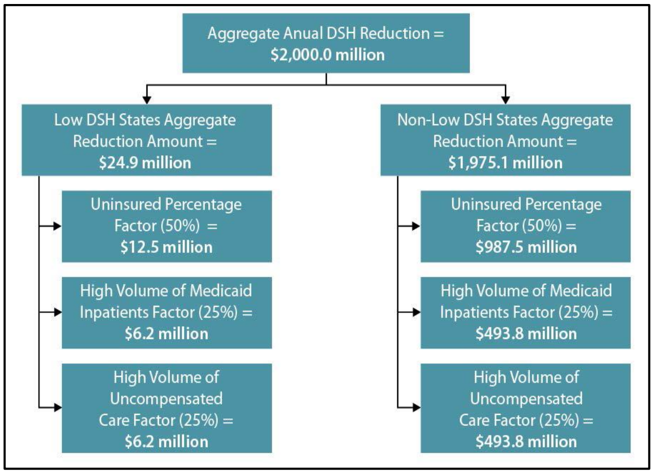
Then, for each group of states, half of each group's DSH reductions would be allocated according to the uninsured percentage factor and half of the DSH reductions would be allocated according to how states target their DSH funds. As shown in

Figure 2, the DSH reductions would be allocated according to the uninsured percentage factor (50%), how states target their DSH funds according to the "high volume of Medicaid inpatient factor" (25%), and how states target their DSH funds according to the "high level of uncompensated care factor" (25%). Each state's reduction would be limited to 90% of the unreduced allotment amount, which preserves at least 10% of states' allotments.

The methodology would not reduce any portion of a state's Medicaid DSH allotment that was included in the budget neutrality calculation for a coverage expansion that was approved under a Section 1115 waiver as of July 31, 2009. This would affect the District of Columbia, Indiana, Maine, Massachusetts, and Wisconsin.

Figure 2 shows CMS's illustrative example of the methodology using a $2.0 billion aggregate Medicaid DSH reduction on FY2017 allotments. Under this example, CMS estimates that low DSH states would have an average allotment reduction of 4.6% and non-low DSH states would have an average allotment reduction of 17.2%.

Figure 2. Illustrative Example of Medicaid DSH Reduction Methodology



Source: CRS using the illustrative DSH reduction factor weighting allocation from Centers for Medicare & Medicaid Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions," 82 *Federal Register* 35155, July 28, 2017.

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