MEDICAID: STATE DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT REDUCTIONS FOR FYs 2014 AND 2015

SUMMARY

On May 15, 2013, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (78 FR 28551) a proposed rule delineating a methodology for implementing annual reductions in state disproportionate share hospital (DSH) allotments as required by section 2551 of the Patient Protection and Affordable Care Act. The comment period closes on July 12, 2013.

The proposed rule addresses reductions in state Medicaid DSH allotments for FYs 2014 and 2015, although the original ACA provision specifies annual reductions for FYs 2014 through 2020, and subsequent legislation extended the reductions through FY 2022. CMS indicates that a methodology for implementing reductions in FY 2016 and later will be proposed in future rulemaking. This rule proposes no method to take into account the differential effects of state decisions regarding the Medicaid coverage expansion provided for under the ACA in the proposed state DSH allotment reductions for FYs 2014 and 2015.

Background

Under section 1923 of the Social Security Act ("the Act"), state Medicaid programs must provide DSH payments to hospitals meeting federal minimum requirements for serving a disproportionate share of low income patients, and may extend DSH payments to other hospitals. States are provided annual federal allotments for this purpose; these allotments represent the maximum federal matching payments the state is permitted to claim for DSH payments. Depending on a state's DSH expenditures, federal matching for DSH payments for a state in a year may fall below the allotment. In general, since 1998 the state allotments are increased each year by the Consumer Price Index. DSH allotments were increased for FYs 2009 and 2010 under the American Recovery and Reinvestment Act of 2009.

A state's DSH allotment for a fiscal year is also capped at the higher of its previous year allotment or 12 percent of the total (federal and state) non-administrative Medicaid expenditures for that year. Preliminary allotments are announced prior to the start of the fiscal year and then finalized after the fiscal year ends to properly take into account the 12 percent limit. The most recent *Federal Register* notice regarding DSH allotments published on July 24, 2012 (77 FR 43301) provides final allotments for FYs 2010 and 2011 and preliminary allotments for FY 2012.

Additional policies affect DSH allotments. Sixteen designated "low-DSH" states received additional annual increases in their DSH allotments in the past, but since FY 2009 have received the same annual CPI adjustment as other states. (To qualify as a low-DSH state, total DSH expenditures for FY 2000 had to be greater than 0 but less than 3 percent of the state's total Medicaid state plan expenditures for that year.) In addition, special statutory

rules apply to calculating the DSH allotments for Hawaii and Tennessee, and Hawaii is treated as a low-DSH state beginning in FY 2013.

In order to receive federal matching funds for DSH, a state must at a minimum provide DSH payments to all hospitals with (1) a Medicaid inpatient utilization rate (MIUR) in excess of one standard deviation above the mean rate for the state, or (2) a low-income utilization rate of 25%. All DSH hospitals must retain at least two obstetricians with staff privileges willing to serve Medicaid patients, with exceptions. A state may not identify a hospital as a DSH hospital if its MIUR is below 1%. If these requirements are met, a state can identify many or few hospitals as DSH hospitals. A hospital-specific DSH cap applies – federal matching funds are not available for DSH payments that exceed the amount of a hospital's uncompensated cost of providing inpatient and outpatient services to Medicaid patients and the uninsured, minus payments received by the hospital for these patients.

Prior to enactment of the ACA, the Congressional Budget Office projected total DSH allotments of $9.9 billion for FY 2014 increasing to $11.0 billion in FY 2019.The ACA specified the reductions in aggregate annual DSH allotments shown in the following table, and imposed certain requirements for implementing the reductions across states. While the early year reductions are relatively small, by 2018 and 2019, annual DSH allotments would be reduced by about half.

Aggregate Reductions in Medicaid State DSH Allotments under the ACA	
Fiscal year	Reduction (in $ millions)
2014	500
2015	600
2016	600
2017	1,800
2018	5,000
2019	5,600
2020*	4,000
2021*	4,000
2022*	4,000
*The original ACA provision specified reductions through 2020, and was extended through 2021 by the Middle Class Tax Relief and Job Creation Act (P.L. 112-96) and through 2022 by the American Taxpayer Relief Act of 2012 (P.L. 112-240).	

The ACA specifies certain factors that must be taken into account by the Secretary in developing a methodology for distributing the reductions among the states. First, the largest percentage reductions in DSH allotments are to be imposed on states that have the lowest percentage of uninsured or that do not target their DSH payments on hospitals with high volumes of Medicaid beneficiaries and hospitals with high levels of uncompensated care. In addition, a smaller percentage reduction is to be applied to "low-DSH" states. Finally, for

states with a coverage expansion approved under section 1115 as of July 31, 2009, the methodology must take into account the extent to which the state's DSH allotment was included in the section 1115 budget neutrality adjustment.

The ACA reductions apply to the state DSH allotments, and states would retain flexibility within the federal requirements described above to determine which hospitals qualify for DSH payments and the amount of DSH payments they receive. However, as discussed further below, under the proposed methodology states are given the incentive to target DSH payments to hospitals with a high volume of Medicaid patients and a high level of uncompensated care.

Impact of State Decisions Regarding the ACA Medicaid Expansion

CMS discusses state choices about implementing the ACA Medicaid coverage expansion for adults, and proposes that the methodology for implementing DSH reductions be limited in this rule to FYs 2014 and 2015, with future rulemaking to address FY 2016 and later years. Noting its view that states that choose to expand Medicaid and the hospitals located in them would benefit greatly from expanding Medicaid coverage, CMS indicates these expansion states may also be subject to greater reductions in DSH allotments than they would if all states were to implement the coverage expansion, because they would have lower rates of uninsurance than other states.

Further, CMS goes on to say, *"Given the statutory reductions in the funding for Medicaid DSH in the Affordable Care Act, we intend to account for the different circumstances among states in the formula in future rulemaking."* The decision to propose limiting the proposed rule methodology to FYs 2014 and 2015 is made because the data that the reductions are based on for these two years will not reflect differential state decisions regarding the ACA Medicaid expansion. CMS believes there are not currently sufficient data on the relative impacts resulting from state decisions regarding the Medicaid expansion, and such data may not be available until 2016. CMS intends to continue evaluating the potential implications for accounting for cover expansion in the DSH reduction methodology, and intends to address this issue in separate rulemaking for DSH allotments for 2016 and later years.

Proposed DSH Health Reform Methodology (DHRM) -- Overview

The methodology proposed for distributing the ACA-specified DSH reductions among the states for FYs 2014 and 2015 involves a series of steps and calculations. First, prior to the start of a fiscal year, CMS would estimate unreduced DSH allotments for each state under existing rules. These amounts would serve as the base to which the DSH reductions would be applied. Next, states would be separated into two groups, one consisting of the 17 low-DSH states, and the second consisting of all other (non low-DSH) states. A series of reduction factors, detailed below, would then be calculated and applied to determine each state's reduced DSH allotment.

CMS proposes weighting factors for three of the reduction factors that would be applied to individual state DSH allotments within the low-DSH state and other state groups. As

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described earlier, the ACA provides that the largest percentage reductions in DSH payments are to be imposed on states that have the lowest percentage of uninsured or that do not target their DSH payments on hospitals with high volumes of Medicaid beneficiaries and hospitals with high levels of uncompensated care. CMS proposes that the Uninsured Percentage Factor be given a weight of 33 and 1/3 percent, while the combined weights of the two targeting factors would be 66 and 2/3 percent, with the High Level of Uncompensated Care Factor and the High Volume of Medicaid Inpatients Factor each receiving a weight of 33 and 1/3 percent. CMS notes that the current DSH allotments are unrelated to the amount of state DSH payments made to hospitals with high Medicaid volume or high levels of uncompensated care, and the proposed methodology would incentivize states to target DSH payments to such hospitals.

CMS seeks comments on the proposed weighting factors and how they would affect different hospital types, along with views on alternative weighting factors. A variety of possible alternative weighting assignments are described, such as 50 percent for the uninsured factor and 50 percent for the two targeting factors combined, split at 25 percent each. CMS also indicates that it could have assigned zero weight to either the uninsured factor or the targeting factors.

CMS states its intention to propose to use, whenever possible, data sources for the DHRM that are transparent and readily available to CMS, the states, and the public. In particular, CMS proposes to use the data from the Census Bureau's American Community Survey to measure the state-level percentage of uninsured. In addition, data derived from Medicaid DSH audit and reporting data, existing DSH allotments, and Form-64 CMS Medicaid Budget and Expenditures System data would be used. In general, data for the most recently available year would be used. With respect to the Medicaid DSH audit and reporting data, CMS discusses issues regarding the data reported by states during the transition period for state plan rate years 2005 through 2010, which varies in quality and accuracy. CMS indicates that it may require significant resources to ensure that these data are compiled and prepared for use in the DHRM. In this case, CMS would use the most recent data available in usable form, which may not be the most recently submitted data. CMS intends to issue detailed guidance to states by the end of calendar year 2013 that would be applicable to DSH audits and reports due to CMS by the end of calendar year 2014.

CMS also proposes that states report additional information that would be used in the DHRM. In one case, CMS indicates its intention to collect information directly from state Medicaid agencies outside of the proposed rule. Specifically, states would submit information used to determine which hospitals are deemed disproportionate share under section 1923(b) of the Act. CMS does not currently collect this information, but believes it is readily available to states. Additionally, CMS proposes to amend the state DSH reporting regulations at §447.299(c) to require that states report the Medicaid provider number, Medicare provider number, and total annual costs incurred by each hospital for furnishing inpatient and outpatient hospital services. In the preamble, the total cost data is described as coming from the hospital's Medicare cost report.

The choice of the American Community Survey for data on the uninsured survey was recommended to CMS by the Census Bureau. The advantages of this data source over the Annual Social and Economic Supplement to the Current Population Survey, as described by CMS, are that it has a much larger sample size, is fielded over the course of a full year, and respondents are asked to report on their insurance status at the time of the survey rather than over the course of the previous year. CMS reports that is considering adjusting the definition of the uninsured for the DSH reductions applicable in FY 2016 and beyond that will be proposed in future rulemaking.

Details of Proposed DSH Health Reform Methodology

Details of Proposed Methodology. As described earlier, CMS proposes to start with the unreduced DSH allotments for each state and then apply a series of factors to determine each state's reduced DSH allotment. Preliminary DSH allotment estimates would be used to develop the DSH reduction factors. **A table on the next page provides an overview of the proposed methodology, which is described in detail below**.

Factor 1 is the low-DSH adjustment factor (LDF). The ACA requires that a smaller percentage reduction be imposed on low-DSH states than others. CMS proposes that this adjustment would be calculated by first separating the states into two groups: the 17 low-DSH states, and all others. The required DSH allotment reduction amount (e.g., $500 million for FY 2014) would be allocated to each of the two groups in proportion to the unreduced DSH allotments. For example, based on the illustrative data included in Table 1 shown in the proposed rule (and appended to this summary) the low-DSH group accounts for 4.5 percent of total unreduced DSH allotments.[1] This step of the calculation would therefore assign 4.5 percent of the total DSH reductions (about $22 million) to be distributed among the low-DSH group and the remaining $478 million to the other group.

Next, each state's unreduced preliminary DSH allotment for the year would be calculated as a percentage of the state's estimated Medicaid service expenditures for that year. These state amounts would be averaged (nonweighted mean) for the two groups. The average of the low-DSH states divided by the average for the other (non-low DSH) states, expressed as a percentage, would be the LDF. In the illustrative table, CMS reports that the estimated result of this calculation is an LDF of 27.97 percent.

The original proportionately allocated DSH reduction would be multiplied by the LDF, and that result would be the total amount of the DSH reduction distributed among the low-DSH states, with the balance allocated to the non low-DSH states. Using the illustrative figures, the $22 million would be multiplied by 27.97 percent, and the resulting $6.2 million would be the total reduction distributed among low-DSH states. The balance ($500 million minus $6.2 million, or $493.8 million) would be distributed among the other states.

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[1] Table 1 as published in the proposed rule (and included here as an attachment) incorrectly identifies Arizona as a low-DSH state and omits Arkansas as a low-DSH state.

CMS indicates that it considered using alternative proportional relationships to establish the LDF, including the proportion of each group's annual Medicaid DSH expenditures to total Medicaid expenditures.

Proposed DSH Health Reform Methodology: Overview of Key Steps in Allocation of DSH Allotment Reductions Figures based on NPRM Illustrative Table 1, FY 2014		
Starting Point: Aggregate amounts for FY 2014		
Total DSH allotment reduction	**$500 million**	
Total estimated unreduced DSH allotments	**$11.7 billion**	
Step 1. Divide states into two groups: the low-DSH states and others (non-low DSH states), and calculate a total DSH allotment reduction for each group, applying the required low-DSH adjustment factor		
	Low DSH states	**Other states**
Number of states in group	17*	34 (includes DC)
Unreduced FY 2014 DSH allotment (CMS estimates)	$521 million	$11.2 billion
Proportion of estimated unreduced FY 2014 DSH allotment	4.5% ($521 m / $11.7 b)	95.5% ($11.2 b / $11.7 b)
Proportionally Allocate $500 million FY 2014 DSH allotment reduction between the two state groups	$22 million (4.5% x $500 million)	$478 million (95.5% x 500 million)
Apply Low DSH adjustment factor, estimated to be 27.97%, to determine total group DSH Reduction	Adjusted total group allotment reduction: **$6.2 million** (27.97% x $22 million)	Adjusted total group allotment reduction: **$493.8 million** ($500 million-$6.2 million)
Step 2. Allocate each group's total DSH allotment reduction among hospitals in the group, based on three factors weighted of $33^{1/3}$ % each		
A. Uninsured Percentage Factor (UPF) weight = 33 1/3%	$2.1 million**	$164.6 million
B. High Volume of Medicaid Inpatients (HMF) weight = 33 1/3%	$2.1 million**	$164.6 million
C. High Volume of Medicaid Inpatients (HUF) weight = 33 1/3%	$2.1 million**	$164.6 million
Sum of reductions for all three factors (A+B+C, equal to adjusted total group allotment reduction above)	$6.2 million**	$493.8 million
Resulting Reduced DSH Allotments	$515 million	$10.7 billion
*As provided under the ACA, Hawaii is treated as a low-DSH state beginning in FY 2013. **Sums do not add to total due to rounding Note: Further adjustments would be made with respect to a few states to take into account the extent to which DSH allotments were included in the budget neutrality calculation for a coverage expansion approved under a section 1115 demonstration as of July 31, 2009.		

Factor 2: Uninsured Percentage Factor (UPF). The ACA requires that larger percentage DSH allotment reductions be imposed on states with the lowest percentage of uninsured or those that do not target DSH payments to hospitals with high Medicaid inpatient volume or high uncompensated care. As noted earlier, CMS intends to use the

Census Bureau ACS as the data source for this factor. Specifically, the most recent "1 year estimates" data available at the time of the calculation would be used.

CMS proposes to calculate a UPF as described below, use it to distribute 33 1/3 percent of the total DSH reduction for each of the two state groups (low-DSH states and others). That is, for the low-DSH states, using the figures from the illustrative table, one-third of the $6.2 million total DSH allotment reduction, or just under $2.1 million would be based on the UPF. For other states, one-third of the total $494 million reduction, or $167 million, would be based on this factor.

1. Calculate each state's "uninsured value" by dividing the total state population by the number of uninsured in the state. (Note that this is the inverse of the percentage of uninsured, which is the number of uninsured divided by the state population. For example, in a state with 5 uninsured people and a total population of 100, the uninsured rate is 5 percent and the uninsured value would be 20.)

2. Divide each state's uninsured value (from step 1) by the sum of uninsured values for the state group (i.e., the low-DSH group and the non-low DSH group). This will result in a percentage for each state, and for each of the two state groups, the percentages will sum to 100.

3. Divide each state's preliminary unreduced DSH allotment by the sum of all unreduced allotments in the state group. The resulting percentage of DSH allotments is then multiplied by the percentage calculated in step 2 and the result is an allocation weighting factor for the state. The purpose of this step is to weight the state's uninsured value by its proportion of DSH allotments to ensure that larger and smaller states are given fair weight in calculating the UPF.

4. Separately for each of the two state groups, each state's allocation weighting factor from step 3 is divided by the sum of all the weighting factors for the group, and the result is the state's UPF.

5. The UPF portion of the final aggregate DSH allotment reduction allocation for a state would be calculated as the product of multiplying the state's UPF by the aggregate DSH allotment reduction allocated to the UPF factor for the state group using the (proposed one-third) weighting factor described earlier. (In the illustrative table, this amounts to $2.1 million for the 17 low-DSH states and $164.6 million for the other 34 states.)

Factor 3: High Volume of Medicaid Inpatients Factor (HMF). CMS proposes to calculate an HMF as described below, and use it to distribute one-third (33 1/3 percent) of the total DSH reduction for each of the two state groups (low-DSH states and others). The ACA specifies that for this purpose the existing statutory definition (1923(b)(1)(A)) of hospitals with a high volume of Medicaid patients applies. Under the definition, hospitals with a Medicaid inpatient utilization rate (MIUR) that is at least 1 standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state

are considered to have a high volume of Medicaid inpatients. These hospitals are among those that a state must provide DSH payments to in order to receive federal matching funds for DSH payments. (In the rule CMS refers to these as "federally deemed" hospitals.) The proposed formula would result in a smaller reduction in DSH allotments for those states that target a large percentage of DSH payments to hospitals meeting this definition.

For this factor, CMS proposes to rely on in part on MIUR information collected from states on an annual basis outside of the proposed rule. CMS notes that states must already determine the mean MIUR for hospitals receiving Medicaid payments in the state and the value of one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state. Additional data elements that would be used to calculate this factor include information reported under existing regulations on the DSH hospital payment amount reported for each DSH (§477.299(c)(17)) and the MIUR for each DSH (§477.299(c)(3)).

CMS indicates that a state that does not timely provide the separately required information for use in this factor, it will assume that the state has the highest value of one standard deviation above the mean reported among all states. (For an average state, replacing missing data using this highest value assumption would likely lower the number of hospitals in the state assumed to qualify as meeting the federal minimum MIUR standard, and therefore the state would receive a greater reduction in its DSH allocation than if it had submitted the correct information.)

The proposed HMF is a state-specific percentage that would be computed as follows, separately for each of the two state groups:

1. For each state, identify High Medicaid Volume hospitals as those with an MIUR at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state.

2. For each state, determine the total amount of DSH payments made to non-High Medicaid Volume hospitals from the most recently submitted and accepted DSH audit template.

3. For each state, divide the total amount of all DSH payments made to non-high Medicaid volume hospitals in the state by the sum of these amounts for all states in the group. This percentage is the state's HMF. It is the state's share of the all the DSH payments made by all the states in the group to hospitals that are not High Medicaid Volume.

4. The HMF reduction for a state is its HMF percentage multiplied by the aggregate reduction amount allocated to the factor for the state group. As proposed, one-third of the total DSH allotment reduction for each state group would be distributed based on the HMF.

CMS notes that under this proposed methodology a number of interactions could occur for states among the DSH payment methodologies, DSH allotment and DSH allotment reductions. CMS believes that most of these interactions would be consistent with the goal of incentivizing targeted DSH payments. For example, a state that paid all of its DSH allotment to hospitals that are High Medicaid Volume would receive no reduction from this factor, consistent with the goal. Further, CMS notes that if a state's DSH allotment was large enough so that it could pay all of its High Medicaid Volume hospitals up to the hospital-specific DSH payment limit and have funds left over, the funds paid to hospitals that are not High Medicaid Volume would be subject to reduction under the proposed formula. CMS views this result as also promoting targeted DSH payments.

Factor 4: High Level of Uncompensated Care Factor (HUF). The second proposed targeting factor, the HUF, would be used to distribute the remaining one-third of the DSH allotment reduction for each of the two state groups. CMS proposes to rely on the existing statutory definition of uncompensated care (1923(g)(1)) that is used in determining the hospital-specific limit on federal matching payments for state DSH payments.[2] The most recent available DSH audit and reporting data provided by states would be used. Specifically, CMS would use the following amounts reported by states for each DSH: DSH payment amount (§477.299(c)(17)), uncompensated care amount (§477.299(c)(16)), total Medicaid cost amount (§477.299(c)(10)), and total uninsured cost amount (§477.299(c)(14)). CMS notes that as required by the statute, the proposed uncompensated care data used in this factor excludes bad debt. The proposed data source excludes bad debt, including unpaid co-pays and deductibles, associated with individuals with a source of third party coverage for the service received during the year.

For calculating the HUF, a hospital with a ratio of uncompensated care costs to total Medicaid and uninsured inpatient and outpatient hospital service costs that exceeds the mean ratio for the state would be considered a High Uncompensated Care Hospital. CMS indicates that it considered identifying a metric that is higher than the mean for this purpose, and solicits comments on this alternative.

The proposed HUF would be calculated as follows for each of the two state groups:

1. For each state, determine each hospital's uncompensated care level by dividing its uncompensated care cost by the sum of its total Medicaid cost and its total uninsured cost. This data element would come from the state's most recent accepted DSH audit template.

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[2] The state must calculate for each hospital, for each fiscal year, the difference between the costs incurred by that hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals and individuals who have no health insurance or other source of third party coverage for the inpatient hospital and outpatient hospital services they receive, less all applicable revenues for these hospital services. This difference, if any, between incurred inpatient hospital and outpatient hospital costs for these individuals and associated revenues is considered a hospital's uncompensated care cost limit, or hospital-specific DSH limit.

2. Calculate the weighted mean uncompensated care level for each state. (CMS does not indicate how it intends to calculate this "weighted" mean.)

3. Identify all the High Uncompensated Care Hospitals in a state as those that meet or exceed the state's mean uncompensated care level calculated in step 2.

4. Determine the amount of DSH payments in each state that are paid to <u>non</u>-High Uncompensated Care Hospitals.

5. For each state, divide the total amount of all DSH payments made to non-high Uncompensated Care Hospitals in the state by the sum of these amounts for all states in the group. This percentage is the state's HUF. It is the state's share of the all the DSH payments made by all the states in the group to hospitals that are <u>not</u> High Uncompensated Care Hospitals.

6. The HUF reduction for a state is its HUF percentage multiplied by the aggregate reduction amount allocated to the factor for the state group. As proposed, one-third of the total DSH allotment reduction for each state group would be distributed based on the HUF.

As with the HMF, CMS discusses potential interactions among the HUF, DSH allotments, DSH payment methodologies and DSH allotment reductions. In this case, CMS has identified some potential scenarios under which the interactions could work against the goal of this methodology. It offers a numerical example under which a hospital may not be considered to have a high level of uncompensated care even though it provides a higher percentage of services to Medicaid and uninsured individuals and has a greater total qualifying uncompensated care costs than another hospital that does qualify as having a high level of uncompensated care. *"Specifically, Hospital A has $20 million in total hospital costs, $11 million in DSH-eligible Medicaid and uninsured costs, and $5 million in uncompensated care cost. Hospital B has $50 million in total hospital costs, $2 million in DSH-eligible Medicaid and uninsured costs, and $1 million in uncompensated care cost. Assuming the weighted mean uncompensated care cost level in the state is 50 percent, Hospital B would be considered to have high level of uncompensated care and Hospital A would not. Given that Hospital A has 5 times the total uncompensated care of Hospital B and serves a much higher percentage of Medicaid and uninsured individuals, the results of this scenario are counter to the intent of the methodology."*

To address its concern, CMS proposes to modify the DSH reporting requirements in order to collect total hospital cost from Medicare cost report data for all DSH hospitals. (As discussed earlier, the regulatory requirements for state DSH reporting would be modified to require reporting of Medicaid and Medicare provider numbers and total annual costs incurred by each hospital for furnishing inpatient and outpatient hospital services. However, the proposed regulatory text does not specific the Medicare cost report as the source for the cost data.) Through separately issued rulemaking for FY 2016 and thereafter, CMS intends to substitute total cost for the denominator in step 1 of the HUF calculation. Because total cost is not currently available, CMS seeks comments

on alternatives to the use of total uncompensated care in the denominator to alleviate the data limitations.

CMS believes the proposed HUF calculation captures the goal of tying the level of DSH reductions to the state's targeting of DSH payments to hospitals with high levels of uncompensated care. However, citing data limitations, it states that the proposed methodology does not precisely distinguish how states direct DSH payments among High Uncompensated Care Hospitals, and welcomes comments on alternative methodologies.

Factor 5: Section 1115 Budget Neutrality Factor. The ACA requires that the DSH reduction methodology 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 demonstration as of July 31, 2009. These states are provided full DSH allotments, but the terms of the demonstration may limit the authority of the state to make DSH payments to hospitals because all or a portion of the DSH allotment was included in the budget neutrality adjustment calculation under a section 1115 demonstration or to fund uncompensated care pools or safety net care pools. For these states, DSH payments are limited to the allotment less any allotment amounts included in the budget neutrality calculation

CMS proposes to exclude from DSH allotment reduction for the HMF and HUF factors the amount of DSH allotment that each state currently continues to divert for coverage expansion in the budget neutrality calculation. DSH allotment amounts included in the budget neutrality calculation for other purposes, including uncompensated care pools and safety net pools, would still be subject to reduction. For a section 1115 coverage demonstration not approved as of July 31, 2009, all DSH allotment amounts would be subject to reduction. CMS proposes that for the non-excluded amounts, it would assign an average reduction amount based on the state group. Comments are sought on the specifics of the proposed approach for this factor and alternatives.

In the illustrative table included in the proposed rule, CMS identifies four states as potentially affected by this adjustment: District of Columbia, Maine, Massachusetts, and Wisconsin. CMS notes that the states affected may change over time depending on how coverage continues to be financed.

Impact Analysis and Related Information

CMS estimates that the proposed DSH allotment reductions for FYs 2014 and 2015 would affect the ability of some or all states to maintain DSH payments at FY 2013 levels. However, CMS cannot estimate the effect on hospitals. States would retain the flexibility of setting DSH payment methodologies, and CMS notes that states could choose to apply reductions proportionately across hospitals or to modify payment methods in order to target reductions to hospitals that do not have a high volume of Medicaid inpatients or high level of uncompensated care.

The proposed rule includes an illustrative table (Table 1), showing state-level effects of the proposed methodology for allocating the DSH reduction amounts among the states. Table 1 is reproduced here as an attachment to this summary. Note that the table incorrectly identifies Arizona as a low-DSH state and omits Arkansas as a low-DSH state.

The proposed rule table shows that the $500 million required DSH allotment reduction for FY 2014 represents a 4.3 percent reduction in aggregate DSH allotments – 4.4 percent for the non-low DSH state group in the aggregate and 1.2 percent for the low-DSH states. Across individual non-low DSH states, the CMS estimated reductions range from 1.86 percent (Nevada) to 6.26 percent (Connecticut). The largest reduction – 7.14 percent – is shown for Arkansas, but as noted above Arkansas is incorrectly included in the table as a non-low DSH state. Among the low-DSH states, the highest percentage reduction in the FY 2014 DSH allotment is 2.29 percent (Hawaii) and several states show a reduction of less than 1 percent.

ATTACHMENT: ILLUSTRATIVE TABLE 1 REPRODUCED FROM THE PROPOSED RULE

NOTE: The table as published in the proposed rule and reproduced here incorrectly identifies Arizona as a low-DSH state and omits Arkansas as a low-DSH state.

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		33.3%	33.3%	33.3%	100.0%		
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351		
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000		
A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor* Col J, UPF WS	Reduction Based on HMF High Volume Factor* Col O , HMF WS	Reduction Based On HUF High Level Factor* Col O, HUC WS	Total Reduction* C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment* F/B	FY 2014 Reduced Allotment* B - F
Alabama	$327,306,706	$4,450,693	$6,450,832	$5,965,703	$16,867,229	5.15%	$310,439,477
Arkansas	$107,771,720	$1,225,578	$2,320,621	$4,144,131	$7,690,330	7.14%	$100,081,389
California	$1,166,861,709	$12,496,019	$19,339,288	$787,771	$32,623,078	2.80%	$1,134,238,632
Colorado	$98,458,114	$1,227,835	$953,242	$3,262,103	$5,443,181	5.53%	$93,014,933
Connecticut	$212,882,410	$4,646,855	$4,209,148	$4,474,769	$13,330,772	6.26%	$199,551,638
District of Columbia /1	$65,195,237	$1,703,076	$463,119	$844,089	$3,010,283	4.62%	$62,184,954
Florida	$212,882,410	$1,987,539	$2,887,967	$5,215,949	$10,091,455	4.74%	$202,790,954
Georgia	$286,060,738	$2,882,526	$3,130,957	$5,060,927	$11,074,410	3.87%	$274,986,328
Illinois	$228,848,590	$3,298,528	$3,645,082	$3,899,617	$10,843,227	4.74%	$218,005,363
Indiana	$227,518,076	$3,045,530	$3,282,746	$1,280,446	$7,608,722	3.34%	$219,909,354
Kansas	$43,906,997	$627,702	$922,471	$683,318	$2,233,492	5.09%	$41,673,505
Kentucky	$154,339,747	$2,009,128	$2,429,559	$2,068,748	$6,507,436	4.22%	$147,832,311
Louisiana	$731,960,000	$8,157,359	$12,281,637	$4,906,454	$25,345,450	3.46%	$706,614,550

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*					
FOR ILLUSTRATION PURPOSES ONLY - FY 2014 DSH HEALTH REFORM METHODOLOGY							
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		33.3%	33.3%	33.3%	100.0%		
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351		
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000		

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor* Col J, UPF WS	Reduction Based on HMF High Volume Factor* Col O , HMF WS	Reduction Based On HUF High Level Factor* Col O, HUC WS	Total Reduction* C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment* F/B	FY 2014 Reduced Allotment* B - F
Maine /1	$111,763,265	$2,189,425	$1,324,174	$2,413,463	$5,927,063	5.30%	$105,836,203
Maryland	$81,161,419	$1,430,089	$1,639,479	$1,726,902	$4,796,470	5.91%	$76,364,948
Massachusetts /1	$324,645,675	$14,612,915	$1,031,865	$1,076,550	$16,721,329	5.15%	$307,924,346
Michigan	$282,069,193	$4,528,369	$3,256,081	$5,661,017	$13,445,466	4.77%	$268,623,727
Mississippi	$162,322,837	$1,771,408	$1,928,694	$715,775	$4,415,876	2.72%	$157,906,961
Missouri	$504,265,209	$7,606,111	$7,179,807	$11,117,502	$25,903,421	5.14%	$478,361,788
Nevada	$49,229,057	$432,077	$226,353	$258,039	$916,469	1.86%	$48,312,588
New Hampshire	$170,410,795	$3,039,010	$2,714,290	$2,903,827	$8,657,127	5.08%	$161,753,668
New Jersey	$685,215,257	$10,273,222	$9,989,871	$9,086,087	$29,349,180	4.28%	$655,866,077
New York	$1,709,711,855	$28,517,869	$17,330,775	$19,682,882	$65,531,526	3.83%	$1,644,180,330
North Carolina	$314,001,555	$3,717,078	$6,628,232	$3,952,052	$14,297,361	4.55%	$299,704,194
Ohio	$432,417,395	$6,970,234	$6,496,637	$9,942,522	$23,409,393	5.41%	$409,008,002
Pennsylvania	$597,401,262	$11,667,972	$9,874,704	$12,323,972	$33,866,647	5.67%	$563,534,615
Rhode Island	$69,186,783	$1,128,516	$1,332,369	$1,002,242	$3,463,128	5.01%	$65,723,655
South Carolina	$348,594,946	$3,947,977	$5,769,094	$3,995,248	$13,712,319	3.93%	$334,882,628

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*				
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL	
		33.3%	33.3%	33.3%	100.0%	
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649	
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351	
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000	

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor* Col J, UPF WS	Reduction Based on HMF High Volume Factor* Col O , HMF WS	Reduction Based On HUF High Level Factor* Col O, HUC WS	Total Reduction* C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment* F/B	FY 2014 Reduced Allotment* B - F
Tennessee	$54,007,000	$746,901	$860,219	$920,288	$2,527,408	4.68%	$51,479,592
Texas	$1,017,844,022	$8,522,124	$18,255,733	$29,359,012	$56,136,869	5.52%	$961,707,154
Vermont	$23,949,271	$590,875	$434,558	$276,383	$1,301,816	5.44%	$22,647,455
Virginia	$93,250,559	$1,416,841	$1,718,425	$1,230,356	$4,365,622	4.68%	$88,884,936
Washington	$196,916,230	$2,744,350	$3,136,466	$3,355,484	$9,236,300	4.69%	$187,679,929
West Virginia	$71,847,813	$977,152	$1,144,386	$995,254	$3,116,792	4.34%	$68,731,021
Total Regular DSH States	$11,164,203,854	$164,588,883	$164,588,883	$164,588,883	$493,766,649	4.42%	$10,670,437,205
LOW DSH STATES							
Alaska	$21,681,747	$51,937	$173,996	$87,475	$313,408	1.45%	$21,368,340
Arizona	$45,916,375	$129,368	$129,235	$42,155	$300,758	0.66%	$45,615,618
Delaware	$9,636,331	$47,282	$0	$0	$47,282	0.49%	$9,589,049
Hawaii	$10,393,800	$62,676	$70,765	$104,311	$237,752	2.29%	$10,156,048
Idaho	$17,496,274	$46,880	$111,960	$50,217	$209,057	1.19%	$17,287,217

		*FOR ILLUSTRATION PURPOSES ONLY - FY 2014 DSH HEALTH REFORM METHODOLOGY					
		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		33.3%	33.3%	33.3%	100.0%		
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351		
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000		

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor* Col J, UPF WS	Reduction Based on HMF High Volume Factor* Col O , HMF WS	Reduction Based On HUF High Level Factor* Col O, HUC WS	Total Reduction* C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment* F/B	FY 2014 Reduced Allotment* B - F
Iowa	$41,917,760	$214,084	$75,590	$115,863	$405,536	0.97%	$41,512,224
Minnesota	$79,499,739	$416,944	$257,348	$623,061	$1,297,353	1.63%	$78,202,386
Montana	$12,081,903	$33,172	$68,731	$89,562	$191,465	1.58%	$11,890,437
Nebraska	$30,120,968	$124,314	$238,785	$249,312	$612,411	2.03%	$29,508,557
New Mexico	$21,681,747	$52,589	$168,797	$52,617	$274,003	1.26%	$21,407,744
North Dakota	$10,167,243	$49,497	$60,321	$13,300	$123,117	1.21%	$10,044,126
Oklahoma	$38,545,326	$97,193	$110,492	$391,760	$599,445	1.56%	$37,945,882
Oregon	$48,181,658	$133,619	$381,129	$9,220	$523,968	1.09%	$47,657,690
South Dakota	$11,756,055	$45,126	$70,228	$36,545	$151,899	1.29%	$11,604,156
Utah	$20,881,618	$64,735	$159,292	$211,938	$435,965	2.09%	$20,445,653
Wisconsin /1	$100,621,875	$507,599	$0	$0	$507,599	0.50%	$100,114,275
Wyoming	$240,907	$768	$1,115	$448	$2,331	0.97%	$238,576
Total Low DSH States	$520,821,329	$2,077,784	$2,077,784	$2,077,784	$6,233,351	1.20%	$514,587,978

	ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*				
	Total Reduction:	**Uninsured Factor UPF**	**Hi Volume Factor HMF**	**High Level Factor HUF**	**TOTAL**
		33.3%	**33.3%**	**33.3%**	**100.0%**
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649
LOW DSH Adj. Factor	**Total Low DSH Reduction:**	$2,077,784	$2,077,784	$2,077,784	$6,233,351
27.97%	**TOTAL:**	$166,666,667	$166,666,667	$166,666,667	$500,000,000

A	B	C	D	E	F	G	H
STATE	**Unreduced FY 2014 DSH Allotment (Estimate)***	**Reduction Based on UPF Uninsured Factor***	**Reduction Based on HMF High Volume Factor***	**Reduction Based On HUF High Level Factor***	**Total Reduction***	**Reduction Amount As Percentage of Unreduced DSH Allotment***	**FY 2014 Reduced Allotment***
		Col J, UPF WS	**Col O , HMF WS**	**Col O, HUC WS**	**C + D + E**	**F/B**	**B - F**
National Total	$11,685,025,183	$166,666,667	$166,666,667	$166,666,667	$500,000,000	4.28%	$11,185,025,183

Notes:
*All of the values on this chart are only for purposes of illustrating the DSH Health
Reform Methodology (DHRM)
/1 Potential DSH Diversion State