

**Medicaid Program; State Disproportionate Share Hospital Allotment Reductions
(CMS-2394-P)
Proposed Rule Summary**

August 4, 2017 (corrected)

On July 27, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule delineating a methodology for implementing reductions in state disproportionate share hospital (DSH) allotments as required by section 2551 of the Patient Protection and Affordable Care Act (ACA). The rule was published in the *Federal Register* (82 *FR* 35163) on July 28, 2017. Comments on the proposed rule are due to CMS by 5pm on August 28, 2017.

The proposed rule would amend existing regulations in 42 CFR Part 447, Subpart E addressing reductions in state Medicaid DSH allotments. It proposes a DSH Health Reform Methodology (DHRM) for making allotment reductions beginning in FY 2018 and thereafter.

The process for distributing DSH reductions among states as proposed under this rule is almost identical to the approach finalized in 2013 ((78 *FR* 57293) with a major exception. Under the proposed methodology, the impact of the DSH reductions is lessened for states with higher rates of uninsurance. In emphasizing uninsurance, this approach would de-emphasize the importance of how well states target DSH payments to high-Medicaid and high-uncompensated care hospitals.

I. Legislative History and 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.¹ 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. State allotments are increased each year by the Consumer Price Index.²

¹ The regulations implementing section 1923 of the Act, which are amended by this final rule, are found in 42 CFR, Chapter IV, Part 447, Subpart E. A review of federal DSH law and regulations and state DSH expenditures is provided by the Congressional Research Service, *Medicaid Disproportionate Share Hospital Payments*, June 2016.

² DSH allotments were also raised for FY 2009 and FY 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 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 October 26, 2016 (81 *FR* 74432) provides final allotments for FY 2014 and preliminary allotments for FY 2016.

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 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 (LIUR) in excess 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.

Under the ACA, there was an expectation that there would be fewer uninsured individuals and hospitals would experience lower levels of uncompensated care. In anticipation of those effects, Section 2551 of the ACA amended Medicaid DSH payment allotments to provide for reductions in the federal funding available for DSH payments for each of the 50 states and the District of Columbia. Section 2551 of the ACA required annual aggregate reductions for FY 2014 through FY 2020. Subsequent legislation extended the reductions for additional years, modified the amount of the reductions, and delayed the start of the reductions until FY 2018. The most recent amendments to the DSH allotment reductions were in the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) enacted in April of 2015.

Currently, the aggregate annual reduction amounts are:

| Aggregate Reductions in Medicaid State DSH Allotments under the ACA | |
|--|---------------------------------------|
| Fiscal year | Reduction (in \$ billions) |
| 2018 | 2.0 |
| 2019 | 3.0 |
| 2020 | 4.0 |
| 2021 | 5.0 |
| 2022 | 6.0 |
| 2023 | 7.0 |
| 2024 | 8.0 |
| 2025 | 8.0 |

See 82 *FR* 35157; Medicaid Program; State Disproportionate Share Hospital Allotment Reductions (CMS-2394-P)

The ACA also specifies certain factors that must be taken into account by the Secretary in developing the DHRM for distributing the reductions among the states.³ In 2013, CMS published a final rule (78 *FR* 57293) describing a DHRM to be used to distribute the DSH reductions among the states for two years: FY 2014 and FY 2015. At the time, CMS sought comments on whether states' coverage expansions under the ACA should be accounted for in the DHRM. In the preamble of the final rule, it indicated that it received many comments in opposition to accounting for the coverage expansion and several comments in support of doing so and in finalizing a methodology applicable for only two years it was providing itself additional time to re-evaluate the methodology and to alter the DHRM for subsequent years. CMS notes that as a result of the additional time since the 2013 rule, and in light of improved data sources, it is proposing a new approach for the DHRM as described below.

The data sources available to CMS to incorporate into the DHRM are:

- DSH Medicaid Inpatient Utilization Rate (MIUR) data, reported to CMS annually under §447.294(d).
- Medicaid DSH Audit and Reporting Data required to be reported by states under section 1923(j) of the Act. CMS notes that this is the only comprehensive data source for DSH hospitals and identifies hospital-specific DSH payments and uncompensated care costs in a consistent manner.
- U.S. Census Bureau data, and more specifically, the American Community Survey (ACS) data to target the largest percentage DSH allotment reductions on states with the lowest percentages of uninsured individuals as required by statute.

³ Under Section 1923(f)(7)(B), 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. 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.

DSH Health Reform Methodology (DHRM) for FY 2018 and Subsequent Years

The methodology proposed in this rule for distributing the DSH reductions among the states would involve a series of steps and calculations. First, prior to the start of a fiscal year, CMS would estimate an unreduced DSH allotment for each state following the requirements of section 1923(f) without regard to the ACA reductions. To make adjustments for the reductions CMS would:

1. Separate states into two groups, one consisting of the low-DSH states, and the second consisting of all other (non low-DSH) states. In an illustrative example provided by CMS (and summarized below), there would be 17 low-DSH states.

CMS notes that in this proposed rule it is using estimated unreduced DSH allotments for FY 2017 for illustrative purposes, but it anticipates that more recent data will be available when final allotment reductions are calculated and communicated.

2. Proportionately allocate aggregate DSH reduction amounts to the two groups of states based on each group's proportion of total national unreduced DSH allotments.
3. Apply the low DSH adjustment percentage which has the result of shifting a greater portion of the aggregate DSH reduction amount from low-DSH states to other states.
4. Apply weighting factors. As 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. To accomplish that objective, CMS proposes using the following weights for the three statutory factors that are required to be taken into account in distributing the reduction among states:
 - 50% based on the Uninsured Percentage Factor (UPF)
 - 25% based on the High Level of Uncompensated Care Factor (HUF); and
 - 25% based on the High Volume of Medicaid Inpatients Factor (HMF).

Relative to the approach finalized in 2013 in which each of those factors had a weight of 1/3, this approach puts greater emphasis on the UPF, reducing the impact of the DSH reductions on states with higher rates of uninsurance. CMS notes that it would also give greater weight to more recent data because the UPF would use more recent data than the other factors. The new approach, however, de-emphasizes the importance of how well states target DSH payments to high-Medicaid and high-uncompensated care hospitals.

5. Limit the reduction amounts applied to states to 90% of each state's unreduced DSH allotment to ensure that each state is able to retain at least some ability to continue to make DSH payments. The portion of the statutory reduction that is not applied to states because of this rule would be redistributed to the other states within each group ((low-DSH states and others)) based on the proportion of each remaining state's allotment reduction amount to the aggregate allotment reduction amount for the group.

CMS notes that this step was not needed in the 2013 DHRM because allotment reduction amounts that would have applied in FYs 2014 and 2015 were smaller than the amount of the reductions for 2018 and thereafter. The larger reductions required for 2018 and later places some states at risk of having their entire DSH programs eliminated.

6. – 8. Determine each state's UPF, HUF, and HMF.
9. Adjust for any state with a budget neutrality requirement under an existing section 1115 research and demonstration waiver. The statute requires that for states with a coverage expansion approved under section 1115 as of July 31, 2009, the DHRM must take into account the extent to which the state's DSH allotment was included in the section 1115 budget neutrality adjustment. This ensures that any DSH amount that such states divert specifically for coverage expansion in their budget neutrality calculation is excluded from reductions under this methodology.
10. Identify each state-specific DSH allotment reduction amount.
11. Subtract that amount from each state's unreduced allotment to determine their available DSH allotment for the applicable year.

Details of Proposed DSH Health Reform Methodology

CMS proposes to begin 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.**

Low-DSH adjustment factor (LDF). The ACA requires that a smaller percentage reduction be imposed on low-DSH states than others. CMS proposes to calculate this adjustment by first separating the states into two groups: low-DSH states, and all others. The DSH allotment reduction amount would then 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. Using these figures, this step of the calculation

would therefore assign 4.5 percent of the total DSH reductions (about \$90 million) to be distributed among the low-DSH group and the remaining \$1.91 billion 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 (duplicated below), CMS reported that the estimated result of this calculation is an LDF of 27.83 percent.

The original proportionately allocated DSH reduction for the low DSH states would be multiplied by the LDF, and that result is 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 proposed rule illustrative figures, the \$90 million would be multiplied by 27.83 percent, and the resulting \$24.9 million would be the total reduction distributed among low-DSH states. The balance (\$2 billion minus \$24.9 million, or \$1.975 billion) would be distributed among the other states.

| Proposed DSH Health Reform Methodology: Overview of Key Steps in Allocation of DSH Allotment Reductions Figures based on NPRM Illustrative Table 1 | | |
|--|---|---|
| Starting Point: Aggregate amounts for FY 2017 | | |
| Total illustrative DSH allotment reduction | \$2.0 billion | |
| Total estimated unreduced DSH allotments | \$12.0 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 2017 DSH allotment (CMS estimates) | \$537 million | \$11.46 billion |
| Proportion of estimated unreduced FY 2017 DSH allotment | 4.5% ($\$537 \text{ m} / \12.0 b) | 95.5% ($\$11.46 \text{ b} / \12.0 b) |
| Proportionally Allocate \$2 billion FY 2017 DSH allotment reduction between the two state groups | \$90 million ($4.5\% \times \2 billion) | \$1.91 billion ($95.5\% \times \2 billion) |
| Apply low DSH adjustment factor (LDF), estimated to be 27.83%, to determine total group DSH Reduction | Adjusted total group allotment reduction: \$24.9 million ($27.83\% \times \90 million) | Adjusted total group allotment reduction: \$1.975 billion ($\$2 \text{ billion} - \24.9 million) |
| Step 2. Allocate each group's total DSH allotment reduction among hospitals in the group, based on three factors weighted at 50% (UPF); 25% (HMF); and 25% (HUF) | | |
| A. Uninsured Percentage Factor (UPF) weight = 50% | \$12.5 million | \$988 million |
| B. High Volume of Medicaid Inpatients Factor (HMF) weight = 25% | \$6.2 million | \$494 million |
| C. High Uncompensated Care Factor (HUF) weight = 25% | \$6.2 million | \$494 million |
| Sum of reductions for all three factors (A+B+C, equal to adjusted total group allotment reduction above) | \$24.9 million | \$1.975 million |
| Resulting Reduced DSH Allotments | \$512.3 million | \$9.5 billion |
| Notes: Sums do not add to total due to rounding. Further adjustments would take into account DSH allotments in states with expansion waivers as of July 31, 2009 and for states for which the reduction caps applies (step 5 above). | | |

Factor 2: Uninsured Percentage Factor (UPF). The ACA requires that a larger percentage DSH allotment reduction 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 proposes 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, which would be used to distribute one-half (50 percent) of the total DSH reduction for each of the two state groups (low-DSH states and others). Using the figures from the proposed rule illustrative table, one-half of the \$24.9 million total DSH allotment reduction to low-DSH states, or about \$12.5 million, would be based on the UPF, as would one-half of the total \$1.975 billion reduction to other states, or \$988 million.

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 would result in a percentage for each state, and for each of the two state groups, the percentages would 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 for a state is calculated by multiplying the state’s UPF by the aggregate DSH allotment reduction allocated to the UPF factor for the state group using the (one-half) weighting factor described earlier. (In the proposed rule illustrative table, this amounts to \$12.5 million for the 17 low-DSH states and \$988 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-quarter (25 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 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 “federally deemed” hospitals to which a state must provide DSH payments in order to receive federal matching funds for DSH payments. CMS notes that the 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 would rely in part on MIUR information collected from states on an annual basis. CMS has initiated collection, and 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 (§447.299(c)(17)) and the MIUR for each DSH (§447.299(c)(3)).

The HMF is a state-specific percentage that CMS proposes to compute 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, 25 percent of the total DSH allotment reduction for each state group would be distributed based on the HMF.

CMS notes that under this methodology a number of interactions could occur for states among the DSH payment methodologies, DSH allotment and DSH allotment reductions. It 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 HUF would be used to distribute the remaining 25 percent of the DSH allotment reduction for each of the two state groups. CMS proposed 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.⁴ The most recent available DSH audit and reporting data provided by states will be used. Specifically, CMS would use the following amounts reported by states for each DSH: DSH payment amount (§447.299(c)(17)), uncompensated care amount (§447.299(c)(16)), total Medicaid cost amount (§447.299(c)(10)), total uninsured cost amount (§447.299(c)(14)), and total hospital cost amount (§447.299(c)(20)). CMS notes that as required by the statute, the uncompensated care data used in this factor 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 proposes to calculate the HUF 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 total hospital cost. This data element would come from the state's most recent accepted DSH audit template.
2. Calculate the mean uncompensated care level for each state.
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. **CMS is also considering identifying a metric higher than the mean for the purposes of those hospitals and is specifically seeking comments on alternate methodologies for this step.**
4. Determine the amount of DSH payments in each state that are paid to non-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 aggregate amount of DSH payment made

⁴ 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.

- to non-high uncompensated care level hospitals for the entire state group.
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, 25 percent of the total DSH allotment reduction for each state group would be distributed based on the HUF.

In the preamble, CMS notes that in the 2013 DSH allotment reduction final rule there were potential scenarios where interactions in the methodology would have resulted in outcomes inconsistent with the intent of the approach. In the 2013 approach, for example, there could have been a hospital that would not have been considered to have a higher level of uncompensated care even though it provided a higher percentage of services to Medicaid and uninsured individuals and had greater total qualifying uncompensated care costs than another hospital that did qualify as having a high level of uncompensated care. CMS believes it has addressed this problem by dividing, in step 1, by *total hospital costs* instead of by the *sum of a hospital's Medicaid and uninsured costs* as finalized in 2013.

CMS seeks comments on whether its proposed DHRM and the implementation of the HUF would be effective in tying the level of DSH reductions to the targeting of DSH payments to hospitals with high levels of uncompensated care. Taking into account data limitations and that the proposed methodology does not precisely distinguish how states direct DSH payments among hospitals that are identified as at or above the mean uncompensated care level, it is soliciting comments on alternative methodologies regarding state targeting of DSH payments to hospitals with high levels of uncompensated care.

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, for the specific fiscal year subject to reduction, in calculating the DSH allotment reduction for the HMF and HUF factors, the amount of DSH allotment included in the budget neutrality calculation for coverage expansion. 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.

For the non-excluded amounts, an average reduction amount would be assigned based on the state group. CMS considered using alternative percentages for this assignment that would be higher or lower than the average but was concerned that alternative percentages might provide an unintended benefit or penalty to states with DSH diversions approved under section 1115 of the Act. **It is seeking comment regarding the use of different percentages for the reductions to diversion amounts that do not qualify under the budget neutrality factor and alternative budget neutrality factor methodologies.**

CMS proposes to determine for each reduction year if any portion of a state's allotment should be subject to this provision. To qualify annually, CMS and the state would have to have included the state's DSH allotment in the budget neutrality calculation for a coverage expansion that was approved under section 1115 of the Act as of July 31, 2009, and the coverage expansion would have to still exist in the approved section 1115 demonstration at the time that reduction amounts are calculated for the fiscal year. If a state subsequently reduced this amount, the approved amount remaining under the section 1115 would not be subject to reduction.

Impact Analysis and Related Information

CMS estimates that the DSH allotment reductions beginning in FY 2018 would affect the ability of some or all states to maintain DSH payments at their FY 2017 levels. By statute, the reductions will total \$43 billion for FYs 2018 through FY 2025. However, CMS says it cannot estimate the precise federal financial effect on states or hospitals because of the complexity of the interaction between the DHRM methodology, state DSH allotments, and future state changes to DSH methodologies. CMS points believes that the proposed DHRM attempts to mitigate the negative impact on states that continue to have high percentages of uninsured and are targeting DSH to hospitals with high volume of Medicaid patients and high uncompensated care. States 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 Table 1 showing illustrative state-level effects of the proposed methodology for allocating the DSH reduction amounts among the states. It is reproduced here as an attachment to this summary.

ATTACHMENT: ILLUSTRATIVE TABLE 1 REPRODUCED FROM THE PROPOSED RULE

TABLE 1: FY 2017 DSH HEALTH REFORM METHODOLOGY

| *FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY | | | | | |
|---|--|----------------------|----------------------|-----------------------|-----------------|
| | ILLUSTRATIVE DSH Reduction Factor Weighting Allocation | | | | |
| | Total Reduction: | Uninsured Factor UPF | Hi Volume Factor HMF | High Level Factor HUF | TOTAL |
| | | 50.00% | 25.00% | 25.00% | 100.00% |
| | Total Reg. DSH Reduction: | \$987,536,279 | \$493,768,140 | \$493,768,140 | \$1,975,072,559 |
| LOW DSH Adj. Factor | Total Low DSH Reduction: | \$12,463,721 | \$6,231,860 | \$6,231,860 | \$24,927,441 |
| 27.83% | TOTAL: | \$1,000,000,000 | \$500,000,000 | \$500,000,000 | \$2,000,000,000 |

| A | B | C | D | E | F | G | H |
|----------------------|---|---|---|--|----------------------------------|---|--|
| STATE | Unreduced FY 2017 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 C + D + E | Reduction Amount As Percentage of Unreduced DSH Allotment F/B | FY 2017 Reduced Allotment B - F |
| Alabama | \$337,648,430 | \$24,336,783 | \$22,311,475 | \$12,205,968 | \$58,854,226 | 17.43% | \$278,794,204 |
| Arizona | \$111,176,922 | \$7,137,605 | \$3,547,314 | \$540,535 | \$11,225,454 | 10.10% | \$99,951,468 |
| California | \$1,203,730,377 | \$84,684,522 | \$27,524,140 | \$41,213,794 | \$153,422,456 | 12.75% | \$1,050,307,921 |
| Colorado | \$101,569,041 | \$8,631,358 | \$7,177,442 | \$2,752,327 | \$18,561,127 | 18.27% | \$83,007,914 |
| Connecticut | \$219,608,734 | \$27,749,875 | \$8,953,379 | \$12,499,484 | \$49,202,738 | 22.40% | \$170,405,996 |
| District of Columbia | \$67,255,174 | \$11,161,638 | \$948,482 | \$4,788,317 | \$16,898,437 | 25.13% | \$50,356,737 |
| Florida | \$219,608,734 | \$11,604,440 | \$7,724,576 | \$14,761,318 | \$34,090,334 | 15.52% | \$185,518,400 |
| Georgia | \$295,099,237 | \$16,322,138 | \$9,642,846 | \$10,330,646 | \$36,295,629 | 12.30% | \$258,803,608 |

***FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY**

| | | ILLUSTRATIVE DSH Reduction Factor Weighting Allocation | | | | | |
|---------------------------|-----------------|--|----------------------|-----------------------|-----------------|-----------------|-----------------|
| Total Reduction: | | Uninsured Factor UPF | Hi Volume Factor HMF | High Level Factor HUF | TOTAL | | |
| | | 50.00% | 25.00% | 25.00% | 100.00% | | |
| Total Reg. DSH Reduction: | | \$987,536,279 | \$493,768,140 | \$493,768,140 | \$1,975,072,559 | | |
| LOW DSH Adj. Factor | | Total Low DSH Reduction: | \$12,463,721 | \$6,231,860 | \$6,231,860 | \$24,927,441 | |
| 27.83% | TOTAL: | | \$1,000,000,000 | \$500,000,000 | \$500,000,000 | \$2,000,000,000 | |
| A | B | C | D | E | F | G | H |
| Illinois | \$236,079,390 | \$21,211,561 | \$21,228,808 | \$2,226,180 | \$44,666,550 | 18.92% | \$191,412,840 |
| Indiana | \$234,706,837 | \$17,212,117 | \$7,854,285 | \$2,660,409 | \$27,726,811 | 11.81% | \$206,980,026 |
| Kansas | \$45,294,302 | \$3,871,800 | \$3,187,693 | \$1,866,967 | \$8,926,460 | 19.71% | \$36,367,842 |
| Kentucky | \$159,216,333 | \$16,485,287 | \$7,021,414 | \$6,556,338 | \$30,063,039 | 18.88% | \$129,153,294 |
| Louisiana | \$752,888,159 | \$44,629,718 | \$8,761,366 | \$28,576,335 | \$81,967,418 | 10.89% | \$670,920,741 |
| Maine | \$115,294,586 | \$9,949,588 | \$1,191,719 | \$1,053,779 | \$12,195,085 | 10.58% | \$103,099,501 |
| Maryland | \$83,725,829 | \$9,314,506 | \$3,064,435 | \$2,498,384 | \$14,877,325 | 17.77% | \$68,848,504 |
| Massachusetts | \$334,903,321 | \$89,406,469 | \$8,587,673 | \$7,322,652 | \$105,316,795 | 31.45% | \$229,586,526 |
| Michigan | \$290,981,574 | \$29,838,010 | \$17,552,322 | \$19,346,010 | \$66,736,341 | 22.93% | \$224,245,233 |
| Mississippi | \$167,451,660 | \$10,119,288 | \$4,755,050 | \$2,557,905 | \$17,432,243 | 10.41% | \$150,019,417 |
| Missouri | \$520,198,191 | \$39,063,452 | \$29,634,901 | \$23,891,614 | \$92,589,967 | 17.80% | \$427,608,224 |
| Nevada | \$50,784,519 | \$2,924,122 | \$436,562 | \$544,246 | \$3,904,930 | 7.69% | \$46,879,589 |
| New Hampshire | \$175,795,169 | \$16,765,244 | \$2,912,141 | \$2,025,265 | \$21,702,651 | 12.35% | \$154,092,518 |
| New Jersey | \$706,865,615 | \$56,618,281 | \$44,292,058 | \$52,834,997 | \$153,745,336 | 21.75% | \$553,120,279 |
| New York | \$1,763,732,651 | \$177,505,591 | \$78,224,710 | \$73,714,317 | \$329,444,617 | 18.68% | \$1,434,288,034 |
| North Carolina | \$323,922,884 | \$21,676,870 | \$14,090,407 | \$20,538,422 | \$56,305,699 | 17.38% | \$267,617,185 |

| *FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY | | | | | | | |
|---|--------------------------|--|----------------------|-----------------------|-----------------|--------|-----------------|
| | | ILLUSTRATIVE DSH Reduction Factor Weighting Allocation | | | | | |
| Total Reduction: | | Uninsured Factor UPF | Hi Volume Factor HMF | High Level Factor HUF | TOTAL | | |
| | | 50.00% | 25.00% | 25.00% | 100.00% | | |
| Total Reg. DSH Reduction: | | \$987,536,279 | \$493,768,140 | \$493,768,140 | \$1,975,072,559 | | |
| LOW DSH Adj. Factor | Total Low DSH Reduction: | \$12,463,721 | \$6,231,860 | \$6,231,860 | \$24,927,441 | | |
| 27.83% | TOTAL: | \$1,000,000,000 | \$500,000,000 | \$500,000,000 | \$2,000,000,000 | | |
| A | B | C | D | E | F | G | H |
| Ohio | \$446,080,243 | \$46,702,161 | \$25,434,391 | \$29,795,707 | \$101,932,258 | 22.85% | \$344,147,985 |
| Pennsylvania | \$616,277,012 | \$63,782,334 | \$32,922,465 | \$24,331,996 | \$121,036,794 | 19.64% | \$495,240,218 |
| Rhode Island | \$71,372,839 | \$8,426,370 | \$6,425,719 | \$1,860,620 | \$16,712,709 | 23.42% | \$54,660,130 |
| South Carolina | \$359,609,303 | \$23,233,999 | \$22,965,009 | \$23,842,222 | \$70,041,229 | 19.48% | \$289,568,074 |
| Tennessee* | \$0 | \$0 | \$0 | \$0 | \$0 | 0.00% | \$0 |
| Texas | \$1,050,004,264 | \$48,245,203 | \$50,044,327 | \$49,773,279 | \$148,062,808 | 14.10% | \$901,941,456 |
| Vermont | \$24,705,984 | \$4,369,886 | \$1,875,609 | \$775,093 | \$7,020,587 | 28.42% | \$17,685,397 |
| Virginia | \$96,196,942 | \$7,735,598 | \$122,311 | \$3,188,924 | \$11,046,833 | 11.48% | \$85,150,109 |
| Washington | \$203,138,079 | \$19,249,651 | \$12,038,303 | \$10,449,879 | \$41,737,833 | 20.55% | \$161,400,246 |
| West Virginia | \$74,117,949 | \$7,570,819 | \$1,314,810 | \$2,444,211 | \$11,329,840 | 15.29% | \$62,788,109 |
| Total Regular DSH States | \$11,459,040,284 | \$987,536,279 | \$493,768,140 | \$493,768,140 | \$1,975,072,559 | 17.24% | \$9,483,967,725 |
| LOW DSH STATES | | | | | | | |
| Alaska | \$22,366,812 | \$258,424 | \$851,319 | \$136,279 | \$1,246,022 | 5.57% | \$21,120,790 |
| Arkansas | \$47,367,170 | \$799,743 | \$33,070 | \$1,146,287 | \$1,979,100 | 4.18% | \$45,388,070 |
| Delaware | \$9,940,805 | \$254,209 | \$205,569 | \$94,226 | \$554,005 | 5.57% | \$9,386,800 |

***FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY**

| | | ILLUSTRATIVE DSH Reduction Factor Weighting Allocation | | | | | |
|----------------------|---------------------------|--|----------------------|-----------------------|-----------------|-------|---------------|
| | Total Reduction: | Uninsured Factor UPF | Hi Volume Factor HMF | High Level Factor HUF | TOTAL | | |
| | | 50.00% | 25.00% | 25.00% | 100.00% | | |
| | Total Reg. DSH Reduction: | \$987,536,279 | \$493,768,140 | \$493,768,140 | \$1,975,072,559 | | |
| LOW DSH Adj. Factor | Total Low DSH Reduction: | \$12,463,721 | \$6,231,860 | \$6,231,860 | \$24,927,441 | | |
| 27.83% | TOTAL: | \$1,000,000,000 | \$500,000,000 | \$500,000,000 | \$2,000,000,000 | | |
| A | B | C | D | E | F | G | H |
| Hawaii | \$10,701,306 | \$403,540 | \$326,243 | \$78,866 | \$808,649 | 7.56% | \$9,892,657 |
| Idaho | \$18,049,095 | \$264,628 | \$49,829 | \$87,268 | \$401,724 | 2.23% | \$17,647,371 |
| Iowa | \$43,242,210 | \$1,394,059 | \$115,140 | \$1,361,179 | \$2,870,379 | 6.64% | \$40,371,831 |
| Minnesota | \$82,011,647 | \$2,774,292 | \$218,017 | \$565,875 | \$3,558,184 | 4.34% | \$78,453,463 |
| Montana | \$12,463,647 | \$174,295 | \$522,983 | \$208,536 | \$905,813 | 7.27% | \$11,557,834 |
| Nebraska | \$31,072,684 | \$638,999 | \$157,417 | \$641,315 | \$1,437,730 | 4.63% | \$29,634,954 |
| New Mexico | \$22,366,812 | \$306,213 | \$136,653 | \$45,268 | \$488,134 | 2.18% | \$21,878,678 |
| North Dakota | \$10,488,492 | \$265,499 | \$54,018 | \$11,994 | \$331,511 | 3.16% | \$10,156,981 |
| Oklahoma | \$39,763,220 | \$514,542 | \$1,587,344 | \$446,030 | \$2,547,915 | 6.41% | \$37,215,305 |
| Oregon | \$49,704,028 | \$1,015,201 | \$788,620 | \$931,845 | \$2,735,666 | 5.50% | \$46,968,362 |
| South Dakota | \$12,127,506 | \$245,843 | \$18,050 | \$24,036 | \$287,929 | 2.37% | \$11,839,577 |
| Utah | \$21,541,402 | \$341,688 | \$1,159,479 | \$446,117 | \$1,947,284 | 9.04% | \$19,594,118 |
| Wisconsin | \$103,801,167 | \$2,808,415 | \$436 | \$1,298 | \$2,810,149 | 2.71% | \$100,991,018 |
| Wyoming | \$248,521 | \$4,131 | \$7,674 | \$5,441 | \$17,245 | 6.94% | \$231,276 |
| Total Low DSH States | \$537,256,524 | \$12,463,721 | \$6,231,860 | \$6,231,860 | \$24,927,441 | 4.64% | \$512,329,083 |
| | | | | | | | |

***FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY**

| | | ILLUSTRATIVE DSH Reduction Factor Weighting Allocation | | | | | |
|----------------------------------|---------------------------------|---|-----------------------------|------------------------------|-----------------|----------|-----------------|
| Total Reduction: | | Uninsured Factor UPF | Hi Volume Factor HMF | High Level Factor HUF | TOTAL | | |
| | | 50.00% | 25.00% | 25.00% | 100.00% | | |
| Total Reg. DSH Reduction: | | \$987,536,279 | \$493,768,140 | \$493,768,140 | \$1,975,072,559 | | |
| LOW DSH Adj. Factor | Total Low DSH Reduction: | \$12,463,721 | \$6,231,860 | \$6,231,860 | \$24,927,441 | | |
| 27.83% | TOTAL: | \$1,000,000,000 | \$500,000,000 | \$500,000,000 | \$2,000,000,000 | | |
| A | B | C | D | E | F | G | H |
| National Total | \$11,996,296,808 | \$1,000,000,000 | \$500,000,000 | \$500,000,000 | \$2,000,000,000 | 16.67% | \$9,996,296,808 |

*Under section 1923(f)(6)(A)(vi) of the Act the DSH allotment for Tennessee is established at \$53.1 million per year for FY 2015 through FY 2025. Therefore, Tennessee is not subject to reductions under section 1923(f)(7) of the Act.