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

FINAL RULE SUMMARY

September 17, 2013

On September 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a final 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 (ACA). The rule will be published in the *Federal Register* on September 18, 2013.

The final rule addresses reductions in state Medicaid DSH allotments for FYs 2014 and 2015 only, 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.

The rule adopts the methodologies set forth in a proposed rule published in the May 15, 2013 *Federal Register* (78 FR 28551), with some technical changes. Comments received by CMS on the proposed rule are discussed. A technical guide to the final methodologies will be separately published.

While it adopts methodologies for calculating DSH allotments to the states, this final rule does not set forth the actual state allotments for FY 2014, nor does it include a state-by-state impact analysis or provide illustrative state allotments such as those that were shown in a table in the proposed rule.[1] CMS indicates that it anticipates "timely calculating the DSH allotments and state-specific reductions for FY 2014," although no deadlines are provided for publishing the allotments.

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.[2] 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.

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[1] CMS acknowledges that Table 1 in the proposed rule inadvertently transposed Arkansas and Arizona.

[2] 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 2013.

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 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 (LIUR) 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.[3] 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 early year reductions are relatively small, by 2018 estimated annual DSH allotments are 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).	

[3] Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2009 Baseline: Medicaid".

The ACA also 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 final 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. 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.

The decision by CMS to limit the methodology to FYs 2014 and 2015 in this rule is made because 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. For example, data on the uninsured from the Census Bureau's American Community Survey for periods beginning January 1, 2014 or later will not be available until after the DSH allotment reductions for FYs 2014 and 2015 are calculated.

CMS reports receiving varying comments regarding how to take into account state decisions on expansion. Some comments indicated that that states should not be rewarded for extending coverage under the ACA Medicaid expansion, while others expressed concern that states choosing to expand Medicaid should not be forced to subsidize those that have opted not to expand coverage. CMS intend to address the issue in rulemaking on DSH reductions beginning in FY 2016, saying that "...considering the limits on 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 when the relevant data will be available."

DSH Health Reform Methodology (DHRM) for FYs 2014 and 2015 -- Overview

The methodology adopted in this rule 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 will estimate an unreduced DSH allotment for each state following the requirements of section 1923(f) without regard to the ACA reductions. Next, states are 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, are then calculated and applied to determine each state's reduced DSH allotment. The final rule makes technical corrections to the proposed regulatory text including changes with respect to definitions of terms at 447.294(b) and the specific data submission requirements for states at 447.294(d).

CMS adopts weighting factors for three of the reduction factors that will be applied to individual state DSH allotments within the low-DSH state and other state groups. 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. CMS finalizes, as proposed, that the Uninsured Percentage Factor (UPF), the High Level of Uncompensated Care Factor (HUF) and the High Volume of Medicaid Inpatients Factor (HMF) each receive 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 weighting methodology would incentivize states to target DSH payments to such hospitals.

CMS discusses various comments it received on the proposed weighting factors, and states that although the three factors are related, the interactions among the factors are varied and inconsistent. A hospital may, for example, have a high volume of Medicaid inpatients and no uncompensated care costs.

CMS discusses its intention 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 finalizes its proposal to use the data from the Census Bureau's American Community Survey to measure the state-level percentage of uninsured. 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 in the proposed rule, 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 it 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. In addition to the uninsured data, data derived from Medicaid DSH audit and reporting data, existing DSH allotments, and Form-64 CMS Medicaid Budget and Expenditures System data will be used. In general, data used will be from the most recently available year.

CMS discusses efforts to assure the quality and accuracy of the Medicaid DSH audit and reporting data, particularly during the transition period established with respect to the 2008 DSH final rule.[4] Indicating that it has to date "… received rich, comprehensive audit and reporting data from each state that makes Medicaid DSH payments," CMS will use "the most recent complete national DSH audit and reporting data available at the time of the DSH reduction

[4] The final rule implementing the DSH audit and reporting requirements under section 1923(j) of the Act was published on December 19, 2008 (73 FR 77904).

calculation based on the existing DSH audit and reporting process." CMS intends to issue detailed guidance to states by the end of calendar year 2013 that will be applicable to DSH audits and reports due to CMS by the end of calendar year 2014. Responding to commenters concerned about hospitals excluded from a state's DSH audit and reporting data, CMS indicates that they should work with the state and CMS through the audit and reporting process.

CMS also finalizes requirements that states report additional information for use in the DHRM. CMS intends to collect directly from state Medicaid agencies the information used by the state 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 amends 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. Also, a change to existing regulatory text that was not included in the proposed rule is made to require that Medicaid and Medicare provider numbers be included in the minimum data that states must report with respect to DSH payments made to out-of-state hospitals.

General Comments Received on the Proposed Rule

CMS reports that many commenters supported the overall approach of the proposed rule and the decision to implement a methodology that will apply only for fiscal years 2014 and 2015. In addition, many commenters indicated support for a delay in implementation of the DSH reductions. Responding that this would require a statutory change, CMS notes that the FY 2014 President's Budget proposed a one-year delay in the start of the DSH reductions and reallocation of the FY 2014 reductions to FY 2016 and FY 2017.

In responding to other comments, CMS indicates that under this final rule states retain the existing flexibility to determine DSH payments to hospitals. The calculation of hospital-specific DSH payment limits under section 1923(g) of the Act is not addressed in this rule. In addition, CMS indicates that it will address comments on the January 18, 2012 proposed rule ("Medicaid DSH Payments – Uninsured Definition") in future rulemaking. CMS sees the calculation of the DSH allotment reductions under this rule as separate from the annual independent certified audits and reports required under section 1923(j) and related regulations.

Notably, CMS indicates that for FY 2014 and FY 2015, it will calculate the limit on DSH payments to institutions for mental diseases (IMDs) under section 1923(h) of the Act after the reductions implemented by this final rule "to ensure that the IMD limit experiences a corresponding reduction consistent with the overall reductions in annual state DSH allotments."

CMS clarifies that the statute does not authorize a 2014 DSH allotment for Tennessee; this would require a statutory change. In the proposed rule, CMS included illustrative DSH allotments for Tennessee (and other states) based on the FY 2013 allotments.

CMS disagrees with some commenters who recommended that any DSH amount paid to a hospital with either high Medicaid volume or high levels of uncompensated care be considered properly targeted for both the HMF and HUF. CMS believes that when states target hospitals

with both a high volume of Medicaid and a high level of uncompensated care, the independent calculations of these factors in the final methodology will mitigate the state's allotment reduction.

Some commenters expressed concern that the methodology will potentially penalize states that target payments to hospitals based on the LIUR, which unlike the MIUR is not incorporated into the proposed targeting formulas. CMS responds that the proposed (and finalized) formulas follow statutory direction, and that if high LIUR hospitals also have high uncompensated care levels, the HUF will mitigate DSH reduction amounts.

Details of Final DSH Health Reform Methodology for FYs 2014 and 2015

Details of Methodology. As described earlier, CMS will 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 will be used to develop the DSH reduction factors. **A table on the next page provides an overview of the adopted methodology, which is described in detail below**. As noted earlier, CMS intends to separately publish a technical guide to the DSH reduction calculation methodologies and data sources.

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 finalizes its proposal to calculate this adjustment 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) will 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.[5] Using these figures, 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 will be calculated as a percentage of the state's actual Medicaid service expenditures for that year. (This is a change from the proposed rule, which would have used estimated Medicaid service expenditures, not actual.) These state amounts will 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 proposed rule illustrative table, CMS reported that the estimated result of this calculation is an LDF of 27.97 percent.

The original proportionately allocated DSH reduction for the low DSH states will 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 $22 million would be multiplied by 27.97 percent, and the resulting $6.2

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

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.

Final 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 (LDF), 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 at $33^{1/3}$ % each		
A. Uninsured Percentage Factor (UPF) weight = 33 1/3%	$2.1 million***	$164.6 million
B. High Volume of Medicaid Inpatients Factor (HMF) weight = 33 1/3%	$2.1 million***	$164.6 million
C. High Uncompensated Care Factor (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

*The figures are based on the May 15, 2013 proposed rule Table 1; the final rule includes no similar table.
**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 finalizes its proposal 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 will be used.

Many commenters expressed concern that the ACS undercounts the number of undocumented uninsured individuals. CMS replies that the Census Bureau collects data from all foreign-born individuals who participate in its surveys, regardless of legal status. These individuals are asked whether they are naturalized US citizens or non-citizens. While separate counts of unauthorized migrants are therefore not possible, the Census Bureau believes that unauthorized immigrants are included in the ACS counts.

CMS finalizes calculation of a UPF as described below, which will be used to distribute 33 1/3 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-third of the $6.2 million total DSH allotment reduction to low-DSH states, or just under $2.1 million, would be based on the UPF, as would one-third of the total $494 million reduction to other states, or $167 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 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 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-third) weighting factor described earlier. (In the proposed rule 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 finalizes its proposal 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 "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 will 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 will rely in part on MIUR information collected from states on an annual basis outside of the final rule. 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 will 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 in the preamble to the final rule that in the case of 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.)

Some commenters suggested that hospitals significantly in excess of one standard deviation above the mean MIUR in the state receive additional protections. For example, hospitals 3 standard deviations or more above the mean might receive DSH payments equal to the hospital-specific limit. CMS responds that the final rule preserves existing state flexibility in determining DSH payments and that the DHRM methodology will promote state targeting, but indicates it will consider further targeting in future rulemaking.

The HMF is a state-specific percentage that will 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.

In the proposed rule, CMS noted that under this 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 noted 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 targeting factor, the HUF, will be used to distribute the remaining one-third of the DSH allotment reduction for each of the two state groups. CMS will 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.[6] The most recent available DSH audit and reporting data provided by states will be used. Specifically, CMS will 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 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. In addition, responding to comments suggesting the use of uncompensated care costs from worksheet S-10 of the CMS 2552-10 cost report, CMS states that the cost report definition of uncompensated care is not consistent with the Medicaid program definition.

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 will be considered a High Uncompensated Care Hospital.

[6] 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.

The HUF will 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.

2. Calculate the mean uncompensated care level for each state.[7]

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 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 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 all the DSH payments made by all the states in the group to hospitals that are not 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.

In the proposed rule, CMS identified some potential scenarios under which the HUF as calculated could work against the goal of this methodology. It offered 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."*

Consistent with the proposed rule discussion, CMS agrees with commenters that the HUF may produce paradoxical outcomes, and that total cost is a better denominator in step one of the HUF calculation. However, CMS believes the paradoxical outcomes will be minimal and the calculation method "represents the most reasonable method for determining hospitals with high levels of uncompensated care costs given limited data availability." To address the data

[7] The proposed rule preamble stated that a "weighted" mean uncompensated care level would be calculated for each state. Responding to comments, CMS states it has removed the term and reiterates that a separate technical guide will be issued providing additional information on the DHRM calculations.

limitations CMS is finalizing its proposals to require that states report total cost data and Medicare provider numbers on the annual DSH audit and reporting submissions. The provider numbers will permit alignment of DSH audit and reporting data with Medicare cost report information from the Healthcare Cost Report Information System (HCRIS). CMS indicates, however, that HCRIS does not include data for all Medicaid DSH hospitals. CMS intends in future rulemaking to substitute total cost for the denominator in step 1 of the HUF calculation for DSH reductions beginning in FY 2016.

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 finalizes its proposed budget neutrality methodology. For the specific fiscal year subject to reduction, it will exclude from 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, are still be subject to reduction. For a section 1115 coverage demonstration not approved as of July 31, 2009, all DSH allotment amounts are subject to reduction. For the non-excluded amounts, an average reduction amount will be assigned based on the state group.

In the illustrative table included in the proposed rule, CMS identified 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 DSH allotment reductions for FYs 2014 and 2015 will affect the ability of some or all states to maintain DSH payments at FY 2013 levels. By statute, the reductions will total $500 million for FY 2014 and $600 million for FY 2015. However, CMS cannot estimate the precise federal financial effect because they cannot anticipate how states will change DSH methodologies in response to the rule. For the same reason they cannot determine the effect on hospitals. 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 final rule does not include any state-specific impact estimates. However, the proposed rule included an illustrative table showing state-level effects of the then-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 transposed Arizona (not a low-DSH state) and Arkansas (a low-DSH state).

ATTACHMENT: ILLUSTRATIVE TABLE 1 REPRODUCED FROM THE PROPOSED RULE

NOTE: The table as published in the May 13, 2013 proposed rule and reproduced here incorrectly identified Arizona as a low-DSH state and omits Arkansas as a low-DSH state. No similar table is included in the final rule.

***FOR ILLUSTRATION PURPOSES ONLY – FY 2014 DSH HEALTH REFORM METHODOLOGY (FROM PROPOSED RULE)**

		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

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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

***FOR ILLUSTRATION PURPOSES ONLY – FY 2014 DSH HEALTH REFORM METHODOLOGY (FROM PROPOSED RULE)**

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		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 (FROM PROPOSED RULE)**

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	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
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**

***FOR ILLUSTRATION PURPOSES ONLY – FY 2014 DSH HEALTH REFORM METHODOLOGY (FROM PROPOSED RULE)**

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	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649
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27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000

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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