United States Government Accountability Office

Report to Congressional Requesters

July 2019

MEDICAID

States' Use and Distribution of Supplemental Payments to Hospitals

GAO-19-603

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GAO Highlights

Highlights of GAO-19-603, a report to congressional requesters

Why GAO Did This Study

Medicaid, the joint federal-state program that finances health care coverage for low-income and medically needy individuals, spent an estimated $177.5 billion on hospital care in fiscal year 2017. About a quarter ($46.3 billion) of those hospital payments were supplemental payments—typically lump sum payments made to providers that are not tied to a specific individual's care. States determine hospital payment amounts within federal limits. In fiscal year 2017, DSH payments totaled about $18.1 billion. Beginning in fiscal year 2020, the amount of DSH payments each state can make is scheduled to be reduced.

GAO was asked to study Medicaid DSH payments to hospitals. Among other things, GAO examined hospital uncompensated care costs and DSH payments by state Medicaid program and hospital characteristics.

GAO analyzed data from the 2014 DSH audits—states' independently audited and certified reports of hospital-level uncompensated care costs and DSH payments—from 47 states and the District of Columbia (48 states). Three states were excluded from the analysis because they either did not make DSH payments or the submitted data were unreliable. The 2014 data were the most recently available audited, hospital-specific, data at the time of GAO's analysis. We provided a draft of this report to HHS for review. HHS provided technical comments, which we incorporated as appropriate.

View GAO-19-603. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Medicaid disproportionate share hospital (DSH) payments are one type of supplemental payment and are designed to help offset hospitals' uncompensated care costs for serving Medicaid beneficiaries and uninsured patients. Under the Medicaid DSH program, uncompensated care costs include two components: (1) costs related to care for the uninsured; and (2) the Medicaid shortfall—the gap between a state's Medicaid payment rates and hospitals' costs for serving Medicaid beneficiaries. GAO's analysis of hospitals receiving DSH payments showed that in 2014, costs related to care for the uninsured comprised 68 percent of total uncompensated care costs, and the remaining 32 percent was the Medicaid shortfall.

Across states, GAO found that total DSH payments varied significantly in 2014. DSH payment levels are generally tied to state DSH spending in 1992 and since 1993 states have been subject to a limit on the amount of federal funding that may be used for DSH payments.

State Disproportionate Share Hospital (DSH) Payments, 2014

DSH payments to hospitals (millions)	Number of states
$500 or more	8
$200 to $499	11
$50 to $199	15
Less than $50	14

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: GAO's analysis includes hospitals receiving DSH payments in the 48 states with reliable 2014 DSH audits.

The amount of DSH payments made to hospitals varied significantly by state. Among hospitals receiving DSH payments, nationally:

- Medicaid DSH payments covered 51 percent of the uncompensated care costs. In 19 states, DSH payments covered at least 50 percent of uncompensated care costs.
- DSH payments comprised about 14 percent of total Medicaid payments, yet wide variation existed. For example, DSH payments comprised about 97 percent of Medicaid payments to DSH hospitals in Maine and 0.7 percent of Medicaid payments to DSH hospitals in Tennessee.

Some types of hospitals received a greater proportion of DSH payments relative to their share of total uncompensated care costs. For example, states generally provided more DSH payments to public hospitals (in comparison to private and non-profit hospitals) and teaching hospitals (as compared to non-teaching hospitals) relative to their share of total uncompensated care costs.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSRIP	delivery system reform incentive payment
DSH	disproportionate share hospital
HHS	Department of Health and Human Services
IMD	institutions for mental disease
MACPAC	Medicaid and CHIP Payment and Access Commission
PPACA	Patient Protection and Affordable Care Act
UPL	upper payment limit

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July 19, 2019

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
House of Representatives

Medicaid, the joint, federal-state program that finances health care coverage for low-income and medically needy individuals, spent an estimated $177.5 billion on hospital care in 2017, the most recent year data were available. As a component of Medicaid spending, hospital expenditures exceed spending for any other type of Medicaid service.[1] About a quarter ($46.3 billion) of Medicaid hospital payments were supplemental payments—typically lump sum payments made to providers that are not tied to a specific individual's care.[2] One type of Medicaid supplemental payment, disproportionate share hospital (DSH) payments, is designed to help offset hospital uncompensated care costs for services provided to Medicaid beneficiaries and uninsured low-income patients. Under Medicaid DSH, uncompensated care costs consist of two components: (1) costs related to the care of uninsured patients, for which hospitals are generally not fully compensated; and (2) the Medicaid shortfall—the gap between a state's Medicaid payments and hospital costs for serving Medicaid beneficiaries. States may also make other types of supplemental payments, such as those that provide additional Medicaid payments for certain services or providers. Additionally,

[1]Medicaid hospital spending estimates include both fee-for-service and managed care payments for inpatient and outpatient hospital services. They also include payments for nursing facility services and home health services provided by hospitals. See Medicaid and CHIP Payment Access Commission (MACPAC), *Report to Congress on Medicaid and CHIP* (Washington, D.C.: March 2019).

[2]See MACPAC, *MACStats: Medicaid and CHIP Data Book* (Washington, D.C.: December 2018).

Medicare makes payments to eligible hospitals to offset uncompensated care costs.[3]

At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), oversees the Medicaid program, providing guidance and overseeing states' compliance with federal requirements, including those for Medicaid DSH payments. States are responsible for the day-to-day administration of the Medicaid program, including determining payment amounts to individual hospitals consistent with any applicable federal limits.

Medicaid has been on our high-risk list since 2003, in part, because of concerns relating to the appropriate oversight of Medicaid dollars, including better oversight of supplemental payments.[4] You asked us to study Medicaid supplemental payments to hospitals. This report describes

(1) states' changes in their use of Medicaid supplemental payments; and

(2) hospital uncompensated care costs and DSH payments by state Medicaid program and hospital characteristics.

For both objectives, we obtained and analyzed data compiled by a contractor on behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), a legislative agency that provides policy and data analysis and makes recommendations to the Congress. The data included state plan rate year 2014 DSH audits and data from Medicare cost reports.[5] The 2014 DSH audits—the most recently available audited data at the time of our analysis—report hospital-specific data on

[3]Medicare is the federal health insurance program for those aged 65 and older, individuals with end-stage renal disease, and certain disabled persons.

[4]See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-157SP (Washington, D.C.: March 6, 2019).

[5]Each year, hospitals participating in the Medicare program must submit cost reports to the program that include cost, utilization, and financial information, as well as information on various hospital characteristics. For the purposes of this report, the Medicare cost report data was used to identify hospital characteristics.

uncompensated care costs and DSH payments.[6] A state plan rate year is the 12-month period defined in a state's approved Medicaid state plan. For purposes of this report, the term "2014 DSH audits" refers to the audits conducted in the 2014 state plan rate year.[7] The data we analyzed, which were submitted by 48 states and the District of Columbia, do not include a census of all hospitals, but only those hospitals that were reported in the 2014 DSH audits.[8] Two states, Massachusetts and Hawaii, did not submit a 2014 DSH audit, because they did not make DSH payments.[9] Additionally, while South Dakota submitted a 2014 DSH audit, we excluded the state from our analysis over concerns about the reliability of the reported cost measures.[10] To assess the reliability of the CMS and state data, we interviewed MACPAC and CMS officials, reviewed relevant data manuals and other documentation, performed electronic tests of the data to identify any outliers or anomalies, and compared the data with data from other published sources. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

To describe changes in states' use of Medicaid supplemental payments, we reviewed existing research, including our prior work and reports by MACPAC, and the Kaiser Family Foundation. Additionally, we reviewed relevant laws and regulations.

We conducted this performance audit from January 2019 to July 2019 in accordance with generally accepted government auditing standards.

[6]Since 2010, states have been required to submit annual reports and independent certified audits of their DSH payments to hospitals. See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed.* GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

[7]A state plan rate year usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. According to the National Association of State Budget Officers, 46 states' fiscal years begin in July and end in June of the following calendar year; Alabama and Michigan follow the federal fiscal year, which begins in October and ends in September the following calendar year; New York begins its fiscal year on April 1; and Texas begins its fiscal year on September 1.

[8]We refer to the 48 states and the District of Columbia that submitted reliable 2014 DSH audits as 49 states.

[9]Massachusetts and Hawaii had section 1115 demonstration authority to use their DSH allotments to fund uncompensated care pools.

[10]We also excluded 13 hospitals from our analysis that did not report a value for uncompensated care costs.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS and states jointly administer the Medicaid program and generally share in the financing of Medicaid payments according to a formula established in law.[11] States may deliver health care services to Medicaid beneficiaries through fee-for-service payments to participating providers or through Medicaid managed care plans, through which states pay plans a fixed amount per beneficiary—typically per member per month—to provide a specific set of Medicaid-covered services. States finance their share (nonfederal share) of Medicaid program spending in a variety of ways, including state funds, such as state general funds appropriated to the state Medicaid program and funds collected through taxes levied on health care providers. Within limits, however, states may also use other sources of funds—including funding from local government providers, such as county-owned or county-operated hospitals, or from local governments on behalf of government providers. Federal law allows states to finance up to 60 percent of the nonfederal share of Medicaid payments from local government funds.[12]

Medicaid Payments to Hospitals

State Medicaid agencies have two primary mechanisms for making payments to hospitals—base payments and supplemental payments—and both can qualify for federal matching funds.

- Base payments are payments to hospitals for specific services provided to Medicaid beneficiaries through both fee-for-service and managed care. These payments are set by state Medicaid programs or managed care plans, and can vary considerably across states for

[11]The federal government matches state spending for most services using a statutory formula—the Federal Medical Assistance Percentage—under which the federal government pays a share of Medicaid expenditures based on each state's per capita income relative to the national average. Certain services, such as those for adults eligible under the Patient Protection and Affordable Care Act, and for certain expenditures, such as administrative costs, may be matched at different rates.

[12]This limit is applied in the aggregate—that is, across each state's entire Medicaid program—and not for individual payments or categories of service. 42 U.S.C. § 1396a(a)(2), 42 C.F.R. § 433.53(b),(c)(2) (2018).

the same services. Payment amounts for the same service may also vary within a state. States' Medicaid base payments are typically lower than other payers', and often are below the costs of providing services.[13]

- Supplemental payments are typically lump sum payments made to hospitals that are not specifically tied to an individual's care. Like all Medicaid payments, supplemental payments are required to be economical and efficient.[14] Supplemental payments can be grouped into two broad categories: (1) DSH payments, which states are required to make to certain hospitals; and (2) non-DSH payments, which states are allowed to make, but are not required by law.

DSH Payments

DSH payments are designed to help offset uncompensated care costs for hospitals serving a high proportion of Medicaid beneficiaries and uninsured low-income patients.[15] In fiscal year 2017, total DSH payments to hospitals nationally were about $18.1 billion.[16] States may distribute DSH payments to any eligible hospital in the state; however, under federal law, the total amount of DSH payments to a hospital must not be more than the total amount of uncompensated care provided by the hospital (both the Medicaid shortfall and uncompensated costs for care for the uninsured). To be eligible for a DSH payment, hospitals must meet minimum requirements such as having a Medicaid inpatient utilization rate of at least 1 percent.[17] States are required to make DSH payments to certain hospitals—termed deemed-DSH hospitals—with a Medicaid

[13]Federal law requires that Medicaid payments are sufficient to assure quality of care and to enlist enough providers so that care and services are available to Medicaid beneficiaries at least to the extent available to the general population in the geographic area, but does not require that such payments cover the cost of providing such care. 42 U.S.C. § 1396a(a)(30)(A).

[14]See 42 U.S.C. § 1396a(a)(30)(A).

[15]Congress first required states to make Medicaid DSH payments to hospitals in 1981 when it eliminated the requirement that states pay hospitals on a reasonable cost basis. Recognizing that hospitals that serve a large Medicaid and low-income population are particularly dependent on Medicaid reimbursement, Congress directed states to adjust payments to account for the atypical costs experienced by these hospitals in treating this population. See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808-809 (1981) (codified, as amended, at 42 U.S.C. § 1396a(a)-(13)): H. R. Rep. No. 97-208, at 962 (1981) (Conf. Rep.).

[16]See MACPAC, *MACStats: Medicaid and CHIP Data Book.*

[17]In general, hospitals also must have at least two staff obstetricians who treat Medicaid enrollees, although there are certain exceptions to this requirement for rural and children's hospitals.

inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate that exceeds 25 percent.

The amount of federal funding each state may claim for DSH payments is limited by federal law. Since fiscal year 1993, each state is subject to a federal DSH allotment that establishes the maximum federal funding available for the payments. A state's DSH allotment is largely based on its fiscal year 1992 DSH spending, although Congress has since made several incremental adjustments to these allotments. Ultimately, however, the states that spent the most in fiscal year 1992 continue to have the largest allotments; conversely, the states that spent the least in fiscal year 1992 have the smallest allotments.

States may choose to make DSH payments to institutions for mental disease (IMD), which can include state-operated psychiatric hospitals.[18] Prior to 1997, a large share of DSH payments went to state-operated IMDs, where they were used to pay for services not covered by Medicaid and any remaining funds were returned to the state treasuries. In general, Medicaid excludes fee-for-service base payments for beneficiaries aged 21-64 who are residents of IMDs—called the IMD exclusion—and using DSH payments allowed states to support the costs of IMDs.[19] In 1997, Congress restricted the total amount of DSH payments a state could make to IMDs as a group by establishing an annual limit on payments to IMDs for each state.[20] Any unspent funds within the IMD-designated limit can be used for other hospital types.

[18]IMDs are any hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. See GAO, *Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, GAO-17-652 (Washington, D.C.: Aug. 9, 2017).

[19]However, CMS has recently approved states receipt of federal matching funds for beneficiaries residing in IMDs under its section 1115 demonstration authority and revised Medicaid managed care regulations to allow states to pay capitated payments to plans for beneficiaries who reside in an IMD for no more than 15 days in a month. 81 Fed. Reg. 27,498, 27,856, 28,861 (May 6, 2016) (codified at 42 C.F.R. §§ 438.3(e), 438.6(e)). In addition, the SUPPORT for Patients and Communities Act provides states with the option to cover substance use disorder treatment in certain IMDs for fiscal years 2019 through 2023, subject to certain requirements. Pub. L. No. 115-271, §§ 5051-5052 (Oct. 24, 2018).

[20]Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4721(b), 111 Stat. 251, 513.

Non-DSH Payments

Non-DSH payments include four types of supplemental payments that states may make, but are not required to do so, to hospitals and other providers.

- Medicaid upper payment limit (UPL) payments are lump-sum payments that are made in addition to fee-for-service base payments. The UPL is a limit or ceiling on the amount of a state's Medicaid payments for which the federal government will match spending. The UPL is based on the difference between Medicaid fee-for-service base payments and an estimate of what Medicare would pay for comparable services.[21] The UPL is not a hospital-specific limit, but is applied in the aggregate across certain categories of providers. States have some flexibility in deciding which hospitals will receive a UPL payment, and how to allocate UPL payments among hospitals. In fiscal year 2017, UPL payments totaled nearly $13 billion.[22]
- Uncompensated care pool payments are payments that some states make to hospitals specifically for uncompensated care costs in conjunction with section 1115 demonstration waivers and pilot projects for which they have received approval from the Secretary of HHS. Specifically, section 1115 of the Social Security Act authorizes the Secretary of HHS to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration programs that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.[23] States have received approval to make supplemental payments for hospital uncompensated care in their Medicaid programs. In fiscal year 2017, states reported total spending of about $8 billion through uncompensated care pools.[24]
- Delivery system reform incentive payment (DSRIP) programs, which have also been authorized under section 1115 demonstrations, allow states to make supplemental payments to providers engaging in various improvement projects that align with state delivery system reform objectives. Examples of reform objectives include improving

[21] See, for example, 42 C.F.R. § 447.272 (2018).

[22]See MACPAC, *Medicaid Base and Supplemental Payments to Hospitals* (Washington, D.C.: March 2019).

[23]42 U.S.C. § 1315(a).

[24]See MACPAC, *Medicaid Base and Supplemental Payments to Hospitals*.

care for patients with specific conditions or increasing capacity.[25] In fiscal year 2017, DSRIP program payments totaled about $7.3 billion.[26]

- Graduate medical education payments help support teaching hospitals, and can include teaching costs, such as physician resident salaries, though states are not required to make such payments to teaching hospitals. States have significant flexibility in designing and administering these payments; however, the payments are subject to the UPL. In fiscal year 2017, Medicaid graduate medical education payments totaled about $2 billion.[27]

The Patient Protection and Affordable Care Act (PPACA) and DSH Allotments

Effective January 1, 2014, PPACA allowed states to expand Medicaid eligibility to certain non-pregnant, non-elderly individuals.[28] PPACA also required a phased reduction in DSH allotments to states, reflecting the expectation that the number of uninsured individuals would decline—and so would hospital spending on uncompensated care. As of May 2019, there were 37 "expansion states"—those states that chose to expand Medicaid eligibility—and 14 "non-expansion states"—those that did not choose to expand Medicaid. Congress has delayed the reduction in DSH allotments several times. The reductions are scheduled to begin in fiscal year 2020.

Between 2013 and 2014, both expansion and non-expansion states reported different degrees of change in care for the uninsured and Medicaid shortfall. In particular, MACPAC reported that between 2013 and 2014, the year in which most state Medicaid expansions took effect, expansion states' uncompensated care costs for the uninsured declined

[25]To receive payments under DSRIP, participating hospitals must develop a plan—subject to CMS and state approval, that identifies the specific projects that they plan to implement—from a menu of options, along with data-driven milestones that hospitals must reach in order to receive full payment. Such payments could be made for projects such as improving care for patients with certain conditions or increasing delivery system capacity.

[26]See MACPAC, *Medicaid Base and Supplemental Payments to Hospitals*.

[27]See MACPAC, *Medicaid Base and Supplemental Payments to Hospitals*.

[28]As enacted, PPACA required all states to expand Medicaid coverage to this group or else face the potential loss of all federal Medicaid funds, including for the population already covered under the current program. However, the U.S. Supreme Court ruled that the federal government could not impose such a sanction on states not expanding their Medicaid programs, thereby rendering expansion to this group optional for states. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

by $2.2 billion (19 percent), while non-expansion states' uncompensated care costs for the uninsured increased by $0.6 billion (5 percent). During the same period, expansion states' Medicaid shortfall increased by $2.2 billion (36 percent), and non-expansion states' Medicaid shortfall increased by $1.8 billion (546 percent).[29]

States Increasingly Made Supplemental Payments to Hospitals

States' use of supplemental payments has grown in recent decades, partly due to the flexibility supplemental payments provide. This flexibility is twofold: supplemental payments provide states with flexibility in financing the nonfederal share of supplemental payments, and flexibility to target the payments to specific hospitals or types of hospitals.

States Increasingly Made Supplemental Payments to Hospitals, while Reducing or Freezing Hospitals' Base Payments

Total supplemental payments to hospitals have grown over time, while states' base payments have often been frozen or reduced. Congress imposed limits on DSH spending in the 1990s, and since then states' use of non-DSH payments has grown. Between fiscal year 2000 and fiscal year 2017, DSH payments increased about 16 percent, from $15.6 billion to $18.1 billion.[30] In prior work, we reported that in fiscal year 2006 state Medicaid agencies made at least $6.3 billion in non-DSH payments, though the exact amounts are unknown, because states did not report all their payments to CMS.[31] By fiscal year 2017, the amount of non-DSH payments had increased to $30.4 billion.[32] Both uncompensated care pool payments and DSRIP programs are relatively new types of non-DSH payments, and thus contributed to the overall increase in supplemental payments. In prior work, we reported that, as of February 2017, CMS authorized nearly $38.7 billion in DSRIP spending nonconsecutively over 2011 to 2022 in four states with the largest DSRIP programs.[33]

[29]See MACPAC, *Report to Congress on Medicaid and CHIP: Annual Analysis of Disproportionate Share Hospital Allotments to States* (Washington, D.C.: March 2019).

[30]See CMS, Medicaid Expenditure Report, Fiscal Year 2000, accessed June 17, 2019, HTTPS://WWW.MEDICAID.GOV/MEDICAID/FINANCE/STATE-EXPENDITURE-REPORTING/EXPENDITURE-REPORTS/INDEX.HTML.

[31]See GAO-08-614. We reported that CMS expenditure reports do not capture all of the non-DSH payments made by states.

[32]See MACPAC, *Medicaid Base and Supplemental Payments to Hospitals*.

[33]See GAO, *Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures*. GAO-18-220 (Washington, D.C.: Jan. 19, 2018).

Our prior work found that new or increased supplemental payments helped mitigate the increasing gap between Medicaid base payments and hospital costs. While supplemental payments increased, the number of states reducing or freezing base payments to hospitals has increased, in part, because states reported challenges paying the nonfederal share with state general funds. Our work found that from 2008 to 2011, across all providers, the number of states making at least one base payment reduction grew from 13 to 34, while the number of states increasing at least one base payment fell over the same period. Across all 4 years, states most frequently reported reducing base payments for hospitals.[34]

The Kaiser Family Foundation's annual survey data shows the trend continued in more recent years.[35] Specifically, over half of states froze or reduced inpatient hospital base payments each fiscal year from 2011 to 2018, ranging from a low of 28 states in 2011 and 2018, to a high of 39 states in 2012. (See table 1.)

Table 1: Number of States Restricting or Increasing Medicaid Fee-For-Service Inpatient Hospital Base Payments, Fiscal Years 2011 to 2018

Fiscal year	Restricting[a]	Increasing
2011	28	23
2012	39	12
2013	38	13
2014	30	21
2015	32	19
2016	31	20
2017	34	17
2018	28	23

Source: GAO analysis of data from the Kaiser Family Foundation. | GAO-19-603

[a]Restrictions include base payment reductions and freezes.

In a September 2018 study of five states, MACPAC found that hospitals and state Medicaid officials often prefer increases to supplemental payments rather than increases to base payments, because

[34]See GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, GAO-13-55 (Washington, D.C.: Nov. 15, 2012).

[35]We reviewed results from 8 years of Kaiser Family Foundation state surveys; for a list of sources, see appendix I.

supplemental payments come with more predictability.[36] MACPAC found that all five states reported reducing hospital base payments from 2007 to 2011. After 2011, all five states kept base payments frozen with no adjustment for inflation. As a result, base payments to hospitals in these states were lower in 2018 relative to other payers and hospital costs. To address the growing gap between base payments and hospital costs, states collaborated with hospitals to establish or increase supplemental payments. In the five states, supplemental payments ranged from 18 percent to 61 percent of total hospital payments.

States Have Relied on Multiple Sources of Funds to Finance Their Nonfederal Share

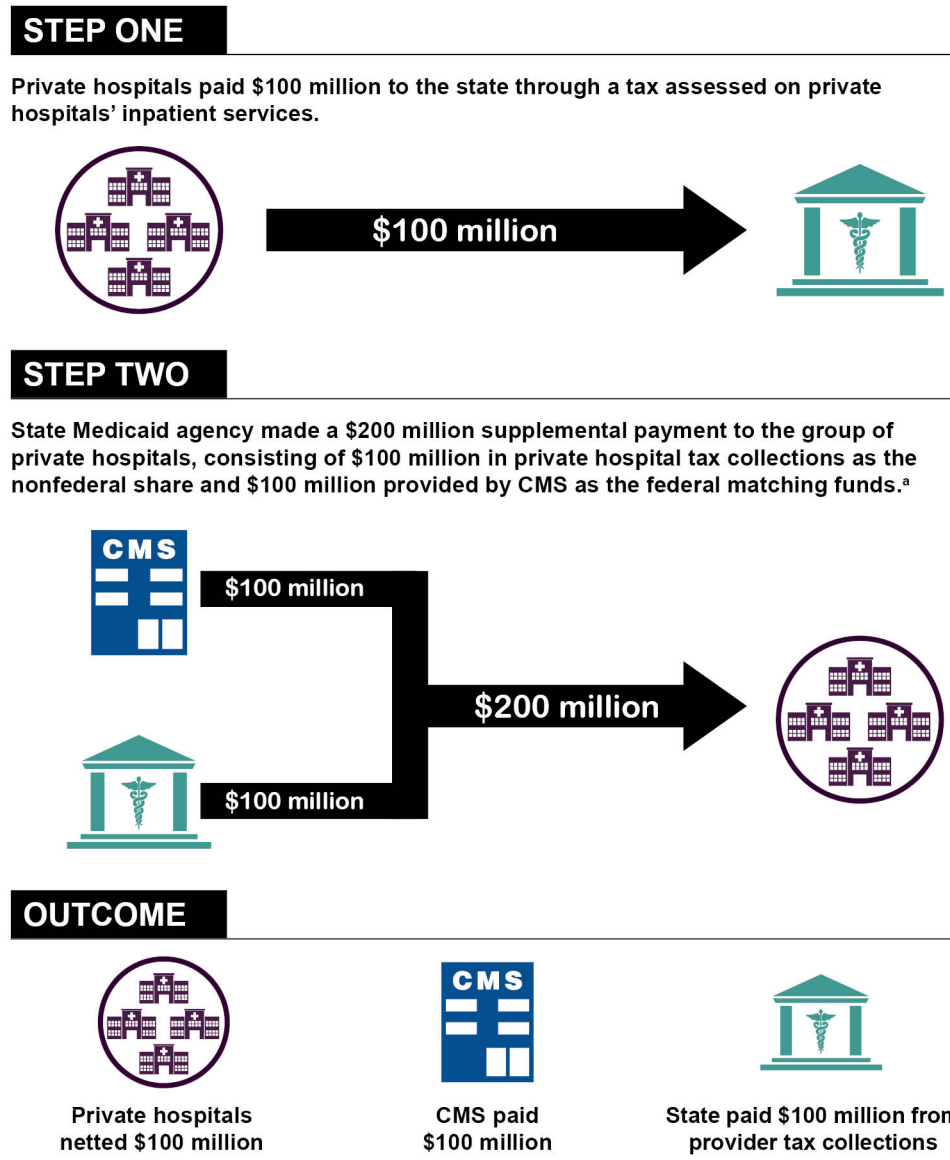
More often than with base payments, states have relied on sources other than state general funds to finance the nonfederal share of supplemental payments. For example, states may receive funds for the nonfederal share of supplemental payments through taxes levied on health care providers. (See fig. 1.) In previous work, we found that funds from local governments and health care providers constituted about 50 percent of the nonfederal share for DSH and non-DSH payments in fiscal years 2008 through 2012.[37] In contrast, funds from local governments and health care providers constituted approximately 30 percent of base payments during the same time period. The MACPAC study of five states also found that states and hospitals preferred supplemental payments, because hospitals can track the extent to which their tax assessments are recouped through supplemental payments.[38]

[36]See Thomas Marks, et al., Health Management Associates, *Factors Affecting the Development of Medicaid Hospital Payment Policies: Findings from Structured Interviews in Five States*, a report prepared under contract with MACPAC, September 2018.

[37]See GAO-14-627.

[38]See Marks, *Factors Affecting the Development of Medicaid Hospital Payment Policies*.

Figure 1: Example of a State Provider Tax Assessment on Private Hospitals' Inpatient Services



Source: GAO. | GAO-19-603

Note: CMS is the Centers for Medicare & Medicaid Services, the federal agency that oversees states' administration of the Medicaid program.

[a]The federal government matches state spending for most services using a statutory formula—the Federal Medical Assistance Percentage—under which the federal government pays a share of Medicaid expenditures based on each state's per capita income relative to the national average. In this example, we used a Federal Medical Assistance Percentage of 50 percent.

In a July 2014 report, we found that the number of states relying on provider taxes increased, and that provider tax revenues were then used for the nonfederal share of supplemental payments.[39] In particular, the total number of provider taxes increased from 119 taxes in 42 states in 2008 to 159 taxes in 47 states in 2012—a 34 percent increase.[40] Kaiser Family Foundation data show this trend has continued.[41] According to state survey data, the number of states using inpatient hospital provider taxes has steadily increased from fiscal year 2011 to 2018, ranging from a low of 34 states in 2011, to a high of 42 states in 2017 and 2018. (See table 2.)

Table 2: States with Inpatient Hospital Provider Taxes, Fiscal Years 2011 to 2018

Fiscal year	Number of states with inpatient hospital provider taxes
2011	34
2012	38
2013	39
2014	40
2015	39
2016	40
2017	42
2018	42

Source: GAO analysis of data from the Kaiser Family Foundation. | GAO-19-603

Supplemental Payments Allow States to Target Payments to Certain Hospitals or Types of Hospitals

Supplemental payments provide states with flexibility that allows them to address states' goals by targeting payments to particular hospitals or hospital types, such as public hospitals or teaching hospitals. States may choose to target supplemental payments to hospitals that may not have the highest uncompensated care costs. Our prior work found some states' DSH payments were not proportionally targeted to hospitals with the highest uncompensated care costs, which DSH payments are designed to address.[42] Based on our prior analysis of annual hospital-specific 2010

[39]See GAO-14-627.

[40]The net increase in provider taxes was 40. Overall, 63 new provider taxes were implemented in 32 states, and 23 provider taxes were ended during this same time period.

[41]We reviewed results from 8 years of Kaiser Family Foundation state surveys; for a list of sources, see appendix I.

[42]See GAO-13-48.

DSH data, we reported that in 30 of 42 states, hospitals receiving the largest share of state DSH payments did not provide the largest share of total uncompensated care. Moreover, our prior review of the independent DSH audits found that

- 41 states made DSH payments to 717 hospitals that exceeded the individual hospitals' uncompensated care costs as calculated by the auditors,
- 9 states did not accurately calculate the uncompensated care costs of 206 hospitals in those states for purposes of making DSH payments, and
- 15 states made DSH payments to a total of 58 hospitals that either did not retain their DSH payments or were not qualified to receive them.[43]

States' criteria for identifying eligible DSH hospitals and how much funding they receive vary, but were often related to hospital ownership, hospital type, and geographic factors. Our prior work found that 2006 DSH payments to individual hospitals varied widely, ranging from 1 cent to about $395 million. For example, California reported both the lowest and highest 2006 DSH payment amounts; the state made a total of only $160 in DSH payments to 96 private hospitals and paid $2 billion in DSH payments to 51 government hospitals.[44]

Based on our analysis of 2014 DSH audits, several states targeted DSH payments to certain hospitals and hospital types, including the following:

- Public hospitals: States targeting nearly all (93 percent or higher) of their DSH funding to public hospitals included Arkansas (99 percent),

[43]See GAO-13-48. In particular, auditors found that 18 of these hospitals did not retain their DSH payments, while the remaining 40 hospitals did not meet the federal requirements—such as having a Medicaid inpatient volume of at least 1 percent—necessary to receive DSH payments.

Federal law requires that hospitals be allowed to retain DSH payments they receive and that the payments be available to offset the hospitals' uncompensated care costs. 42 U.S.C. §1396r-4(j)(2)(A), 42 C.F.R. § 455.304(d)(1) (2018).

[44]For 2006 DSH payments, California distributed a pro-rata share of the $160 pool to private hospitals that qualified for DSH payments. In California, some private hospitals received as little as 1 cent in DSH payments. See GAO, *Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted*, GAO-10-69 (Washington, D.C.: Nov. 20, 2009).

California (100 percent), Illinois (99 percent), Iowa (93 percent), Maine (100 percent), and Washington (97 percent).

- Nonprofit hospitals: Nebraska targeted 98 percent of its DSH funding to nonprofit hospitals.
- High-teaching hospitals: Arkansas targeted 98 percent of DSH funding to high-teaching hospitals, defined as teaching hospitals with an intern-and-resident-to-bed ratio of 0.25 or greater.
- IMDs: Maine makes DSH payments to the two state-run IMDs. In 2014, 18 states directed their entire IMD-designated DSH limit to IMDs. (For additional information on DSH payments to IMDs, see table 9 in app. II).

Similarly, states can target UPL payments to certain hospitals. We and the HHS Office of the Inspector General have reported that some states concentrated these payments to a small number of providers.[45]

GAO and Others Have Noted Concerns With States' Use of Supplemental Payments

Our work has highlighted a number of concerns about the use of non-DSH payments from various perspectives, highlighting the need for transparent reporting, ensuring expenditures meet Medicaid purposes, and concerns regarding arrangements that shift costs from the states to the federal government.[46] For example, in November 2012, we recommended that Congress consider requiring CMS to improve the transparency of and accountability for non-DSH payments by requiring facility-specific payment reporting and annual audits. The report noted that the annual DSH reports and audits that states began submitting in 2010 were important steps toward improving transparency and

[45]See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*, GAO-04-228 (Washington, D.C.: Feb.13, 2004); as well as HHS, Office of the Inspector General, *Audit of Oregon's Medicaid Upper Payment Limits for Non-State Government Nursing Facilities for State Fiscal Years 2002 and 2003*, A-09-03-00055 (Washington, D.C.: 2005); HHS, Office of the Inspector General, *Adequacy of Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit, A-04-03-03023* (Washington, D.C.: 2005); and HHS, Office of the Inspector General, *Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit*, A-10-04-00001 (Washington, D.C.: 2005).

[46]See, for example, GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years*, GAO-12-694 (Washington, D.C.: July 20, 2012); *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614 (Washington, D.C.: May 30, 2008); and *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, HEHS-94-133 (Washington, D.C.: Aug. 1, 1994).

accountability for Medicaid DSH payments; however, similar information is lacking for non-DSH payments. Moreover, the report stated that the limited information available on non-DSH payments shows that a large share of these payments are paid to a small number of hospitals; when these payments are combined with Medicaid base payments, hundreds of hospitals may be receiving Medicaid payments well in excess of their actual costs of providing Medicaid services. As of March 2019, Congress has not taken any action, but CMS announced in fall 2018 that it was planning a proposed rule on supplemental payments that, if finalized, would improve transparency by requiring states to provide CMS with certain information on Medicaid supplemental payments. The agency plans to release the proposed rule for comment by fall 2019.

In 2014, we recommended that CMS develop a data collection strategy ensuring states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments.[47] Such data are needed to (1) track trends in financing the nonfederal share, and (2) oversee compliance with current limits on sources of financing the nonfederal share.[48] CMS did not concur with our recommendation, but did acknowledge the agency does not have sufficient data to oversee compliance with the 60 percent limit on local government contributions to a state's nonfederal share.

[47]See GAO-14-627.

[48]In November 2018, CMS officials reported that the agency was still determining a plan to use the information it collects about the source of funds used to finance the nonfederal share of Medicaid payments. CMS officials said that the agency will use the source-of-funds information to provide better transparency regarding Medicaid payments and to ensure states are in compliance with federal statutory requirements (for example, that no more than 60 percent of the nonfederal share of a state's total annual Medicaid expenditures may come from local sources). CMS announced in fall 2018 that it was planning a proposed rule that may address these issues. The agency plans to release the proposed rule for comment by fall 2019.

Hospital Uncompensated Care Costs and DSH Payments Varied by State; Some Types of Hospitals Received a Greater Proportion of DSH Payments

Uncompensated Care Costs Varied by State and Were Mainly for Costs Related to Treating Uninsured Patients

Among hospitals receiving DSH payments in 2014, total uncompensated care costs varied by state, ranging from $5.9 million in North Dakota to $6.2 billion in New York. In the hospitals, most uncompensated care costs were related to costs to care for uninsured patients, rather than the Medicaid shortfall. For example, among hospitals receiving DSH payments in the 48 states studied:

- Costs related to care for the uninsured comprised about two-thirds (67.9 percent) of total uncompensated care costs for DSH hospitals. The remaining share of DSH hospital uncompensated care costs consisted of the Medicaid shortfall.[49]
- In 34 states, costs for care for the uninsured exceeded the Medicaid shortfall. In the remaining 14 states, the Medicaid shortfall exceeded costs related to care for the uninsured.

[49]In the 2014 DSH audits, states generally reported the Medicaid shortfall based on a definition that included third-party payments, meaning that any private insurance payments for Medicaid beneficiaries that are also enrolled in private coverage or Medicare payments for dually eligible enrollees were deducted from the Medicaid shortfall amount. However, according to MACPAC, 87 DSH hospitals did not include payments from third-party payers when calculating Medicaid shortfall, including 2 DSH hospitals in Minnesota, all DSH hospitals in New Hampshire, 3 DSH hospitals in Tennessee, 1 DSH hospital in Virginia, and all DSH hospitals in West Virginia. See MACPAC, *Report to Congress on Medicaid and CHIP: Annual Analysis of Disproportionate Share Hospital Allotments to States*, (Washington, D.C.: March 2019). In response to litigation, in December 2018, CMS withdrew the guidance that defined the Medicaid shortfall to include third-party payments. According to CMS officials and sub regulatory guidance provided to states by CMS, states have until April 30, 2021, to revise DSH audits for 2011 through 2014 and calculate Medicaid shortfall by excluding payments by third-parties, which would generally increase Medicaid shortfall amounts.

- In 15 states, Medicaid paid hospitals more than the total cost of services provided to Medicaid beneficiaries, resulting in a surplus of Medicaid payments—even prior to receiving DSH payments. Termed a negative Medicaid shortfall, these surplus funds can be the result of non-DSH Medicaid supplemental payments. The remaining 33 states had some Medicaid shortfall. (See table 3.) No states had a surplus of total uncompensated care costs.

(For additional information on state uncompensated care costs and DSH payments in 2014, see table 10 in app. II.)

Table 3: Composition of States' Uncompensated Care Costs, 2014

Uncompensated care costs	Number of states	States
Costs for care for the uninsured exceeded the Medicaid shortfall[a]	34	AL, AK, AR, CA, CO, CT, FL, GA, ID, IL, IN, KS, KY, LA, ME, MD, MI, MS, MO, MT, NV, NJ, NM, NC, ND, OK, OR, SC, TN, TX, UT, VA, WI, WY
Medicaid shortfall exceeded costs for care for the uninsured	14	AZ, DE, DC, IA, MN, NE, NH, NY, OH, PA, RI, VT, WA, WV
Total	**48**	
States with a negative Medicaid shortfall	15	AK, FL, ID, IL, MD, MI, MO, NM, NC, ND, OK, OR, TN, TX, UT
States with a Medicaid shortfall of 0 or higher	33	AL, AZ, AR, CA, CO, CT, DE, DC, GA, IN, IA, KS, KY, LA, ME, MI, MN, MT, NE, NV, NH, NJ, NY, OH, PA, RI, SC, VT, VA, WA, WV, WI, WY
Total	**48**	

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state disproportionate share hospital (DSH) audits and Medicare cost reports. | GAO-19-603

Notes: The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 demonstration authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year but can correspond to any 12-month period defined by the state.

[a]The Medicaid shortfall is the gap between a state's Medicaid payments and hospital costs for serving Medicaid beneficiaries. A negative Medicaid shortfall amount means that the state paid more than costs for services provided to Medicaid beneficiaries, typically the result of non-DSH payments. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits. As a result, states' Medicaid shortfall amounts for 2014 may be higher than those reported on states' original DSH reports for 2011 through 2014.

Across States, DSH Payments Varied Significantly in Amounts, Percentage of Uncompensated Care Costs Covered, and Percentage of States' Medicaid Spending on Hospitals

DSH payments—both the federal and nonfederal share—varied significantly in the amount that each state paid to hospitals in 2014. (See table 4 and fig. 2.) Wyoming made the smallest amount of DSH payments at about $500,000, while New York made the largest amount in DSH payments at $3.5 billion. Differences in DSH payments are largely the result of differences in the state allocations established in law.

Table 4: State Disproportionate Share Hospital (DSH) Payments, 2014

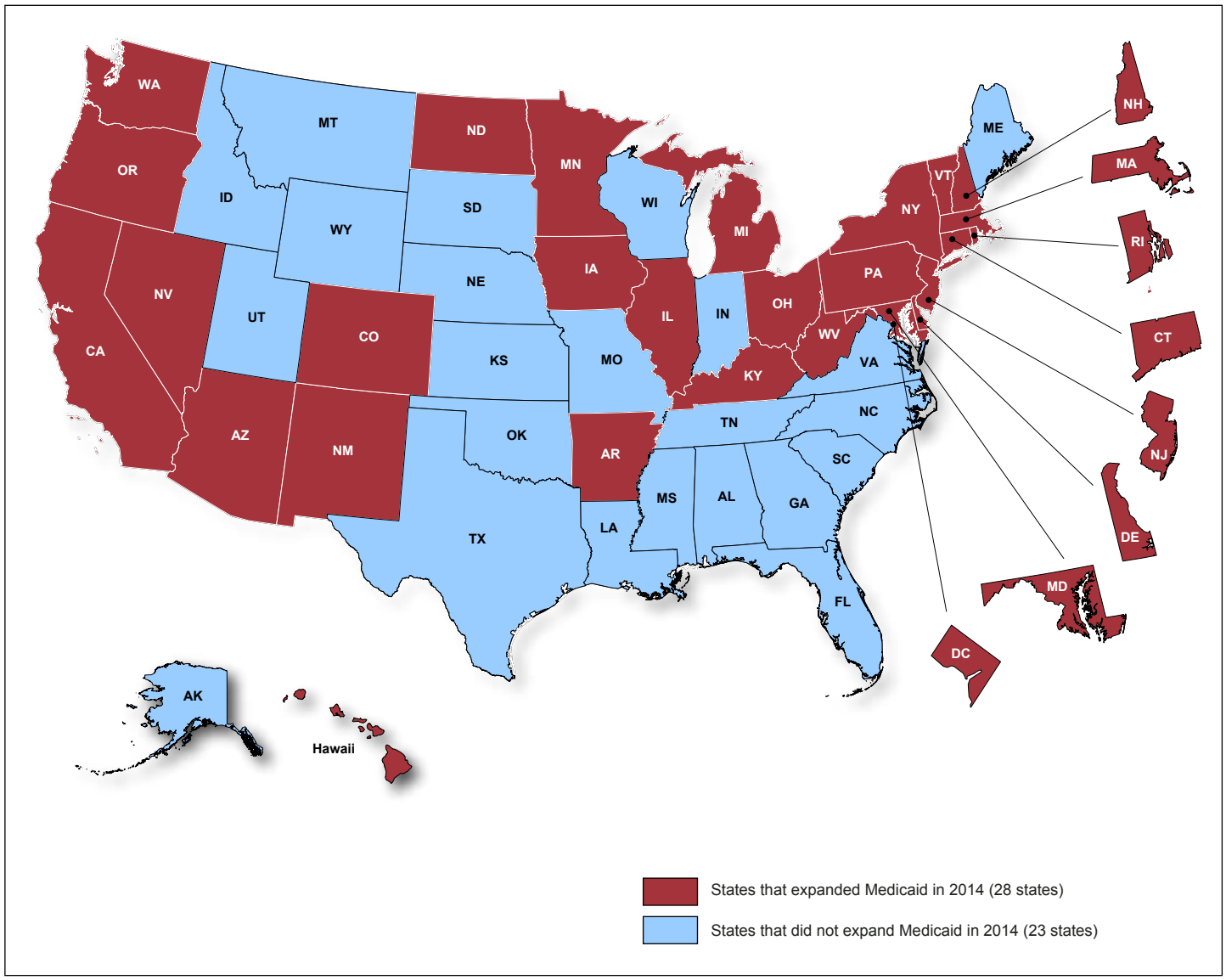
DSH payments (millions)	Number of states	States
$500 or more	8	CA, LA, MO, NJ, NY, OH, PA, TX
$200 to $499	11	AL, FL, GA, IL, IN, KY, MI, MS, NC, SC, WA
$50 to $199	15	AZ, AR, CO, CT, DC, IA, KS, MD, NE, NV, NH, OR, RI, VA, WV
Less than $50	14	AK, DE, ID, ME, MN, MT, NM, ND, OK, TN, UT, VT, WI, WY

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 demonstration authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state.

Figure 2: Variation in Percent Uninsured, Medicaid Expansion Status, Disproportionate Share Hospital (DSH) payments, and Uncompensated Care for DSH Hospitals, 2014

Interactivity instructions: Roll over on each state to see the data. See appendix II for the non-interactive, printer-friendly version.



Sources: GAO analysis of Medicaid and CHIP Payment and Access Commission (MACPAC)-compiled data from state DSH audits and Medicare cost reports, U.S. Census Bureau, and Kaiser Family Foundation (data); Map Resources (map). | GAO-19-603

Notes: All states that expanded their Medicaid programs in 2014 did so on January 1, 2014, except for Michigan, which expanded Medicaid on April 1, 2014, and New Hampshire, which expanded Medicaid on August 15, 2014. GAO's analysis includes hospitals receiving DSH payments in the 48 states with reliable 2014 DSH audits.

[a]Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the information in the state's reported cost measures.

The proportion of total DSH hospital uncompensated care costs covered by total DSH payments in 2014 also varied considerably by state. Nationally, DSH payments ($18.3 billion) covered about half of DSH hospital uncompensated care costs ($36.2 billion). Nineteen states made DSH payments totaling at least 50 percent of uncompensated care costs for the states' DSH hospitals, while 29 states made DSH payments of less than 50 percent of uncompensated care costs for the states' DSH hospitals. (See table 5.) Four states (California, Illinois, Maryland, and Missouri) made DSH payments that exceeded aggregate hospital uncompensated care costs.[50] (For additional information on state uncompensated care costs and DSH payments in 2014, see table 10 in app. II.)

Table 5: Proportion of Reported Hospital Uncompensated Care Costs Covered by Disproportionate Share Hospital (DSH) Payments, 2014

Percentage of hospital uncompensated care covered by DSH payments	Number of states	States
0-49 percent	29	AZ, CO, CT, DE, FL, GA, ID, KS, KY, MI, MN, MT, NE, NV, NH, NM, ND, OH, OK, OR, PA, TN, UT, VT, VA, WA, WV, WI, WY
50-100 percent	15	AL, AK, AR, DC, IN, IA, LA, ME, MS, NJ, NY, NC, RI, SC, TX
Greater than 100 percent	4	CA, IL, MD, MO

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 demonstration authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year.

[50]According to CMS officials, the agency reviewed 2014 audits for completeness and to identify overpayments, but due to the rescinded third-party payer guidance and ongoing litigation, CMS did not collect potential overpayments for 2014. In April 2019, CMS gave states the option to revise their 2014 DSH audits before April 30, 2021, and CMS will recoup any overpayments when the revised audits are filed. Under California's section 1115 waiver, public hospitals in the state can receive DSH payments up to 175 percent of their uncompensated care costs.

Among hospitals receiving them, DSH payments accounted for 13.6 percent of total Medicaid payments, nationally, but there was considerable variation across states. For example, DSH payments comprised 96.6 percent of Medicaid payments to DSH hospitals in Maine and 0.7 percent of Medicaid payments to DSH hospitals in Tennessee.[51] In 40 states, DSH payments accounted for less than 20 percent of total Medicaid payments to hospitals, but in 8 states, it exceeded 20 percent. (See table 6.) (For additional information on state Medicaid payments to hospitals, see table 11 in app. II.)

Table 6: State Disproportionate Share Hospital (DSH) Payments as a Proportion of Total Medicaid Payments to DSH Hospitals, 2014

DSH spending as a proportion of total Medicaid spending on DSH hospitals	Number of states	States
Less than 10 percent	23	AK, AZ, CO, FL, GA, ID, KY, MD, MI, MN, MT, NE, NV, NM, ND, OH, OK, OR, TN, UT, VA, WI, WY
10 to 19.9 percent	17	CT, DC, IL, IN, IA, KS, MS, MO, NY, NC, PA, RI, SC, TX, VT, WA, WV
20 to 29.9 percent	5	AL, AR, CA, DE, NJ
30 percent or greater	3	LA, ME, NH

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 demonstration authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state.

[51]Maine makes DSH payments to the two state-owned IMDs in the state.

Deemed-DSH, Public, and Teaching Hospitals Received a Greater Share of DSH Payments Relative to their Proportion of Uncompensated Care Costs

Among deemed and non-deemed DSH hospitals, overall deemed-DSH hospitals received larger relative DSH payments compared to non-deemed DSH hospitals.[52] Deemed-DSH hospitals received 69.9 percent of DSH payments in 2014, but carried 51.2 percent of uncompensated care costs, relative to all hospitals receiving DSH payments that year. Each of the 48 states that distributed DSH payments in 2014 had at least one deemed-DSH hospital. (See table 7 for hospital type definitions.) Most of these states (36) provided deemed-DSH hospitals with a greater share of DSH payments relative to their share of total uncompensated care costs. (See table 8 for a summary of how states' DSH payments to deemed-DSH hospitals compared to the hospitals' share of uncompensated care costs, and table 12 in app. II for additional information by state.)

Table 7: Hospital Type Definitions

Hospital type	Definition
Deemed-disproportionate share hospital	Hospital that has a Medicaid inpatient utilization rate that is at least one standard deviation above the average Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or a low-income utilization rate that exceeds 25 percent.
Ownership status	
Public	Hospitals identified as governmental.
Private	Hospitals identified as proprietary under the ownership of an individual, corporation, partnership, or other arrangement.
Non-profit	Hospitals identified as voluntary nonprofit, operated by a church or other organization.
Hospital teaching status	
High-teaching	Teaching hospitals provide training for future health care professionals, as well as treatment for patients. Hospitals with an intern-and-resident-to-bed ratio of 0.25 or greater are considered high-teaching.
Low-teaching	Teaching hospitals provide training for future health care professionals, as well as treatment for patients. Hospitals with an intern-and-resident-to-bed ratio of less than 0.25 are referred to as low-teaching.

Source: 42 U.S.C. § 1396r-4(b) (deemed-DSH status), Medicare Provider Reimbursement Manual (ownership status), Medicaid and CHIP Payment and Access Commission and the University of North Carolina (teaching status). | GAO-19-603

[52]We measured the relative size of the DSH payments by comparing the percentage of total DSH payments one type of hospital received relative to the percentage of total uncompensated care attributed to the type of hospital.

Table 8: Disproportionate Share Hospital (DSH) Payments Relative to Hospital Uncompensated Care Costs for Deemed-DSH Hospitals, 2014

Share of deemed-DSH hospital payments relative to hospital uncompensated care costs	Number of states	States
Greater share of DSH payments relative to their share of total uncompensated care costs	36	AK, AR, CA, CO, CT, DE, FL, GA, ID, IN, KS, KY, ME, MI, MN, MS, MO, MT, NE, NV, NJ, NM, NY, NC, ND, OH, OR, PA, TN, TX, VT, VA, WA, WV, WI, WY
Smaller share of DSH payments relative to their share of total uncompensated care costs	9	AL, IL, LA, MD, NH, OK, RI, SC, UT
States that only made DSH payments to deemed-DSH hospitals	3	AZ, DC, IA

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: Deemed-DSH hospitals are those with Medicaid inpatient utilization at least one standard deviation above average range for the state or a low-income utilization rate of over 25 percent. The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 demonstration authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year.

In terms of ownership and teaching hospital status, hospitals that were publicly owned or teaching hospitals also generally received a greater proportion of DSH payments relative to their share of total uncompensated care costs.

- Among the three different ownership groups (public, non-profit, and private), public hospitals generally received a larger share of DSH payments relative to their share of uncompensated care. Among hospitals receiving DSH payments in 2014, public (36.7 percent) and nonprofit (53.7 percent) hospitals accounted for more uncompensated care costs than that of privately owned hospitals (9.6 percent). States generally provided more DSH payments to public hospitals (62.8 percent) relative to their share of total uncompensated care costs (36.7 percent). (For additional information on DSH payments and hospitals' uncompensated care costs by ownership, see table 13 in app. II.)

- States distribute DSH payments to teaching hospitals at different rates, but generally provided a greater proportion of DSH payments to high-teaching hospitals (56.5 percent) relative to their share of total DSH hospital uncompensated care costs (44.0 percent). (For additional information on DSH payments and hospitals' uncompensated care costs by hospital teaching status, see table 14 in app. II.)
- Nationally, urban hospitals received a greater share of DSH payments relative to rural hospitals, with 89.6 percent of DSH funds distributed to urban hospitals and the remaining 10.4 percent distributed to rural hospitals. This proportion corresponds to a similar distribution of uncompensated care costs, with 88.2 percent of uncompensated care costs among DSH hospitals carried by urban hospitals and the remaining 11.8 percent carried by rural hospitals. (For additional information on DSH payments and hospitals' uncompensated care costs by urban/rural status, see table 15 in app. II.)

For additional information on variation in uncompensated care and DSH payments by hospital category and sole community provider status, and state characteristics, see tables 16 through 19 in appendix II.

Agency Comments

We provided a draft of this report to HHS for review. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to appropriate congressional committees, to the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114, or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Carolyn L. Yocom
Director, Health Care

Appendix I: Selected Bibliography

This bibliography contains citations for the eight Kaiser Family Foundation reports referenced in the report.

Kaiser Family Foundation and Health Management Associates. *States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019*. Washington, D.C.: Kaiser Family Foundation, and National Association of Medicaid Directors, October 2018.

Kaiser Family Foundation and Health Management Associates. *Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018*. Washington, D.C.: Kaiser Family Foundation, October 2017.

Kaiser Family Foundation and Health Management Associates. *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*. Washington, D.C.: Kaiser Family Foundation and National Association of Medicaid Directors, October 2016.

Kaiser Family Foundation and Health Management Associates. *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016.* Washington, D.C.: Kaiser Family Foundation and National Association of Medicaid Directors, October 2015.

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Kaiser Family Foundation and Health Management Associates. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2011.

Appendix II: Data on Disproportionate Share Hospital Payments and Hospital Uncompensated Care Costs by State

To conduct this analysis, we used data compiled by Acumen for the Medicaid and CHIP Payment and Access Commission. These data consist of measures from several sources. The measures used within this report were collected from state disproportionate share hospital (DSH) audits and Medicare cost reports. The 2014 DSH audits, which report data on hospital uncompensated care costs and DSH payments to hospitals, were submitted by 48 states and the District of Columbia. These data do not include a census of all hospitals, but only those hospitals that were reported in the 2014 DSH audits. As a result, these data do not capture all uncompensated care costs in each state, only uncompensated care costs for those hospitals reported in the 2014 DSH audits. Two states, Massachusetts and Hawaii, did not submit a 2014 DSH audit, because they did not make DSH payments. Additionally, while South Dakota submitted a 2014 DSH audit, we excluded the state from our analysis because of concerns about the reliability of the reported cost measures.

In addition, not all hospitals reported every data element we analyzed. As a result, total uncompensated care costs and total DSH payments vary between tables, as hospitals were excluded from a given table if they did not report the characteristic described by the table. The numbers of hospitals excluded because they did not report a given data element are noted in each table for which this is the case. Likewise, as uncompensated care costs are an important focus of the report, we also excluded from all analyses 13 hospitals that did not report a value for uncompensated care costs.

Table 9: Disproportionate Share Hospital (DSH) Payments and Hospital Uncompensated Care Costs for Institutions for Mental Disease (IMD), by State, 2014

State	IMD payment limit (dollars in millions)	DSH payments to IMDs (dollars in millions)	Percent of IMD limit paid	IMD uncompensated care costs (dollars in millions)
United States	3,392.0	2,830.9	80.9	3,801.2
Alabama	4.5	3.0	67.6	10.1
Alaska	14.4	14.3	99.9	15.3
Arizona	28.5	28.5	100.0	35.5
Arkansas	0.8	0.8	100.0	19.7
California	1.6	0.3	18.3	4.7
Colorado	0.6	.	.	.
Connecticut	105.6	105.6	100.0	245.1
Delaware	5.8	3.2	55.4	24.5
District of Columbia	6.5	4.9	74.6	10.9
Florida	119.8	97.9	81.7	148.9
Georgia	0.0	.	.	.
Idaho	0.0	.	.	.
Illinois	89.4	75.6	84.5	101.3
Indiana	112.5	.	.	.
Iowa	0.0	.	.	.
Kansas	25.5	25.5	100.0	33.8
Kentucky	37.4	35.3	94.4	60.4
Louisiana	129.3	78.2	60.5	83.0
Maine	60.1	38.8	64.5	45.7
Maryland	53.7	53.7	99.9	126.3
Michigan	140.8	110.4	78.4	147.5
Minnesota	5.3	0.5	9.5	0.5
Mississippi	0.0	.	.	.
Missouri	207.2	210.2	101.5	211.3
Montana	0.0	.	.	.
Nebraska	1.8	1.3	72.9	13.9
Nevada	0.0	.	.	.
New Hampshire	94.8	25.1	26.5	25.7
New Jersey	357.4	358.8	100.4	458.2
New Mexico	0.3	.	.	.
New York	605.0	605.0	100.0	682.1
North Carolina	158.0	158.0	100.0	220.3

State	IMD payment limit (dollars in millions)	DSH payments to IMDs (dollars in millions)	Percent of IMD limit paid	IMD uncompensated care costs (dollars in millions)
North Dakota	1.0	1.0	100.0	7.7
Ohio	93.4	93.4	100.0	99.3
Oklahoma	3.3	3.3	100.0	20.9
Oregon	20.0	20.0	100.0	73.5
Pennsylvania	369.4	251.3	68.0	263.7
Rhode Island	2.4	0.1	3.7	6.9
South Carolina	72.1	49.1	68.1	58.3
Tennessee	0.0	.	.	.
Texas	292.5	218.5	74.7	293.9
Utah	0.9	0.9	100.0	21.4
Vermont	9.1	0.0	0.0	-1.7
Virginia	7.8	8.2	105.5	13.8
Washington	130.3	130.2	99.9	148.6
West Virginia	18.9	18.9	99.9	41.8
Wisconsin	4.5	1.3	28.3	28.4
Wyoming	0.0	.	.	.

Legend: . = No submitted data

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports, and the Federal Register, vol. 81, no. 207. | GAO-19-603

Notes: IMDs include any hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits. Numbers may not sum to totals due to rounding.

Table 10: Hospital Uncompensated Care Costs and Disproportionate Share Hospital (DSH) Payments, by State, 2014

State	Hospital Uncompensated Care			DSH payments (dollars in millions)	Percent of total uncompensated care covered by DSH payments
	Medicaid shortfall[a] (dollars in millions)	Costs for uninsured (dollars in millions)	Total uncompensated care (dollars in millions)		
United States	11,601.8	24,587.9	36,189.8	18,335.0	50.7
Alabama	123.6	468.9	592.4	481.4	81.3
Alaska	-17.5	57.1	39.6	21.1	53.2
Arizona	859.5	363.1	1,222.6	160.6	13.1
Arkansas	22.8	76.5	99.4	65.5	65.9
California	**380.4**	**1,048.2**	**1,428.6**	**2,340.5**	**163.8**
Colorado	28.8	378.5	407.3	198.6	48.8
Connecticut	235.8	273.9	509.7	155.6	30.5
Delaware	18.4	14.5	33.0	11.6	35.3
District of Columbia	44.6	21.3	65.9	57.4	87.1
Florida	-370.1	1,474.3	1,104.2	334.5	30.3
Georgia	148.3	1,221.9	1,370.2	440.1	32.1
Idaho	-0.3	95.0	94.7	24.4	25.8
Illinois	**-166.5**	**598.6**	**432.1**	**438.8**	**101.5**
Indiana	46.8	379.4	426.2	340.6	79.9
Iowa	49.6	35.6	85.1	50.9	59.8
Kansas	94.1	183.1	277.2	72.2	26.0
Kentucky	205.5	391.9	597.4	221.7	37.1
Louisiana	525.1	650.5	1,175.6	1,131.0	96.2
Maine	7.7	38.0	45.7	38.8	84.8
Maryland	**-186.7**	**277.1**	**90.3**	**98.0**	**108.5**
Michigan	263.8	560.0	823.8	393.2	47.7
Minnesota	330.2	85.4	415.6	49.8	12.0
Mississippi	-34.0	319.3	285.3	222.6	78.0
Missouri	**-186.4**	**884.5**	**698.2**	**714.5**	**102.3**
Montana	18.0	79.6	97.6	18.1	18.5
Nebraska	150.1	140.6	290.7	62.8	21.6
Nevada	155.6	257.5	413.1	79.0	19.1
New Hampshire	371.3	138.5	509.8	117.3	23.0
New Jersey	393.0	1,647.7	2,040.6	1,229.2	60.2
New Mexico	-16.1	122.1	106.1	31.9	30.0
New York	4,282.6	1,928.5	6,211.1	3,525.9	56.8

State	Hospital Uncompensated Care			DSH payments (dollars in millions)	Percent of total uncompensated care covered by DSH payments
	Medicaid shortfall[a] (dollars in millions)	Costs for uninsured (dollars in millions)	Total uncompensated care (dollars in millions)		
North Carolina	-152.5	1,096.1	943.6	481.7	51.1
North Dakota	-5.3	11.2	5.9	1.6	28.0
Ohio	809.0	730.3	1,539.3	687.8	44.7
Oklahoma	-38.1	205.8	167.7	44.0	26.2
Oregon	-31.6	307.9	276.3	85.1	30.8
Pennsylvania	2,001.3	1,761.4	3,762.7	873.5	23.2
Rhode Island	144.6	74.0	218.7	138.3	63.3
South Carolina	164.2	658.8	823.0	486.8	59.1
Tennessee	-318.5	622.8	304.2	23.0	7.5
Texas	-126.0	3,330.7	3,204.7	1,675.1	52.3
Utah	-146.5	236.9	90.4	29.8	32.9
Vermont	76.0	17.4	93.5	37.4	40.1
Virginia	24.7	422.7	447.4	157.4	35.2
Washington	562.6	427.4	990.0	362.5	36.6
West Virginia	590.2	151.1	741.3	86.0	11.6
Wisconsin	262.5	293.2	555.8	36.8	6.6
Wyoming	7.2	29.0	36.2	0.5	1.3

Legend: States in **bold** made DSH payments in excess of the total uncompensated care costs reported.

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. Numbers may not sum to totals due to rounding.

[a]The Medicaid shortfall represents the gap between a state's Medicaid payments and hospital costs for serving Medicaid beneficiaries. In the state plan rate year 2014 DSH audits, states generally reported Medicaid shortfall based on a definition that excluded third party payments. A negative Medicaid shortfall amount means that the state paid more than costs for services provided to Medicaid beneficiaries, typically the result of non-DSH payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall for that year.

Table 11: Medicaid Payments to Hospitals, by State, 2014

State	Medicaid non-disproportionate share hospital supplemental payments		Managed care organization payments		Medicaid fee-for service payments		DSH payments		Total Medicaid payments to hospitals
	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)
United States	14,724.3	11.0	36,663.5	27.3	64,652.3	48.1	18,335.0	13.6	134,375.1
Alabama	267.8	14.8	.	.	1,057.6	58.5	481.4	26.6	1,806.8
Alaska	0.4	0.2	0.1	0.0	203.6	90.4	21.1	9.4	225.2
Arizona	740.3	34.9	800.9	37.7	421.2	19.8	160.6	7.6	2,123.0
Arkansas	45.9	14.6	.	.	203.3	64.6	65.5	20.8	314.8
California	420.1	4.8	2,025.4	23.2	3,945.8	45.2	2,340.5	26.8	8,731.8
Colorado	760.1	27.8	118.0	4.3	1,657.1	60.6	198.6	7.3	2,733.8
Connecticut	33.4	3.0	0.2	0.0	924.8	83.0	155.6	14.0	1,114.1
Delaware	.	.	32.4	69.5	2.5	5.5	11.6	25.0	46.6
District of Columbia	1.3	0.3	169.9	45.0	148.7	39.4	57.4	15.2	377.3
Florida	947.9	13.7	1,025.9	14.8	4,617.2	66.7	334.5	4.8	6,925.4
Georgia	203.2	4.5	1,041.8	23.0	2,838.6	62.7	440.1	9.7	4,523.7
Idaho	8.5	1.5	3.8	0.7	542.9	93.7	24.4	4.2	579.6
Illinois	951.4	23.6	371.6	9.2	2,275.3	56.4	438.8	10.9	4,037.1
Indiana	.	.	482.5	22.3	1,337.1	61.9	340.6	15.8	2,160.3
Iowa	29.7	6.0	42.9	8.7	372.5	75.1	50.9	10.3	495.9
Kansas	58.8	9.0	284.3	43.4	240.0	36.6	72.2	11.0	655.3
Kentucky	157.4	5.7	1,285.4	46.6	1,092.8	39.6	221.7	8.0	2,757.2
Louisiana	32.0	1.4	291.2	12.4	896.2	38.1	1,131.0	48.1	2,350.5
Maine	.	.	.	.	1.4	3.4	38.8	96.6	40.1
Maryland	.	.	788.7	49.1	720.0	44.8	98.0	6.1	1,606.7
Michigan	1,565.9	26.7	1,348.2	23.0	2,548.2	43.5	393.2	6.7	5,855.5
Minnesota	148.7	6.1	1,270.2	51.8	983.0	40.1	49.8	2.0	2,451.7
Mississippi	288.3	16.6	123.5	7.1	1,102.3	63.5	222.6	12.8	1,736.7
Missouri	.	.	375.0	8.8	3,175.9	74.5	714.5	16.8	4,265.5
Montana	39.8	13.4	0.1	0.0	237.9	80.4	18.1	6.1	295.8
Nebraska	8.8	1.4	184.0	28.7	384.5	60.1	62.8	9.8	640.1

State	Medicaid non-disproportionate share hospital supplemental payments		Managed care organization payments		Medicaid fee-for service payments		DSH payments		Total Medicaid payments to hospitals
	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)	Percent of total Medicaid payments to hospitals	Total (dollars in millions)
Nevada	93.2	11.5	149.6	18.5	487.1	60.2	79.0	9.8	808.9
New Hampshire	0.5	0.2	76.5	25.0	111.6	36.5	117.3	38.3	305.9
New Jersey	182.2	4.2	1,560.1	36.1	1,345.3	31.2	1,229.2	28.5	4,316.7
New Mexico	76.8	11.4	354.8	52.7	209.7	31.2	31.9	4.7	673.1
New York	631.0	3.0	7,443.2	35.9	9,106.0	44.0	3,525.9	17.0	20,706.0
North Carolina	1,412.5	29.3	95.3	2.0	2,831.4	58.7	481.7	10.0	4,821.0
North Dakota	.	.	10.1	25.5	27.9	70.3	1.6	4.1	39.7
Ohio	490.0	6.4	3,455.5	45.2	3,011.7	39.4	687.8	9.0	7,645.0
Oklahoma	292.0	26.4	0.0	0.0	768.0	69.6	44.0	4.0	1,103.9
Oregon	74.1	3.3	1,224.7	54.0	885.0	39.0	85.1	3.8	2,268.9
Pennsylvania	994.8	15.7	2,796.4	44.3	1,654.8	26.2	873.5	13.8	6,319.4
Rhode Island	11.2	1.1	332.0	33.1	522.7	52.0	138.3	13.8	1,004.3
South Carolina	73.8	2.7	798.0	29.5	1,346.6	49.8	486.8	18.0	2,705.3
Tennessee	784.7	22.5	1,267.3	36.4	1,407.7	40.4	23.0	0.7	3,482.6
Texas	1,855.8	18.5	2,789.3	27.7	3,735.8	37.2	1,675.1	16.7	10,056.0
Utah	246.8	26.0	301.3	31.7	373.1	39.2	29.8	3.1	951.0
Vermont	.	.	.	.	315.8	89.4	37.4	10.6	353.2
Virginia	164.9	9.8	473.6	28.1	890.7	52.8	157.4	9.3	1,686.7
Washington	-6.9	-0.2	883.3	31.3	1,583.5	56.1	362.5	12.8	2,822.4
West Virginia	190.7	22.8	144.0	17.2	416.9	49.8	86.0	10.3	837.6
Wisconsin	438.4	17.2	442.3	17.3	1,637.9	64.1	36.8	1.4	2,555.4
Wyoming	8.1	13.2	.	.	52.9	86.0	0.5	0.8	61.5

Legend: . = No submitted data

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Note: The data represent only hospitals included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. One hospital had missing data on Medicaid non- DSH supplemental payments. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid

state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. Numbers may not sum to totals due to rounding.

Table 12: Hospital Uncompensated Care Costs and Disproportionate Share Hospital (DSH) Payments, by Hospital Deemed-DSH Status and State, 2014

State	Total hospitals receiving DSH funds	Total deemed-DSH hospitals[b]	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]		Total DSH payments (dollars in millions)	Percent of total DSH payments	
				Deemed-DSH	Non-deemed-DSH		Deemed-DSH	Non-deemed-DSH
United States	2,793	876	36,189.8	51.2	48.8	18,335.0	69.9	30.1
Alabama	65	4	592.4	7.1	92.9	481.4	6.4	93.6
Alaska	4	1	39.6	38.6	61.4	21.1	68.0	32.0
Arizona	42	42	1,222.6	95.2	4.8	160.6	100.0	0.0
Arkansas	7	4	99.4	92.1	7.9	65.5	99.6	0.4
California	48	45	1,428.6	96.3	3.7	2,340.5	97.2	2.8
Colorado	71	16	407.3	52.2	47.8	198.6	62.6	37.4
Connecticut	9	3	509.7	11.6	88.4	155.6	19.9	80.1
Delaware	3	2	33.0	99.5	0.5	11.6	99.9	0.1
District of Columbia	6	6	65.9	100.0	.	57.4	100.0	.
Florida	74	40	1,104.2	59.7	40.3	334.5	85.5	14.5
Georgia	134	34	1,370.2	35.1	64.9	440.1	54.4	45.6
Idaho	25	7	94.7	49.9	50.1	24.4	50.5	49.5
Illinois	59	49	432.1	110.7	-10.7	438.8	99.9	0.1
Indiana	52	11	426.2	55.8	44.2	340.6	60.5	39.5
Iowa	7	7	85.1	100.0	.	50.9	100.0	.
Kansas	66	16	277.2	36.4	63.6	72.2	54.2	45.8
Kentucky	102	34	597.4	48.6	51.4	221.7	70.0	30.0
Louisiana	72	39	1,175.6	74.3	25.7	1,131.0	74.0	26.0
Maine	2	1	45.7	36.2	63.8	38.8	36.7	63.3
Maryland	11	8	90.3	142.2	-42.2	98.0	59.9	40.1
Michigan	121	20	823.8	37.7	62.3	393.2	40.5	59.5
Minnesota	57	13	415.6	59.0	41.0	49.8	91.6	8.4
Mississippi	58	16	285.3	63.5	36.5	222.6	63.8	36.2
Missouri	119	32	698.2	48.6	51.4	714.5	49.5	50.5

State	Total hospitals receiving DSH funds	Total deemed-DSH hospitals[b]	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]		Total DSH payments (dollars in millions)	Percent of total DSH payments	
				Deemed-DSH	Non-deemed-DSH		Deemed-DSH	Non-deemed-DSH
Montana	34	3	97.6	8.8	91.2	18.1	15.0	85.0
Nebraska	28	15	290.7	74.8	25.2	62.8	85.2	14.8
Nevada	22	6	413.1	64.9	35.1	79.0	94.6	5.4
New Hampshire	29	6	509.8	46.5	53.5	117.3	22.9	77.1
New Jersey	69	23	2,040.6	59.7	40.3	1,229.2	81.9	18.1
New Mexico	7	3	106.1	58.8	41.2	31.9	79.6	20.4
New York	196	52	6,211.1	49.4	50.6	3,525.9	74.5	25.5
North Carolina	76	20	943.6	51.0	49.0	481.7	71.4	28.6
North Dakota	4	1	5.9	-45.5	145.5	1.6	24.6	75.4
Ohio	161	18	1,539.3	26.5	73.5	687.8	33.2	66.8
Oklahoma	50	13	167.7	36.9	63.1	44.0	36.0	64.0
Oregon	59	15	276.3	28.9	71.1	85.1	51.6	48.4
Pennsylvania	211	47	3,762.7	23.0	77.0	873.5	54.2	45.8
Rhode Island	14	3	218.7	20.0	80.0	138.3	17.3	82.7
South Carolina	63	15	823.0	41.2	58.8	486.8	39.1	60.9
Tennessee	66	19	304.2	32.7	67.3	23.0	66.3	33.7
Texas	182	108	3,204.7	76.6	23.4	1,675.1	83.4	16.6
Utah	42	5	90.4	33.9	66.1	29.8	6.4	93.6
Vermont	13	1	93.5	34.7	65.3	37.4	43.4	56.6
Virginia	26	8	447.4	41.7	58.3	157.4	91.1	8.9
Washington	60	14	990.0	40.1	59.9	362.5	63.5	36.5
West Virginia	52	10	741.3	29.4	70.6	86.0	60.2	39.8
Wisconsin	104	20	555.8	41.1	58.9	36.8	51.5	48.5
Wyoming	11	1	36.2	4.3	95.7	0.5	29.2	70.8

Legend: . = No submitted data.

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other

Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year. Numbers may not sum to totals due to rounding.

[a]A negative percent of uncompensated care denotes hospitals in that category received more in Medicaid payments than those hospitals' costs, typically a result of non-DSH payments, according to the Centers for Medicare & Medicaid Services.

[b]Deemed-DSH hospitals are those with Medicaid inpatient utilization that is at least one standard deviation above the average Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or that have a low-income utilization rate of over 25 percent.

Table 13: Hospital Uncompensated Care Costs and Disproportionate Share Hospital (DSH) Payments, by Hospital Ownership Status and State, 2014

		Percent of total uncompensated care costs[a]				Percent of total DSH payments		
State	Total uncompensated care costs (dollars in millions)	Public[b]	Private	Nonprofit	Total DSH payments (dollars in millions)	Public	Private	Nonprofit
United States	36,051.5	36.7	9.6	53.7	18,258.9	62.8	6.9	30.4
Alabama	592.4	53.8	22.2	24.0	481.2	63.0	17.4	19.6
Alaska	39.6	55.5	.	44.5	21.1	77.5	.	22.5
Arizona	1,222.6	15.3	10.1	74.7	160.6	73.8	5.6	20.6
Arkansas	99.4	71.3	1.7	27.1	65.5	99.2	0.7	0.0
California	1,426.6	100.0	.	.	2,340.4	100.0	.	.
Colorado	407.3	25.7	5.8	68.5	198.6	48.1	5.5	46.4
Connecticut	509.7	51.1	.	48.9	155.6	82.4	.	17.6
Delaware	32.8	74.2	.	25.8	11.6	27.4	.	72.6
District of Columbia	65.9	18.4	4.4	77.2	57.4	12.5	3.6	83.9
Florida	1,104.2	11.9	17.2	70.9	334.5	76.6	4.7	18.7
Georgia	1,313.2	48.3	6.4	45.3	428.3	64.6	3.5	32.0
Idaho	94.7	6.8	15.3	77.8	24.4	12.3	28.5	59.2
Illinois	449.8	116.5	19.6	-36.1	438.6	99.2	0.2	0.6
Indiana	426.2	39.2	5.7	55.1	340.6	35.4	5.3	59.3
Iowa	85.1	74.4	.	25.6	50.9	93.0	.	7.0
Kansas	277.0	36.5	13.9	49.7	72.1	52.5	9.4	38.1
Kentucky	596.9	15.4	11.0	73.6	220.9	19.6	7.8	72.6
Louisiana	1,175.6	28.8	26.5	44.8	1,131.0	28.4	26.5	45.1

State	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]			Total DSH payments (dollars in millions)	Percent of total DSH payments		
		Public[b]	Private	Nonprofit		Public	Private	Nonprofit
Maine	45.7	100.0	.	.	38.8	100.0	.	.
Maryland	90.3	142.1	.	-42.1	98.0	55.0	.	45.0
Michigan	823.8	29.0	7.8	63.2	393.2	49.2	6.2	44.7
Minnesota	415.6	5.4	.	94.6	49.8	26.4	.	73.6
Mississippi	285.3	68.5	8.5	23.1	222.6	72.2	5.7	22.1
Missouri	698.2	37.9	5.0	57.2	714.5	34.1	5.8	60.1
Montana	97.6	0.4	8.6	91.0	18.1	0.8	13.9	85.2
Nebraska	290.7	4.2	0.1	95.7	62.8	1.7	0.3	98.1
Nevada	413.1	30.1	50.1	19.9	79.0	89.3	8.1	2.5
New Hampshire	509.8	5.0	4.7	90.3	117.3	21.4	2.0	76.6
New Jersey	2,040.6	33.6	9.8	56.6	1,229.2	47.7	9.6	42.7
New Mexico	106.1	57.6	4.4	38.1	31.9	77.8	10.4	11.8
New York	6,170.1	47.4	0.3	52.2	3,489.4	77.9	0.1	22.0
North Carolina	943.6	62.0	1.2	36.8	481.7	90.4	0.0	9.6
North Dakota	5.9	130.5	.	-30.5	1.6	60.1	.	39.9
Ohio	1,539.3	12.5	2.0	85.5	687.8	22.8	1.5	75.8
Oklahoma	167.7	19.6	30.1	50.3	44.0	18.3	29.8	51.9
Oregon	276.3	41.6	-1.9	60.3	85.1	63.6	0.1	36.3
Pennsylvania	3,724.9	7.1	14.6	78.4	858.9	29.3	9.8	60.9
Rhode Island	218.7	4.5	13.9	81.5	138.3	1.1	12.3	86.6
South Carolina	823.0	46.6	17.9	35.5	486.8	49.0	19.7	31.3
Tennessee	304.2	-11.5	38.6	73.0	23.0	18.4	16.6	64.9
Texas	3,187.6	54.5	20.2	25.3	1,663.2	61.7	19.3	19.0
Utah	90.4	54.6	8.1	37.3	29.8	88.9	0.7	10.4
Vermont	93.5	.	.	100.0	37.4	.	.	100.0
Virginia	447.4	27.9	9.4	62.6	157.4	77.3	0.8	21.9
Washington	990.0	38.8	2.7	58.6	362.5	96.5	0.1	3.4
West Virginia	741.3	10.6	12.1	77.3	86.0	37.4	3.6	59.0
Wisconsin	555.5	12.1	6.2	81.7	36.8	9.6	7.2	83.2
Wyoming	36.2	34.9	4.3	60.7	0.5	23.0	29.2	47.8

Legend: . = No submitted data; lines in bold denote states where public hospitals account for 100 percent or more of uncompensated care costs.

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. Thirty-one hospitals had missing data on hospital ownership. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year. Numbers may not sum to totals due to rounding.

[a]A negative percent of uncompensated care denotes hospitals in that category received more in Medicaid payments than those hospitals' costs, typically a result of non-DSH payments, according to the Centers for Medicare & Medicaid Services.

[b]Information on ownership type is based on Medicare cost report data. Public hospitals include those hospitals identified as governmental. Private hospitals include those identified as proprietary under the ownership of an individual, corporation, partnership, or other arrangement. Nonprofit hospitals are those identified as voluntary nonprofit, operated by a church or other organization.

Table 14: Hospital Uncompensated Care Costs and Disproportionate Share Hospital (DSH) Payments, by Hospital Teaching Status and State, 2014

		Percent of total uncompensated care costs[a]				Percent of total DSH payments		
State	Total uncompensated care costs (dollars in millions)	High-teaching[b]	Low-teaching	Non-teaching	Total DSH payments (dollars in millions)	High-teaching	Low-teaching	Non-teaching
United States	36,051.5	44.0	23.8	32.2	18,258.9	56.5	16.9	26.6
Alabama	592.4	18.8	34.2	47.0	481.2	23.1	31.6	45.3
Alaska	39.6	.	23.3	76.7	21.1	.	12.0	88.0
Arizona	1,222.6	30.3	13.2	56.5	160.6	67.0	4.8	28.2
Arkansas	99.4	51.4	27.1	21.5	65.5	98.0	0.0	2.0
California	1,426.6	90.0	7.3	2.7	2,340.4	90.3	8.6	1.1
Colorado	407.3	45.4	35.8	18.8	198.6	49.2	32.0	18.7
Connecticut	509.7	53.4	.	46.6	155.6	32.9	.	67.1
Delaware	32.8	.	100.0	.	11.6	.	100.0	.
District of Columbia	65.9	77.2	12.1	10.7	57.4	83.9	4.9	11.3
Florida	1,104.2	13.9	47.3	38.8	334.5	42.8	15.7	41.5
Georgia	1,313.2	19.5	23.9	56.5	428.3	37.7	20.6	41.6
Idaho	94.7	.	54.8	45.2	24.4	.	48.7	51.3
Illinois	449.8	94.4	-2.0	7.6	438.6	79.8	2.8	17.5

State	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]			Total DSH payments (dollars in millions)	Percent of total DSH payments		
		High-teaching[b]	Low-teaching	Non-teaching		High-teaching	Low-teaching	Non-teaching
Indiana	426.2	34.7	25.7	39.6	340.6	40.7	25.6	33.7
Iowa	85.1	74.4	14.4	11.2	50.9	93.0	5.6	1.5
Kansas	277.0	42.3	10.0	47.7	72.1	23.6	4.7	71.8
Kentucky	596.9	21.2	32.5	46.3	220.9	38.1	25.4	36.4
Louisiana	1,175.6	61.5	11.2	27.3	1,131.0	63.6	11.1	25.3
Maine	45.7	.	.	100.0	38.8	.	.	100.0
Maryland	90.3	-63.9	36.2	127.7	98.0	3.8	33.4	62.8
Michigan	823.8	55.1	14.7	30.2	393.2	54.4	8.1	37.6
Minnesota	415.6	34.3	42.5	23.2	49.8	78.6	16.0	5.4
Mississippi	285.3	37.3	10.4	52.2	222.6	45.8	14.0	40.1
Missouri	698.2	13.0	24.3	62.7	714.5	21.6	19.6	58.8
Montana	97.6	.	33.0	67.0	18.1	.	30.4	69.6
Nebraska	290.7	44.2	32.4	23.5	62.8	75.3	13.7	11.0
Nevada	413.1	34.9	30.3	34.8	79.0	88.2	6.4	5.5
New Hampshire	509.8	21.4	14.7	63.9	117.3	9.5	7.5	83.0
New Jersey	2,040.6	40.6	24.5	35.0	1,229.2	44.1	17.9	38.0
New Mexico	106.1	44.6	45.0	10.4	31.9	75.5	9.3	15.2
New York	6,170.1	73.5	18.1	8.4	3,489.4	76.4	20.2	3.4
North Carolina	943.6	26.4	42.6	30.9	481.7	30.1	40.6	29.3
North Dakota	5.9	.	-45.5	145.5	1.6	.	24.6	75.4
Ohio	1,539.3	31.0	29.1	40.0	687.8	36.8	22.9	40.3
Oklahoma	167.7	.	52.8	47.2	44.0	.	69.0	31.0
Oregon	276.3	21.5	30.3	48.2	85.1	42.6	14.0	43.4
Pennsylvania	3,724.9	42.3	27.9	29.9	858.9	40.2	15.7	44.1
Rhode Island	218.7	69.5	10.2	20.3	138.3	74.7	8.6	16.7
South Carolina	823.0	31.1	22.3	46.6	486.8	26.2	20.0	53.8
Tennessee	304.2	-9.7	31.7	78.0	23.0	48.1	19.6	32.3
Texas	3,187.6	47.1	21.2	31.7	1,663.2	48.7	17.9	33.4
Utah	90.4	32.2	-3.4	71.2	29.8	76.1	1.1	22.8
Vermont	93.5	34.7	.	65.3	37.4	43.4	.	56.6
Virginia	447.4	44.9	25.2	29.9	157.4	88.7	5.8	5.5
Washington	990.0	14.0	33.9	52.1	362.5	34.5	12.8	52.7
West Virginia	741.3	20.7	42.5	36.8	86.0	37.8	0.2	62.0

State	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]			Total DSH payments (dollars in millions)	Percent of total DSH payments		
		High-teaching[b]	Low-teaching	Non-teaching		High-teaching	Low-teaching	Non-teaching
Wisconsin	555.5	36.0	37.6	26.4	36.8	34.0	41.3	24.7
Wyoming	36.2	.	.	100.0	0.5	.	.	100.0

Legend: . = No submitted data.

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. Thirty-one hospitals had missing data on hospital teaching status. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year. Numbers may not sum to totals due to rounding.

[a]A negative percent of uncompensated care denotes hospitals in that category received more in Medicaid payments than those hospitals' costs, typically a result of non-DSH payments, according to the Centers for Medicare & Medicaid Services.

[b]Teaching hospitals are classified into two types. Low-teaching hospitals have an intern-and-resident-to-bed ratio of less than 0.25, and high-teaching hospitals have an intern-and-resident-to-bed ratio of 0.25 or greater.

Table 15: Hospital Uncompensated Care Costs and Disproportionate Share Hospital (DSH) Payments, by Urban and Rural Status and State, 2014

State	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs		Total DSH payments (dollars in millions)	Percent of total DSH payments	
		Urban[a]	Rural[b]		Urban	Rural
United States	36,051.5	88.2	11.8	18,258.9	89.6	10.4
Alabama	592.4	81.7	18.3	481.2	82.0	18.0
Alaska	39.6	83.1	16.9	21.1	90.5	9.5
Arizona	1,222.6	92.1	7.9	160.6	98.2	1.8
Arkansas	99.4	99.0	1.0	65.5	99.7	0.3
California	1,426.6	99.2	0.8	2,340.4	99.9	0.1
Colorado	407.3	96.1	3.9	198.6	92.9	7.1
Connecticut	509.7	100.0	.	155.6	100.0	.
Delaware	32.8	100.0	.	11.6	100.0	.
District of Columbia	65.9	100.0	.	57.4	100.0	.
Florida	1,104.2	97.9	2.1	334.5	97.8	2.2
Georgia	1,313.2	80.9	19.1	428.3	79.8	20.2
Idaho	94.7	76.3	23.7	24.4	84.4	15.6
Illinois	449.8	94.3	5.7	438.6	98.1	1.9
Indiana	426.2	77.7	22.3	340.6	80.8	19.2
Iowa	85.1	96.3	3.7	50.9	98.8	1.2
Kansas	277.0	70.0	30.0	72.1	58.5	41.5
Kentucky	596.9	69.7	30.3	220.9	67.3	32.7
Louisiana	1,175.6	92.1	7.9	1,131.0	91.5	8.5
Maine	45.7	36.2	63.8	38.8	36.7	63.3
Maryland	90.3	93.4	6.6	98.0	100.0	0.0
Michigan	823.8	86.6	13.4	393.2	85.5	14.5
Minnesota	415.6	86.3	13.7	49.8	96.4	3.6
Mississippi	285.3	74.1	25.9	222.6	79.4	20.6
Missouri	698.2	63.0	37.0	714.5	67.1	32.9
Montana	97.6	48.9	51.1	18.1	57.6	42.4
Nebraska	290.7	78.0	22.0	62.8	88.7	11.3
Nevada	413.1	97.3	2.7	79.0	96.5	3.5
New Hampshire	509.8	46.6	53.4	117.3	19.9	80.1
New Jersey	2,040.6	92.6	7.4	1,229.2	89.8	10.2
New Mexico	106.1	89.6	10.4	31.9	84.8	15.2
New York	6,170.1	96.0	4.0	3,489.4	98.0	2.0

State	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs		Total DSH payments (dollars in millions)	Percent of total DSH payments	
		Urban[a]	Rural[b]		Urban	Rural
North Carolina	943.6	78.3	21.7	481.7	73.2	26.8
North Dakota	5.9	.	100.0	1.6	.	100.0
Ohio	1,539.3	77.1	22.9	687.8	78.3	21.7
Oklahoma	167.7	74.3	25.7	44.0	74.8	25.2
Oregon	276.3	85.9	14.1	85.1	93.1	6.9
Pennsylvania	3,724.9	89.6	10.4	858.9	91.5	8.5
Rhode Island	218.7	100.0	.	138.3	100.0	.
South Carolina	823.0	84.6	15.4	486.8	79.2	20.8
Tennessee	304.2	91.8	8.2	23.0	89.2	10.8
Texas	3,187.6	91.6	8.4	1,663.2	89.9	10.1
Utah	90.4	91.9	8.1	29.8	81.1	18.9
Vermont	93.5	34.7	65.3	37.4	43.4	56.6
Virginia	447.4	91.2	8.8	157.4	94.4	5.6
Washington	990.0	95.0	5.0	362.5	94.2	5.8
West Virginia	741.3	73.5	26.5	86.0	49.5	50.5
Wisconsin	555.5	89.3	10.7	36.8	85.5	14.5
Wyoming	36.2	49.7	50.3	0.5	20.1	79.9

Legend: . = No submitted data.

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Note: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. Thirty-one hospitals had missing data on urban and rural status. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year. Numbers may not sum due to rounding.

[a]The U.S. Census Bureau categorizes urban areas as areas with of 50,000 or more people.

[b]Rural areas are any areas not considered urban areas by the U.S. Census Bureau.

Table 16: Percent of Uncompensated Care Costs, by Hospital Category and State, 2014

State	Total uncompensated care costs (dollars in millions)[a]	Percent of total hospital uncompensated care by hospital category					
		Acute care hospital[b]	Children's hospital[c]	Critical access hospital[d]	Long-term care hospital[e]	Psychiatric hospital[f]	Rehabilitation hospital[g]
United States	36,051.5	85.4	2.1	2.0	0.2	10.2	0.1
Alabama	592.4	96.9	.	1.3	.	1.7	.
Alaska	39.6	61.4	.	.	.	38.6	.
Arizona	1,222.6	93.3	1.6	2.2	.	2.9	.
Arkansas	99.4	80.1	.	0.0	.	19.8	.
California	1,426.6	99.7	.	0.1	.	0.2	.
Colorado	407.3	81.8	16.7	1.5	.	.	.
Connecticut	509.7	42.6	8.5	.	0.8	48.1	.
Delaware	32.8	25.8	.	.	.	74.2	.
District of Columbia	65.9	79.2	4.3	.	.	16.5	.
Florida	1,104.2	88.7	1.5	1.2	.	8.6	.
Georgia	1,313.2	100.3	-4.9	3.7	0.9	.	.
Idaho	94.7	88.8	.	9.8	.	.	1.4
Illinois	449.8	71.2	6.5	-0.2	0.0	22.5	.
Indiana	426.2	89.7	.	10.3	.	.	.
Iowa	85.1	100.0	.	.	.	.	.
Kansas	277.0	75.3	3.6	8.9	.	12.2	.
Kentucky	596.9	85.6	.	4.4	.	10.1	-0.1
Louisiana	1,175.6	88.5	1.0	3.3	0.0	7.1	0.1
Maine	45.7	.	.	.	.	100.0	.
Maryland	90.3	-46.5	4.4	.	2.3	139.8	.
Michigan	823.8	74.7	2.4	4.1	0.1	17.9	0.8
Minnesota	415.6	64.2	34.3	1.1	0.3	0.1	.
Mississippi	285.3	90.5	.	7.2	.	2.3	.
Missouri	698.2	70.7	-6.1	5.4	-0.5	30.4	0.2
Montana	97.6	92.1	.	7.6	0.3	.	.
Nebraska	290.7	86.8	6.0	2.4	.	4.8	0.1
Nevada	413.1	99.0	.	1.0	.	.	.
New Hampshire	509.8	82.8	.	11.4	.	5.0	0.8
New Jersey	2,040.6	77.5	.	.	.	22.5	.
New Mexico	106.1	99.2	.	.	.	.	0.8
New York	6,170.1	88.8	0.0	0.4	0.4	10.4	.

State	Total uncompensated care costs (dollars in millions)[a]	Percent of total hospital uncompensated care by hospital category					
		Acute care hospital[b]	Children's hospital[c]	Critical access hospital[d]	Long-term care hospital[e]	Psychiatric hospital[f]	Rehabilitation hospital[g]
North Carolina	943.6	73.8	.	2.6	.	23.3	0.2
North Dakota	5.9	-45.5	.	15.0	.	130.5	.
Ohio	1,539.3	79.6	9.5	4.4	0.0	6.5	.
Oklahoma	167.7	85.0	0.2	2.1	.	12.5	0.2
Oregon	276.3	63.9	1.1	8.4	.	26.6	.
Pennsylvania	3,724.9	86.9	4.5	0.8	0.5	6.9	0.4
Rhode Island	218.7	92.3	.	.	4.5	3.2	.
South Carolina	823.0	91.9	.	0.7	0.3	7.1	.
Tennessee	304.2	73.2	27.1	.	.	-0.3	.
Texas	3,187.6	91.3	-1.0	0.7	0.3	8.7	.
Utah	90.4	61.4	9.0	6.0	.	23.6	.
Vermont	93.5	73.5	.	28.3	.	-1.8	.
Virginia	447.4	96.0	4.0	.	.	.	.
Washington	990.0	79.3	4.2	1.4	.	15.0	.
West Virginia	741.3	88.2	.	6.2	.	5.6	.
Wisconsin	555.5	85.1	6.2	3.3	0.1	5.1	0.2
Wyoming	36.2	88.1	.	11.9	.	.	.

Legend: . = No submitted data

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state disproportionate share hospital (DSH) audits and Medicare cost reports. | GAO-19-603

Notes: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. Thirty-one hospitals had missing data on hospital category. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year. Numbers may not sum to totals due to rounding.

[a]A negative percent of uncompensated care denotes hospitals in that category received more in Medicaid payments than those hospitals' costs, typically a result of non-disproportionate share hospital supplemental payments, according to the Centers for Medicare & Medicaid Services.

[b]An acute care hospital is a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).

[c]A children's hospital is a separately certified hospital, either freestanding or within a larger hospital, which predominantly treats individuals under 21 years of age.

[d]To be designated as a critical access hospital, a facility must, among other requirements, be located in a rural area or an area that is treated as rural; be located either more than 35 miles from the nearest hospital or critical access hospital or more than 15 miles from the nearest hospital in areas with mountainous terrain or only secondary roads; and furnish 24-hour emergency care services 7 days a week.

[e]Long-term care hospitals are certified as acute-care hospitals, but focus on patients who, on average, stay more than 25 days.

[f]A psychiatric hospital is an institution that is primarily engaged in providing, by or under the supervision of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.

[g]Rehabilitation hospitals provide an intensive rehabilitation program, and patients who are admitted must be able to tolerate 3 hours of intense rehabilitation services per day.

Table 17: Disproportionate Share Hospital (DSH) Payments, by Hospital Category and State, 2014

State	DSH payments (dollars in millions)	Percent of total DSH payments by hospital category					
		Acute care hospital[a]	Children's hospital[b]	Critical access hospital[c]	Long-term care hospital[d]	Psychiatric hospital[e]	Rehabilitation hospital[f]
United States	18,258.9	80.8	1.6	2.1	0.3	15.1	0.0
Alabama	481.2	98.2	.	1.1	.	0.6	.
Alaska	21.1	32.0	.	.	.	68.0	.
Arizona	160.6	78.8	2.6	0.9	.	17.7	.
Arkansas	65.5	98.7	.	0.0	.	1.3	.
California	2,340.4	100.0	.	0.0	.	0.0	.
Colorado	198.6	96.8	0.6	2.6	.	.	.
Connecticut	155.6	12.3	17.5	.	2.3	67.8	.
Delaware	11.6	72.6	.	.	.	27.4	.
District of Columbia	57.4	83.0	8.5	.	.	8.5	.
Florida	334.5	79.1	0.2	1.3	.	19.4	.
Georgia	428.3	94.5	0.0	5.3	0.2	.	.
Idaho	24.4	95.0	.	4.1	.	.	1.0
Illinois	438.6	82.6	0.1	0.0	0.1	17.2	.
Indiana	340.6	91.2	.	8.8	.	.	.
Iowa	50.9	100.0	.	.	.	.	.
Kansas	72.1	50.5	3.1	11.1	.	35.3	.
Kentucky	220.9	78.4	.	5.5	.	16.0	0.1
Louisiana	1,131.0	89.4	0.0	3.6	0.0	6.9	0.1
Maine	38.8	.	.	.	.	100.0	.
Maryland	98.0	44.4	0.6	.	0.3	54.8	.

State	DSH payments (dollars in millions)	Percent of total DSH payments by hospital category					
		Acute care hospital[a]	Children's hospital[b]	Critical access hospital[c]	Long-term care hospital[d]	Psychiatric hospital[e]	Rehabilitation hospital[f]
Michigan	393.2	64.3	3.5	3.9	0.1	28.1	0.1
Minnesota	49.8	57.0	40.8	0.7	0.6	1.0	.
Mississippi	222.6	94.8	.	4.4	.	0.8	.
Missouri	714.5	65.0	0.9	4.1	0.4	29.5	0.1
Montana	18.1	79.0	.	19.0	2.0	.	.
Nebraska	62.8	83.7	13.0	0.9	.	2.1	0.3
Nevada	79.0	98.1	.	1.9	.	.	.
New Hampshire	117.3	36.8	.	41.3	.	21.4	0.4
New Jersey	1,229.2	70.8	.	.	.	29.2	.
New Mexico	31.9	98.5	.	.	.	.	1.5
New York	3,489.4	82.7	0.0	0.2	0.8	16.3	.
North Carolina	481.7	64.9	.	2.0	.	32.8	0.2
North Dakota	1.6	24.6	.	15.3	.	60.1	.
Ohio	687.8	67.1	13.5	5.8	0.0	13.6	.
Oklahoma	44.0	90.0	0.9	1.5	.	7.4	0.1
Oregon	85.1	72.3	0.0	4.3	.	23.5	.
Pennsylvania	858.9	64.6	2.2	1.8	0.0	31.1	0.3
Rhode Island	138.3	98.8	.	.	1.1	0.1	.
South Carolina	486.8	88.6	.	1.2	0.1	10.1	.
Tennessee	23.0	90.0	3.0	.	.	7.0	.
Texas	1,663.2	82.1	4.2	0.8	0.4	12.4	.
Utah	29.8	81.0	3.1	12.7	.	3.1	.
Vermont	37.4	76.8	.	23.2	.	0.0	.
Virginia	157.4	88.7	11.3	.	.	.	.
Washington	362.5	61.7	1.0	1.4	.	35.9	.
West Virginia	86.0	47.8	.	30.3	.	22.0	.
Wisconsin	36.8	82.9	7.5	6.1	0.0	3.4	0.0
Wyoming	0.5	61.9	.	38.1	.	.	.

Legend: . = No submitted data

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. Thirty-one hospitals had missing data on hospital category. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH

allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. Numbers may not sum to totals due to rounding.

[a]An acute care hospital is a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).

[b]A children's hospital is a separately certified hospital either freestanding or within a larger hospital, which predominantly treats individuals under 21 years of age.

[c]To be designated as a critical access hospital, a facility must, among other requirements, be located in a rural area or an area that is treated as rural; be located either more than 35 miles from the nearest hospital or critical access hospital or more than 15 miles from the nearest hospital in areas with mountainous terrain or only secondary roads; and furnish 24-hour emergency care services 7 days a week.

[d]Long-term care hospitals are certified as acute-care hospitals, but focus on patients who, on average, stay more than 25 days.

[e]A psychiatric hospital is an institution that is primarily engaged in providing, by or under the supervision of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.

[f]Rehabilitation hospitals provide an intensive rehabilitation program, and patients who are admitted must be able to tolerate 3 hours of intense rehabilitation services per day.

Table 18: Uncompensated Care and Disproportionate Share Hospital (DSH) Payments, by Sole Community Hospital Status and State, 2014

		Percent of total uncompensated care costs[a]			Percent of total DSH payments	
States	Total uncompensated care costs (dollars in millions)	Sole community hospital[b]	Non-sole community hospital	Total DSH payments (dollars in millions)	Sole community hospital	Non-sole community hospital
United States	35,260.3	4.8	95.2	17,743.2	3.1	96.9
Alabama	590.1	9.9	90.1	479.4	11.4	88.6
Alaska	39.6	38.2	61.8	21.1	19.9	80.1
Arizona	1,169.7	13.5	86.5	156.2	3.3	96.7
Arkansas	99.4	8.3	91.7	65.5	0.3	99.7
California	1,426.6	0.2	99.8	2,340.4	0.0	100.0
Colorado	407.3	4.3	95.7	198.6	6.9	93.1
Connecticut	509.7	.	100.0	155.6	.	100.0
Delaware	32.8	.	100.0	11.6	.	100.0
District of Columbia	65.9	.	100.0	57.4	.	100.0
Florida	1,102.2	0.0	100.0	333.6	0.9	99.1
Georgia	1,309.1	6.2	93.8	425.9	6.6	93.4
Idaho	81.3	10.9	89.1	21.9	11.5	88.5
Illinois	449.8	0.3	99.7	438.6	0.0	100.0

States	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]		Total DSH payments (dollars in millions)	Percent of total DSH payments	
		Sole community hospital[b]	Non-sole community hospital		Sole community hospital	Non-sole community hospital
Indiana	420.1	3.5	96.5	336.8	3.7	96.3
Iowa	85.1	2.5	97.5	50.9	0.1	99.9
Kansas	255.1	13.5	86.5	53.7	16.5	83.5
Kentucky	594.7	12.5	87.5	220.1	7.4	92.6
Louisiana	1,128.2	0.2	99.8	1,104.4	0.2	99.8
Maine	16.6	.	100.0	14.2	.	100.0
Maryland	90.3	-1.2	101.2	98.0	0.0	100.0
Michigan	818.6	3.5	96.5	391.9	4.0	96.0
Minnesota	415.6	12.2	87.8	49.8	3.2	96.8
Mississippi	272.6	2.1	97.9	214.2	4.5	95.5
Missouri	689.9	10.0	90.0	708.2	10.2	89.8
Montana	97.6	50.9	49.1	18.1	36.7	63.3
Nebraska	254.4	20.2	79.8	60.8	9.0	91.0
Nevada	409.0	4.0	96.0	78.3	1.7	98.3
New Hampshire	509.8	24.9	75.1	117.3	11.2	88.8
New Jersey	2,040.6	.	100.0	1,229.2	.	100.0
New Mexico	106.1	9.6	90.4	31.9	13.7	86.3
New York	5,724.6	2.1	97.9	3,129.6	1.0	99.0
North Carolina	940.2	5.9	94.1	481.7	9.5	90.5
North Dakota	5.9	-45.5	145.5	1.6	24.6	75.4
Ohio	1,524.8	5.9	94.1	683.1	5.2	94.8
Oklahoma	167.7	8.6	91.4	44.0	9.1	90.9
Oregon	276.3	5.5	94.5	85.1	2.0	98.0
Pennsylvania	3,690.2	2.7	97.3	846.8	0.9	99.1
Rhode Island	218.7	.	100.0	138.3	.	100.0
South Carolina	809.0	8.7	91.3	471.6	12.0	88.0
Tennessee	307.0	0.1	99.9	22.5	0.6	99.4
Texas	3,171.8	3.4	96.6	1,653.0	3.2	96.8
Utah	90.4	14.2	85.8	29.8	6.3	93.7
Vermont	93.5	35.3	64.7	37.4	31.0	69.0
Virginia	433.7	8.2	91.8	149.2	1.2	98.8
Washington	990.0	5.4	94.6	362.5	3.8	96.2
West Virginia	737.2	8.9	91.1	86.0	8.3	91.7

States	Total uncompensated care costs (dollars in millions)	Percent of total uncompensated care costs[a]		Total DSH payments (dollars in millions)	Percent of total DSH payments	
		Sole community hospital[b]	Non-sole community hospital		Sole community hospital	Non-sole community hospital
Wisconsin	555.5	5.0	95.0	36.8	6.6	93.4
Wyoming	36.2	38.4	61.6	0.5	41.7	58.3

Legend: . = No submitted data.

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission compiled data from state DSH audits and Medicare cost reports. | GAO-19-603

Notes: The data represent any hospital included in the 2014 DSH audits. This does not include all hospitals in a state, and thus does not capture all hospital uncompensated care. Some hospitals had missing data and are not included in this table. Thirteen hospitals had missing data for hospital uncompensated care costs. South Dakota did submit a 2014 DSH audit, but was excluded from our analysis due to concerns about the reliability of the reported cost measures. Massachusetts and Hawaii did not make DSH payments in 2014 and did not submit 2014 DSH audits. These states had section 1115 waiver authority to use their DSH allotments to fund uncompensated care pools. The 2014 DSH audits are based on a state plan rate year, which is the 12-month period defined by a state's approved Medicaid state plan in which the state estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments, as well as all other Medicaid payments. The period usually corresponds with the state's fiscal year or the federal fiscal year, but can correspond to any 12-month period defined by the state. In the state plan rate year 2014 DSH audits, states reported the Medicaid shortfall component of their hospital uncompensated care costs based on a definition that excluded third-party payments. In response to litigation, CMS has rescinded its guidance directing states to exclude such payments and is allowing states to submit revised 2014 DSH audits, which may result in an increase in the states' Medicaid shortfall and, therefore, total uncompensated care costs for that year. Numbers may not sum to totals due to rounding.

[a]A negative percent of uncompensated care denotes hospitals in that category received more in Medicaid payments than those hospitals' costs, typically a result of non-DSH payments, according to the Centers for Medicare & Medicaid Services.

[b]A sole community hospital is a hospital that is at least 35 miles from another like hospital (additional criteria apply for rural hospitals).

Table 19: State Characteristics, 2014

State	Medicaid expansion status[a]	Percent uninsured	Percent of population in rural areas	Disproportionate share hospital (DSH) allotment[b] (dollars in millions)
United States	28 expanded	11.7	19.3	11,662.8
Alabama	No	12.1	41.0	328.3
Alaska	No	17.2	34.0	21.7
Arizona	Yes	13.6	10.2	108.1
Arkansas	Yes	11.8	43.8	46.1
California	Yes	12.4	5.1	1,170.3
Colorado	Yes	10.3	13.9	98.7
Connecticut	Yes	6.9	12.0	213.5
Delaware	Yes	7.8	16.7	9.7
District of Columbia	Yes	5.3	0.0	65.4
Florida	No	16.6	8.8	213.5
Georgia	No	15.8	24.9	286.9
Hawaii	Yes	5.3	8.1	10.4
Idaho	No	13.6	29.4	17.5
Illinois	Yes	9.7	11.5	229.5
Indiana	No	11.9	27.6	228.2
Iowa	Yes	6.2	36.0	42.0
Kansas	No	10.2	25.8	44.0
Kentucky	Yes	8.5	41.6	154.8
Louisiana	No	14.8	26.8	732.0
Maine	No	10.1	61.3	112.1
Maryland	Yes	7.9	12.8	81.4
Massachusetts	Yes	3.3	8.0	325.6
Michigan	Yes	8.5	25.4	282.9
Minnesota	Yes	5.9	26.7	79.7
Mississippi	No	14.5	50.7	162.8
Missouri	No	11.7	29.6	505.7
Montana	No	14.2	44.1	12.1
Nebraska	No	9.7	26.9	30.2
Nevada	Yes	15.2	5.8	49.4
New Hampshire	Yes	9.2	39.7	170.9
New Jersey	Yes	10.9	5.3	687.2
New Mexico	Yes	14.5	22.6	21.7
New York	Yes	8.7	12.1	1,714.7

State	Medicaid expansion status[a]	Percent uninsured	Percent of population in rural areas	Disproportionate share hospital (DSH) allotment[b] (dollars in millions)
North Carolina	No	13.1	33.9	314.9
North Dakota	Yes	7.9	40.1	10.2
Ohio	Yes	8.4	22.1	433.7
Oklahoma	No	15.4	33.8	38.7
Oregon	Yes	9.7	19.0	48.3
Pennsylvania	Yes	8.5	21.3	599.1
Rhode Island	Yes	7.4	9.3	69.4
South Carolina	No	13.6	33.7	349.6
South Dakota	No	9.8	43.4	11.8
Tennessee	No	12.0	33.6	0.0
Texas	No	19.1	15.3	1,020.8
Utah	No	12.5	9.4	20.9
Vermont	Yes	5.0	61.1	24.0
Virginia	No	10.9	24.6	93.5
Washington	Yes	9.2	16.0	197.5
West Virginia	Yes	8.6	51.3	72.1
Wisconsin	No	7.3	29.9	100.9
Wyoming	No	12.0	35.2	0.2

Source: U.S. Census Bureau (percent uninsured and rural population), Kaiser Family Foundation (Medicaid expansion status), Federal Register vol. 81, no. 207 (DSH allotments). | GAO 19-603

[a]All states that expanded their Medicaid programs in 2014 did so on January 1, 2014, except for Michigan, which expanded Medicaid on April 1, 2014, and New Hampshire, which expanded Medicaid on August 15, 2014.

[b]DSH allotments represent the aggregate limit of federal payments allowed for DSH payments and do not include the nonfederal share.

Appendix III: GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to the contact named above, Lori Achman (Assistant Director), Dawn Nelson (Analyst-in-Charge), Sean Miskell, and Jeffrey Tamburello made key contributions to this report. Also contributing were Tim Bushfield, Drew Long, Vikki Porter, and Emily Wilson.