REPORT *Published February 17, 2026 · 14 minute read*

Modernizing the Medicaid Disproportionate Share Hospital (DSH) Program

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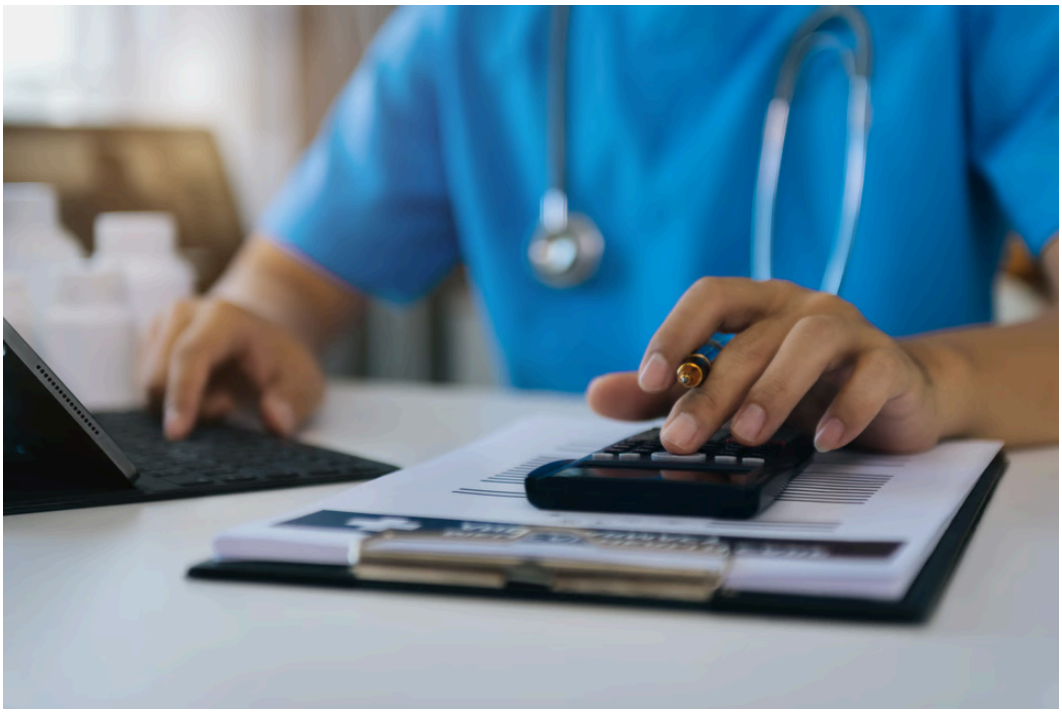

Takeaways

The Medicaid Disproportionate Share Hospital (DSH) program was intended to direct critical funding to hospitals that provide more uncompensated care and serve higher shares of Medicaid and uninsured patients than other hospitals. Unfortunately, several challenges undermine the program's effectiveness, resulting in an ineffective distribution of federal funding. Some states receive more federal funds than they can possibly use, while other states don't receive the support their hospitals need. In addition, not all states target DSH funds to the highest need hospitals. And substantial cuts to the program from the Republican budget bill create instability for all hospitals that receive DSH funds.

Congress should take action to improve the effectiveness of the DSH program by:

1. Creating a formula to target funds to states in most need.
2. Increasing transparency to promote state accountability.
3. Delaying scheduled DSH cuts to avoid further destabilizing hospitals, and, once the above reforms are in place, repealing the scheduled cuts.

The Medicaid Disproportionate Share Hospital (DSH) program is a lifeline for hospitals that care for patients who are uninsured or enrolled in Medicaid. But the program's structure is badly outdated. Federal funding to states is based on spending levels from the early 1990s, rather than current measures of need. States have broad discretion to distribute those funds and some fail to focus them on the hospitals at greatest financial risk. The threat of deep DSH cuts, enacted under the Affordable Care Act (ACA) but repeatedly delayed, creates chronic instability for hospitals and state Medicaid programs.

Congress can fix this, and it's time for the federal government to prioritize modernizing the program.

In this report, we outline the current problems with federal funding allotments to states, state distribution of funds to hospitals, and uncertainty stemming from delayed ACA cuts. We then show how lawmakers can modernize the program by refining funding allotments using current measures of need, increasing transparency in state distribution of DSH funds, and delaying the ACA cuts until these improvements are in place, then repealing them entirely. Together, these changes will make the Medicaid DSH program fairer to states, more effective in serving its statutory purpose, and better aligned with the realities facing hospitals today.

The Basics

Treating patients who are uninsured or covered by Medicaid presents financial challenges for hospitals. Uninsured patients who can't pay their bills leave hospitals with uncompensated care costs. Historically, Medicaid's base payments to hospitals have been below cost, a financial gap called the Medicaid shortfall. [1] The shortfall causes fewer providers to accept patients who are uninsured or covered by Medicaid, leaving them with more limited access to care.

Medicaid DSH payments are intended to help cover some of the losses hospitals incur caring for Medicaid and uninsured patients. DSH funding comprises approximately 7% of Medicaid payments to hospitals, or about $16 billion in FY2023. [2] Medicaid DSH payments are one of five types of supplemental payments to hospitals and are the only supplemental payment states are required to make. In many states, the non-DSH supplemental payments may reduce or even eliminate a hospital's Medicaid shortfall. [3]

Total Medicaid DSH funding is the combination of a state-specific federal allotment plus state matching funds. States *must* make DSH payments to some hospitals (called deemed DSH hospitals) and *may* make payments to others. Payments to any hospital may not exceed that hospital's cost of providing uncompensated care to Medicaid and uninsured patients. Aside from some broad parameters, states have discretion in distributing DSH funding.

Federal Allotments

The federal government provides each state a fixed amount of funds for DSH payments each year. These state-specific allotments are based on historic spending and are unrelated to a state's number of uninsured or low-income individuals or to its hospitals' uncompensated care costs. [4] This is due to the evolution of Medicaid DSH payments over time. States began making Medicaid DSH payments in 1981, but the program grew slowly until 1987, when Congress required states to distribute funds to hospitals treating a high share of Medicaid and low-income patients. DSH payments then grew rapidly until

Congress enacted state-specific caps on federal funding to limit spending. Caps were first established for fiscal year 1993, and allotments were largely based on each state's 1992 DSH spending rather than a formula based on hospitals' uncompensated care or Medicaid margins.

Under current law, each state's allotment is either its 2004 allotment or its prior year allotment increased by the Consumer Price Index for All Urban Consumers, whichever is greater. [5] In addition, a state's allotment cannot exceed 12% of its total Medicaid medical assistance expenditures.

While Congress has occasionally adjusted the allotments, spending patterns from 1992 are still evident; states that spent the most in 1992 still have the largest allotments, while states that spent the least have the smallest allotments. [6]

State Financing

To draw down its federal DSH allotment, a state must provide matching funds at its regular Federal Medical Assistance Percentage (FMAP) rates. [7] As with other state Medicaid funds, states are permitted to finance matching funds through several sources, including state general revenue, provider taxes, and local government funds (such as intergovernmental transfers and certified public expenditures). [8]

States typically have two years to spend their DSH allotment after the end of the fiscal year. If a state does not draw down its full federal allotment, the unused funds may not be carried over to future years. Billions of dollars go unused because a state does not have the matching funds and/or because hospitals in the state reached their hospital-specific DSH limit.

For example, $1.9 billion (13%) in federal DSH allotments from fiscal year 2021 were unspent by the deadline. [9] Over half of these unspent DSH allotments were attributable to six states. [10] Four of these states had total DSH budgets that were greater than the amount of hospital-provided uncompensated care. [11]

Hospital Eligibility and State Funding Distribution

The federal government establishes broad criteria regarding hospital eligibility for DSH funds and gives states wide latitude in distributing the funds.

Hospital Eligibility: To receive DSH funds, a hospital must have at least two obstetricians on staff who accept Medicaid patients. Beyond this requirement, states *must* make DSH payments to "deemed DSH" hospitals that meet one of two criteria:

- A Medicaid inpatient utilization rate that is unusually high, relative to the state average, or
- A low-income utilization rate of more than 25%.

Approximately 12% of all US hospitals meet these requirements.

States *may* make DSH payments to hospitals with a Medicaid inpatient utilization rate of 1%. Nearly all US hospitals meet this requirement.

State Funding Distribution: Within these broad parameters, states have substantial discretion to distribute DSH funds. State criteria vary but often include hospital ownership, hospital type, and geographic factors. State DSH policies frequently change in response to state budgets and financing, but the amount of DSH payments is more likely to change than the types of hospitals receiving payment. Payments to any hospital cannot exceed the hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

The Problems

Despite its critical role in supporting hospitals that serve high shares of Medicaid and uninsured patients, the Medicaid DSH program faces several challenges that undermine its effectiveness. First, the state allotment methodology is outdated and results in unfair distribution of federal funds to states. Second, state flexibility in distributing DSH funds can result in insufficient support of the hospitals with the greatest financial need. And third, the repeated, short-term delays of the ACA DSH cuts create chronic financial uncertainty for states and hospitals.

1. Outdated Federal Distribution of Funds

The methodology used to determine each state's federal DSH allotment is out of date and misaligned with state need. Each state's annual federal DSH allotment is based on historical spending patterns from the early 1990s and has never been restructured to reflect states' Medicaid shortfalls or uncompensated care costs. This results in allotments that are disconnected from current data and undermines the DSH program's statutory purpose of stabilizing hospitals that serve a high proportion of low-income and uninsured populations.

According to the most recent data, hospitals in 18 states plus DC have excessive DSH funding on average. [12] DSH funding is excessive when a state's total available DSH funding (federal plus state) is more than its hospitals need to breakeven on their Medicaid patients and to cover their uncompensated care costs. [13] In 32 states, DSH funding is inadequate to cover hospitals' costs.

On a per-person basis, the excessive or inadequate funding varies widely from state to state, as shown in the map below. New Hampshire's total DSH funding is the highest per non-elderly, low-income person, while Wyoming's is the lowest. Twelve states have achieved a happy medium with DSH funding that is +/- $100 of the amount needed to cover hospital's costs (on a per person basis). (The appendix shows the aggregate amounts of excessive and inadequate DSH funding by state. The analysis assumes each state draws down its full federal DSH allotment because data on actual allotments are not available.)

Overall, DSH funding is not covering hospitals' costs by $11.8 billion annually. For the 32 states receiving too little, the shortfall totals $19.3 billion. For the 18 states and DC receiving too much, the excessive funding totals $7.4 billion. [14] **These large mismatches mean that federal DSH allotments, which were $16 billion in FY2023, are misallocated**. [15] This inequitable distribution of funds leads to a situation in which some states have more DSH funds than they can legally use because DSH payments to any hospital may not exceed that hospital's costs of providing uncompensated care. Other states receive too little.

2. Insufficient Support of Highest-Need Hospitals

States have considerable discretion in how they distribute their DSH allotments, and many do not target payments based on hospitals' levels of uncompensated care or Medicaid shortfall. While states are required to make DSH payments to deemed DSH hospitals (those with a high Medicaid inpatient or low-income utilization rates), there are no federal requirements regarding the amount of funding such hospitals receive. Experts have consistently found that DSH payments are poorly aligned with measures of financial need, and experts have called attention to wide variation in how states define eligible hospitals and calculate payments. [16] This disconnect reduces the effectiveness of the DSH program as a tool for stabilizing the hospitals that the program was created to support.

Given that the statutory intent of Medicaid DSH payments is to help cover some of the unpaid costs of caring for Medicaid and uninsured patients, an argument could be made for prioritizing DSH funds for deemed DSH hospitals, which treat higher proportions of these patients. Deemed DSH hospitals comprise about 28% of US hospitals receiving Medicaid DSH funds and receive 59% of all DSH payments. [17] However, these national averages mask state variation; five states focused 100% of their DSH payments on deemed DSH hospitals, while six states distributed just 10% of their DSH funds to deemed DSH hospitals. [18]

When DSH funds are well-targeted, they make a big difference. Deemed DSH hospital margins would be three to four percentage points lower without DSH payments. [19] In

addition, DSH payments accounted for 3.6% of operating revenue for deemed DSH hospitals, compared to 1.3% of operating revenue for all hospitals. [20]

3. Instability Caused by Medicaid Cuts and Temporary Delays to DSH Cuts

The ACA included substantial reductions to federal Medicaid DSH allotments, premised on the assumption that expanded coverage would reduce hospital uncompensated care costs. The ACA did not adjust the federal DSH allotment methodology and instead tailored the cuts to be less in states with higher need. [21] While uncompensated care (as a share of hospital operating expenses) did drop following implementation of the ACA's coverage provisions in 2014, it has remained largely unchanged since 2015. [22] Current DSH federal and state funding doesn't cover hospitals' shortfalls from Medicaid patients and uncompensated care costs, which is a total of $12 billion annually. [23] That shortfall would be even more if the scheduled cuts to DSH allotments took effect.

The DSH cuts were originally scheduled to begin in FY2014 but have been repeatedly delayed by Congress in response to concerns about their impact on safety-net hospitals, particularly in states that did not expand Medicaid. Most recently, Congress delayed the DSH cuts until September 30, 2028.

Although these cuts have not yet been implemented, the recurring threat of large, sudden reductions creates significant financial uncertainty for states and hospitals. The threat is particularly destabilizing in the current environment of Medicaid cuts due to the Republicans' One Big Beautiful Bill Act and the expiration of the ACA's enhanced premium tax credits. Both actions will increase the number of people without insurance coverage, making funds for uncompensated care costs even more important for the hospitals that serve them.

The Solutions

To improve the effectiveness of the Medicaid DSH program and ensure that federal funds are appropriately targeted to states and hospitals in most need, Congress and the Administration should reform the program. Here's how:

1. Target Federal DSH Funds to States in Need

Congress should modernize the methodology for determining federal DSH allotments to align with Congress's original intent and to reflect current measures of state need. Two key indicators should be used in a new methodology: hospital uncompensated care costs and shortfalls in Medicaid's hospital payments. Any methodology should annually rebase

allotments to reflect current state needs. This kind of approach is supported by the Medicaid and CHIP Payment and Access Commission (MACPAC) and other experts. [24]

A phased-in approach may help states and hospitals transition to a new DSH allotment methodology. Congress could consider at least two different approaches. First, Congress could redistribute unused DSH allotments, which amounted to $1.9 billion from FY2021. [25] These, and future unused funds, could be redistributed to states using a new methodology described above. Second, Congress could gradually phase-in the new methodology over time, using the new methodology to allocate increasing portions of total federal funds each year.

2. Target Funds to Highest Need Hospitals

The federal government should require increased transparency to promote state accountability for distribution of DSH funds to the highest need hospitals. States are already required to provide an annual report on their DSH programs to the federal government, but this reporting lacks information on how states distribute DSH funds and how hospitals use the funds along with the many other supplement payments to hospitals. [26] The federal government should require states to report the relevant data necessary to determine whether state distribution of DSH funds and other payments is boosting financial stability for struggling hospitals or boosting revenues for already well-off providers. This transparency would allow stakeholders to benchmark state performance, identify gaps in targeting for patients, as well as hospitals, and apply pressure for reform. It would also enable federal oversight to ensure that payments from many sources for uncompensated care, including federal and state tax exemptions, are neither too much nor too little compared to the need in each community.

3. Repeal ACA DSH Cuts after Modernizing the Program

Given the threats to hospitals posed by Republicans' Medicaid cuts, the expiration of the ACA's enhanced premium tax credits, and the underfunding of hospital costs for the Medicaid shortfall and uncompensated care, it would be particularly harmful to implement the $8 billion in annual Medicaid DSH reductions mandated by the ACA at this time. Congress has been right to delay them and should continue to do so, repealing them entirely only when the previous two policies are in place to help stabilize providers in the short-term and modernize the DSH program in the long-term. The fiscal cost of repeal would be offset with other changes to hospital payments like same service, same price reforms. [27] These reforms, described above, would ensure that DSH funds reflect each state's needs and go to hospitals struggling with uncompensated care costs.

Conclusion

The Medicaid DSH program is too important to leave tied to the past, with an outdated funding formula and ineffective use of federal and state resources. Congress should modernize the program, tying state allotments to real measures of need, ensuring DSH funds reach hospitals doing the most for uninsured and Medicaid patients, and placing the program on a stable financial path.

Appendix

ENDNOTES

1. United States, Congress, Medicaid and CHIP Payment and Access Commission. "Medicaid Base and Supplemental Payments to Hospitals," May 2024, www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/. Accessed 12 Nov. 2025.

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10. These six states are Connecticut, Indiana, Louisiana, New Jersey, Pennsylvania, and Virginia.

11. These four states are Connecticut, Louisiana, New Jersey, and Pennsylvania. United States, Congress, Medicaid and CHIP Payment and Access Commission. "Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States." March 2024, www.macpac.gov/publication/annual-analysis-of-medicaid-disproportionate-share-hospital-allotments-to-states-3/. Accessed 12 Nov. 2025.

12. Authors' calculations based on United States, Congress, Medicaid and CHIP Payment and Access Commission. "Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States." March 2024, www.macpac.gov/publication/annual-analysis-of-medicaid-disproportionate-share-hospital-allotments-to-states-3/. Accessed 12 Nov. 2025; "Hospital Cost Tool," *National Academy for State Health Policy*, 7 Feb. 2025, tool.nashp.org/. Accessed 12 Nov. 2025; "CMS Hospital Cost Report Data Made Easy," *RAND*, 1994–2025, www.hospitaldatasets.org/. Accessed 12 Nov. 2025.

13. A related, but smaller problem is Medicaid's payments to hospitals that do not receive DSH payments. The problem is smaller because those hospitals account for only six percent of hospitals' revenue from Medicaid. (Authors' calculations based on "Hospital Cost Tool," *National Academy for State Health Policy*, 7 Feb. 2025, tool.nashp.org/. Accessed 12 Nov. 2025; "CMS Hospital Cost Report Data Made Easy," *RAND*, 1994–2025, www.hospitaldatasets.org/. Accessed 12 Nov. 2025.) Unfortunately, neither the states nor the federal government have collected the information needed to evaluate hospital margins in non-DSH hospitals in contrast to the robust information for Medicare patients.

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18. The five states that focused 100% of their DSH payments on deemed DSH hospitals are Delaware, Iowa, Illinois, Maine, and Maryland. The six states distributed just 10% of their DSH funds to deemed DSH hospitals.

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