

Chapter 2:

Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

Recommendation

2.1 To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

Key Points

- Medicaid disproportionate share hospital (DSH) payments help to offset two types of hospital uncompensated care: Medicaid shortfall and unpaid costs of care for uninsured individuals.
- Recent lawsuits have challenged how Medicaid shortfall is calculated for Medicaid-eligible patients with third-party coverage, such as Medicare and private insurance. The chronology of events is as follows:
 - In 2010, the Centers for Medicare & Medicaid Services (CMS) issued guidance that third-party payments should be counted when calculating Medicaid shortfall.
 - In March 2018, the U.S. District Court of the District of Columbia vacated CMS's policy nationwide because the Medicaid DSH statute does not explicitly mention third-party payments.
 - CMS is appealing this decision, but in the interim, the agency has instructed states that it will no longer enforce its 2010 guidance.
- The March 2018 district court ruling will substantially increase the amount of Medicaid shortfall that hospitals report, allowing them to receive DSH payments for costs that are paid for by other payers.
- Although the court ruling does not affect the amount of DSH funds allotted to states, it is expected to result in an increase in DSH spending in states with unspent DSH allotments as well as in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs.
- In the Commission's view, the court ruling distorts DSH policy from its intended purpose of paying for uncompensated care costs that are not paid for by other payers.
- Although the March 2018 decision is currently under appeal, MACPAC focused its work on what the preferred policy should be, not the legal issues under consideration by the courts.
- Congress can improve upon CMS's 2010 policy by changing the DSH definition of Medicaid shortfall to only count costs and payments for patients for whom Medicaid is the primary payer.
- If enacted, the Commission's recommendation would remove a disincentive for hospitals to help privately insured patients enroll in Medicaid.
- The approach we recommend is administratively simple and is likely to result in larger DSH payments to hospitals that serve more patients who are uninsured or whose only source of coverage is Medicaid.

CHAPTER 2: Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

Recent lawsuits have challenged how Medicaid shortfall is calculated for the purposes of Medicaid disproportionate share hospital (DSH) payments. Specifically, there is disagreement over what costs and payments can legally be counted as shortfall for Medicaid-eligible patients with third-party coverage, such as Medicare and private insurance. Although these lawsuits are still under appeal, they have raised questions about whether the statute should be changed to ensure that DSH payments do not pay for costs that are paid for by other payers.

DSH payments are statutorily required payments to safety-net hospitals that help to offset two types of uncompensated care: Medicaid shortfall and unpaid costs of care for uninsured individuals. In general, Medicaid shortfall is defined as the difference between a hospital's costs of care for Medicaid-eligible patients and the payments that the hospital receives for these services. For Medicaid-eligible patients with third-party coverage, most of the costs of care for these patients are paid for by other payers because Medicaid is a payer of last resort.

Since at least 2010, the Centers for Medicare & Medicaid Services (CMS) has held that third-party payments should be counted when calculating Medicaid shortfall.¹ However, in March 2018, the U.S. District Court for the District of Columbia vacated CMS's policy nationwide, ruling that it is inconsistent with the plain language of the Medicaid DSH statute since the statute does not explicitly mention third-party payments.^{2,3} CMS is appealing this decision, but in the interim, the agency has instructed states that it will no longer enforce its 2010 guidance (CMS 2018).

With the March 2018 decision in effect, the amount of Medicaid shortfall that hospitals can report is

substantially increased because they are permitted to count as shortfall costs for Medicaid-eligible patients that are paid for by other payers. The ruling is expected to result in an increase in DSH spending in states with unspent federal DSH funding and in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs. Although the court ruling is currently being appealed, we have already observed some of the early effects of the ruling in states that were among the first to file lawsuits against CMS's 2010 policy.

This chapter presents the Commission's analysis of the potential impact of this court ruling and our recommendation for how Medicaid shortfall should be defined for DSH purposes. The Commission examined the effects of changing the statute to allow CMS to implement its 2010 policy and changes that Congress could make to that policy to advance the following policy goals:

- making more DSH funds available to hospitals that serve a high share of Medicaid and uninsured patients;
- not creating a disincentive for hospitals to either serve Medicaid-eligible patients with third-party coverage or help patients enroll in Medicaid; and
- promoting administrative simplicity.

Based on this analysis, the Commission recommends that Congress change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer. Although this policy differs from CMS's 2010 policy, it is both administratively simple and consistent with the way in which many states calculated Medicaid shortfall before CMS's 2010 policy took effect.

Changes to the DSH definition of Medicaid shortfall do not affect the total amount of federal DSH funds available to states, which are referred to as allotments. The Commission's annual analyses of

DSH allotments to states and its recommendations for improving the structure of DSH allotment reductions are included in Chapters 1 and 3 of MACPAC's March 2019 *Report to Congress on Medicaid and CHIP* (MACPAC 2019a, 2019b).

Background

State Medicaid programs are statutorily required to make DSH payments to hospitals that serve a high proportion of Medicaid and other low-income patients (referred to as deemed DSH hospitals); states may also make DSH payments to other hospitals in the state that meet minimum eligibility

criteria. DSH payments to an individual hospital cannot exceed the hospital's uncompensated care costs for Medicaid and uninsured patients, which is referred to as the hospital-specific limit. In addition, total federal funding for DSH payments in each state is limited by federal allotments (Box 2-1).

In state plan rate year (SPRY) 2014, 45 percent of U.S. hospitals received DSH payments totaling \$17.8 billion.⁴ DSH hospitals reported a total \$34.0 billion in uncompensated care on DSH audits, of which \$23.5 billion (69 percent) was attributed to unpaid costs of care for uninsured individuals and \$10.4 billion (31 percent) to Medicaid shortfall (Figure 2-1).⁵ Although most DSH hospitals received

BOX 2-1. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

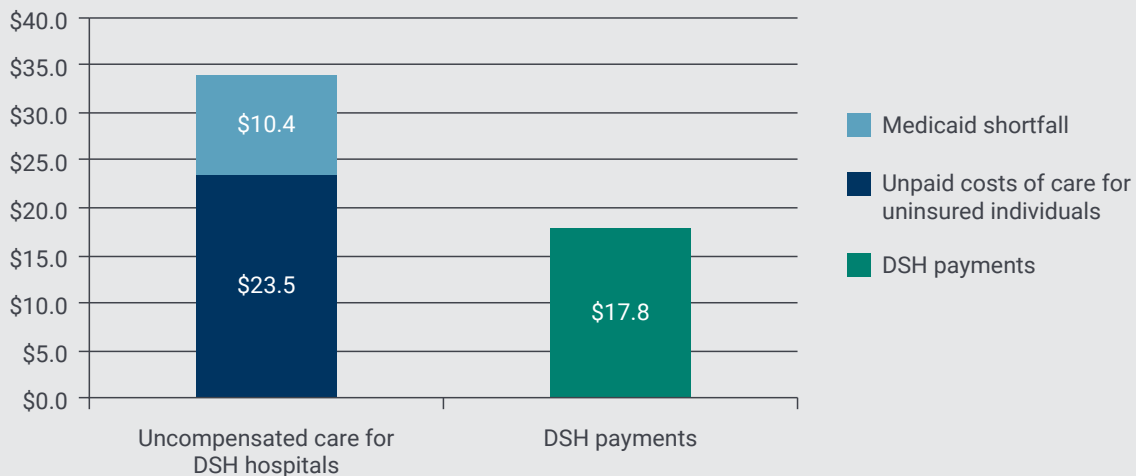
DSH hospital. A hospital that receives disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments; that is, a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions for rural and children's hospitals).

Deemed DSH hospital. A DSH hospital with either (1) a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or (2) a low-income utilization rate that exceeds 25 percent. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act (the Act)).

State DSH allotment. The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other Medicaid service expenditures. If a state does not spend the full amount of its allotment for a given year, the unspent portion is not paid to the state and does not carry over to future years. Allotments are determined annually and are generally equal to the prior year's allotment, adjusted for inflation (§ 1923(f) of the Act).

Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs.

Medicaid DSH audit. A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-five percent of U.S. hospitals were included in DSH audits in 2014, the latest year for which data are available.

FIGURE 2-1. DSH Payments and Uncompensated Care for DSH Hospitals, SPRY 2014 (billions)


Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. The analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

Source: MACPAC, 2019, analysis of as-filed SPRY 2014 DSH audits.

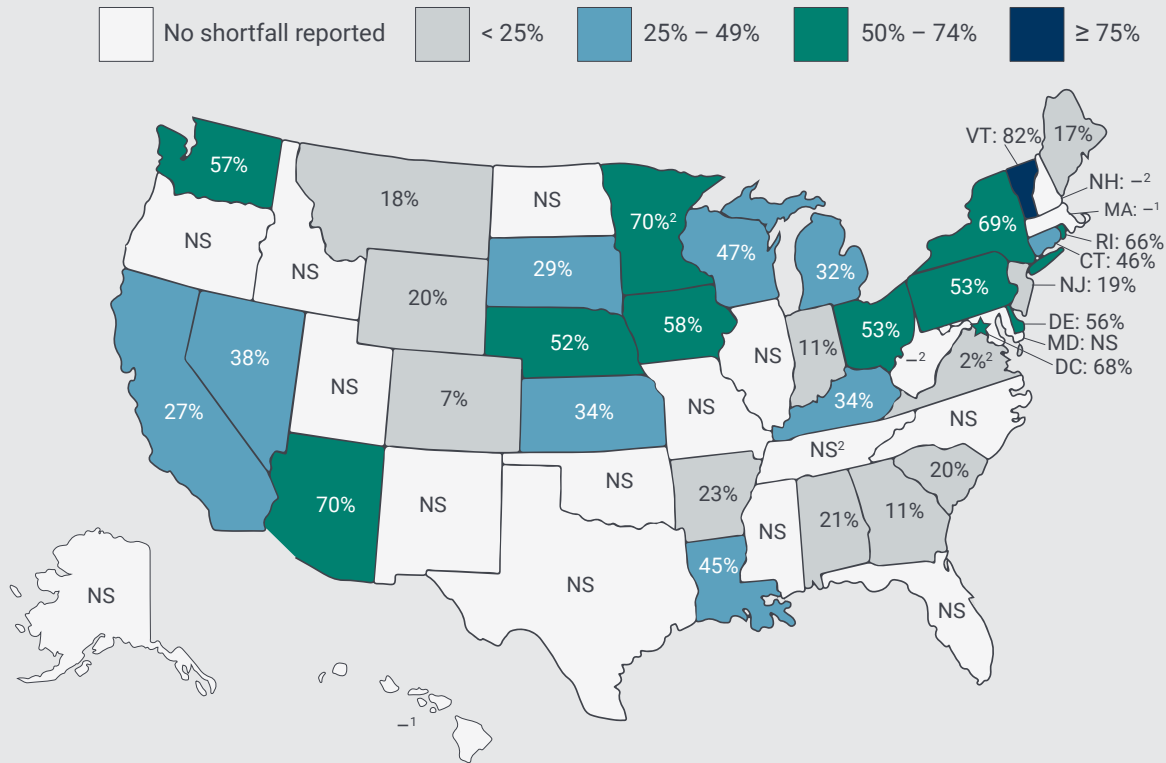
DSH payments well below their hospital-specific limit, 20 percent of DSH hospitals received DSH payments that were greater than 95 percent of their uncompensated care costs in SPRY 2014.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 2-2). In SPRY 2014, 15 states reported no Medicaid shortfall for DSH hospitals and 12 states reported shortfall that exceeded 50 percent of total DSH hospital uncompensated care. Although Medicaid base payments for hospital services are typically below hospital costs, many states make large non-DSH supplemental payments that reduce or eliminate the amount of Medicaid shortfall reported on DSH audits. Complete state-by-state data on Medicaid shortfall and other uncompensated care costs are included in Chapter 3 of MACPAC's March 2019 report to Congress, and more information about other types of Medicaid payments to hospitals is provided in MACPAC's issue brief, *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2019b, 2019c).

As a result of the coverage expansions under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the amount of hospital unpaid costs of care for uninsured individuals is declining and Medicaid shortfall is increasing. For hospitals that received DSH payments in SPRY 2013 and SPRY 2014, the increase in Medicaid shortfall reported on DSH audits (\$4.0 billion) outpaced the decline in unpaid costs of care for uninsured patients (\$1.6 billion) for those years.⁶

Changes in the broader health insurance market have also affected other types of hospital uncompensated care that Medicaid DSH payments do not pay for. For example, between 2006 and 2016, the share of private-sector enrollees in high-deductible health plans grew from 11.4 percent to 46.5 percent; if patients cannot pay their deductibles or other forms of cost sharing, these amounts often become bad debt expenses for hospitals (Miller et al. 2018). Also, although the number of physicians employed by hospitals has grown in recent years, uncompensated care costs for physician services are not included in the DSH definition of uncompensated care.⁷

FIGURE 2-2. Medicaid Shortfall as a Share of Total Uncompensated Care Costs for DSH Hospitals, SPRY 2014



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. NS is no shortfall reported.

– Dash indicates no data available.

¹ Hawaii and Massachusetts did not submit SPRY 2014 DSH audits because they did not make any DSH payments in SPRY 2014.

² Analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

Source: MACPAC, 2019, analysis of as-filed SPRY 2014 DSH audit data.

Medicaid-Eligible Patients with Third-Party Coverage

Individuals can be eligible for Medicaid even if they have other insurance. Many Medicaid enrollees with disabilities and those age 65 and older are also eligible for Medicare; Medicaid funds cover their Medicare premiums and cost sharing. Privately insured individuals with disabilities that affect their ability to live independently may seek Medicaid

coverage to access long-term services and supports even if their private insurance covers their acute health care needs. In some cases, a patient’s medical condition can make a patient eligible for Medicaid; for example, low-birthweight babies are eligible for Supplemental Security Income (SSI), which confers automatic eligibility for Medicaid as well.⁸

In 2017, 18.4 million Medicaid enrollees had third-party coverage (Table 2-1). About two-thirds of these enrollees had Medicare coverage, which is

TABLE 2-1. Number of Medicaid Enrollees with Third-Party Coverage, 2017 (millions)

Source of third-party coverage	Number	Share of total Medicaid enrollees
All sources of third-party coverage	18.4	27%
Medicare	11.5	17%
Private ¹	8.8	13%
Veterans' and military health programs	1.8	3%
Indian Health Service	0.6	1%

Notes: Estimates are based on self-reported information from the American Community Survey. Individuals may report multiple types of coverage. All estimates shown have relative standard errors of less than 3 percent.

¹ In our analysis, private sources of health insurance include employer-sponsored, union-sponsored, and individually purchased health insurance.

Source: SHADAC 2019.

the most common type of third-party coverage for Medicaid enrollees with disabilities and those age 65 and older, and about one-half had private insurance coverage, which is the most common type of third-party coverage for children and adults under age 65 who are eligible for Medicaid on a basis other than disability.

Medicaid is generally the payer of last resort, meaning that other payers must pay claims under their policies before Medicaid will pay for services provided to an eligible individual. Medicare is the primary payer for hospital services for patients dually enrolled in Medicaid and Medicare, but some other public programs, such as the Indian Health Service, are statutorily designated as payers of last resort after Medicaid.

States are statutorily required to coordinate benefits for Medicaid enrollees with any potential third-party coverage. Typically, states will require providers to submit claims to the primary payer first, and then Medicaid will pay any difference between what was paid for by that payer and the amount that Medicaid would have paid for the same service. Because Medicaid often pays lower rates than other insurers, providers may not receive any additional payment from Medicaid. As a result, a provider may choose not to submit a claim to Medicaid for a Medicaid-eligible patient if a third-party payer has already paid for the service in question. This scenario is

most common for individuals with private insurance coverage because private payers typically pay much more than Medicaid.

History of the DSH Definition of Medicaid Shortfall

DSH payments were initially established in 1981 to account for “the situation of hospitals which serve a disproportionate number of low-income patients with special needs” (§ 1902(a)(13)(A) (iv) of the Act), and in 1993, Congress established hospital-specific limits for DSH payments based on a hospital’s overall uncompensated care costs for Medicaid-enrolled and uninsured patients. Hospital-specific limits received renewed attention in 2003, when Congress required states to audit and report DSH hospital uncompensated care costs annually. CMS finalized regulations implementing the audit requirements in 2008 and required states to make DSH payments based on this rule for SPRY 2011 and subsequent years. These regulations describe how uncompensated care costs should be reported, including which hospital services should be included, how uninsured individuals should be counted, and how Medicaid shortfall should be calculated (CMS 2008).⁹

Prior to the 2008 DSH audit rule, states used a variety of methods to account for third-party payments when calculating Medicaid shortfall. Some states subtracted payments received from third-party payers, and some did not. Other states entirely excluded both costs of and payments for Medicaid-eligible patients with third-party coverage from the calculation of Medicaid shortfall. These various methods can now be categorized as following the CMS 2010 policy; following the March 2018 district court decision that vacated the CMS policy; or following the method that would apply if the Commission’s recommendation is taken (Table 2-2).

In 2010, CMS issued subregulatory guidance in the form of frequently asked questions (FAQs) to clarify the 2008 rule, including instructions on how to account for the costs and payments of Medicaid-eligible patients with third-party coverage. These FAQs set out CMS’s policy that the costs of patients with third-party coverage should be included in DSH audits and the amount of third-party payments received for these patients should be subtracted when calculating Medicaid shortfall (CMS 2018). For example, under this guidance, Medicaid shortfall for patients dually eligible for Medicare and Medicaid would be calculated as the total hospital cost of treating the patient, less the amount that Medicare and Medicaid paid for the service provided.

TABLE 2-2. Components of Medicaid Shortfall for Enrollees with and without Third-Party Coverage Under Different Calculation Methods

Method of calculating Medicaid shortfall	Medicaid-eligible patients with third-party coverage			Medicaid-only patients	
	Medicaid payments	Third-party payments	Costs	Medicaid payments	Costs
Count all payments and costs (CMS 2010 policy)	X	X	X	X	X
Do not count third-party payments, but count third-party costs (March 2018 district court ruling)	X		X	X	X
Do not count payments or costs for patients with third-party coverage (MACPAC recommendation)				X	X

Notes: CMS 2010 policy refers to the policy described in CMS’s 2010 subregulatory guidance (CMS 2018). March 2018 district court ruling refers to the policy described in *Children’s Hospital Association of Texas v. Azar*. Components marked with an X are included in calculations for that method.

In states that were not previously counting third-party payments, CMS’s 2010 policy as set out in the FAQs reduced the amount of DSH funds that hospitals were eligible to receive and resulted in state and federal recoupments of DSH payments made to some hospitals. Overall, according to as-filed SPRY 2011 DSH audits, \$0.7 billion of the \$16.6 billion in DSH payments made that year were subject to recoupment or redistribution to other providers because, as recalculated under CMS’s

2010 policy, the payments were made in excess of the hospital-specific limit.¹⁰

In response to these recoupments, several hospitals challenged CMS’s policy on two main fronts. First, on procedural grounds, hospitals argued that the subregulatory guidance issued as FAQs represented a change in policy that was not made through formal rulemaking. Second, on the substance of the policy, hospitals argued that the

statute did not provide CMS with the authority to consider third-party payments in the calculation of Medicaid shortfall.

In response to procedural concerns about the FAQs, CMS issued a notice of proposed rulemaking in August 2016 formalizing the policy that all costs and payments for patients with third-party coverage should be included in the Medicaid shortfall calculation. This rule was finalized in April 2017 and became effective for DSH payments made on or after June 2, 2017 (CMS 2017).

Several hospitals also challenged CMS's final rule. In March 2018, the U.S. District Court for the District of Columbia vacated the 2017 rule nationwide, calling the policy "inconsistent with the plain language of the Medicaid Act".¹¹ Other district courts and appellate courts have also ruled against CMS on both its FAQs and its final rule (Eyman Associates 2018).¹² CMS is appealing the March 2018 decision and other related rulings; in the interim, it has withdrawn the relevant FAQs and stated that it will not enforce the 2017 rule while the March 2018 decision is operative in its current form (CMS 2018).

Effects of the Court Ruling on Medicaid Shortfall

In comparison with calculations made under CMS's 2010 policy, calculations of Medicaid shortfall made under the March 2018 district court decision are substantially higher because third-party payments are no longer counted. Early data are available for New Hampshire and West Virginia, which reported shortfall based on the court ruling in their SPRY 2014 DSH audits: in New Hampshire, shortfall increased from \$61 million to \$149 million, and in West Virginia, shortfall increased from \$122 million to \$589 million from SPRY 2013 to 2014 for hospitals that received DSH payments in both years. Although both New Hampshire and West Virginia also expanded Medicaid to the new adult group in 2014, the increase in shortfall that these states reported between SPRY 2013 and SPRY 2014 was much larger than the 36 percent increase in

shortfall reported in other expansion states that did not change the definition of Medicaid shortfall used during this period (MACPAC 2019b).¹³

The court ruling's effect on the amount of shortfall reported for Medicaid-eligible patients will be different for those enrolled in Medicare and those with private insurance because payments from Medicare are typically lower than payments from private insurance. Below, we examine how Medicaid shortfall was reported for patients in these coverage scenarios under CMS's 2010 policy and how it is expected to change as a result of the district court ruling.

Shortfall for Medicare patients

In 2013, 10.7 million people were dually eligible for Medicare and Medicaid. This number includes individuals who were eligible for different levels of Medicaid coverage for Medicare cost sharing:

- 6.9 million qualified Medicare beneficiaries (QMBs) who received Medicaid assistance with Medicare premiums and cost sharing;
- 2.2 million full-benefit Medicaid enrollees who were not enrolled in the QMB program but still received assistance with Medicare cost sharing; and,
- 1.6 million specified low-income Medicare beneficiaries (SLMBs) and qualified individuals (QIs) who were not eligible for full Medicaid benefits or Medicaid assistance with Medicare cost sharing but received Medicaid assistance with Medicare Part B premiums (MACPAC 2015).¹⁴

Although CMS's 2010 policy instructs hospitals to report costs for all Medicaid-eligible patients, DSH audits often exclude partial-benefit SLMB and QI enrollees. Because Medicaid does not pay for cost sharing for these patients, they may not be identified as Medicaid-eligible to the hospital, making it administratively difficult for hospitals to track costs for them. As a result, Medicaid shortfall is typically only reported for full-benefit Medicaid enrollees and those enrolled in the QMB program.¹⁵

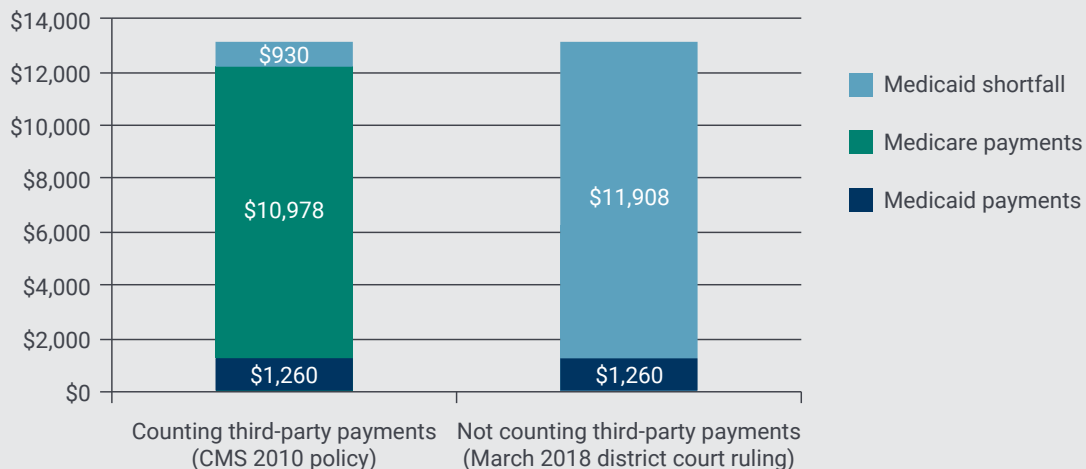
States have the option to determine how much Medicare cost sharing they cover for QMB program enrollees. According to MACPAC’s 2018 review of state policies, most states pay either the Medicare cost sharing amount or the amount that Medicaid would have paid for the same service, whichever is less (referred to as a lesser-of policy). Specifically, 41 states have lesser-of policies for inpatient hospital services and 38 states and the District of Columbia have lesser-of policies for outpatient hospital services (MACPAC 2018a).

Because Medicare is the primary payer for patients dually eligible for Medicare and Medicaid, not counting third-party payments for these patients substantially increases the amount of Medicaid shortfall. For example, Medicare paid hospitals approximately 92.9 percent of costs in 2015, resulting in a \$930 shortfall on the average Medicare inpatient stay under CMS’s 2010 policy.¹⁶ However, if Medicare payments were not counted, the amount of shortfall reported would be more than 10 times higher (Figure 2-3).

Under both CMS’s 2010 policy and the district court ruling, shortfall increases if Medicaid does not pay the full amount of Medicare cost sharing (including the inpatient deductible).¹⁷ If Medicaid does not pay the full amount of the Medicare cost sharing, hospitals are prohibited from billing patients for the difference. However, hospitals can receive Medicare bad debt payments to cover 65 percent of the unpaid amount.

The amount of shortfall that hospitals report for Medicare patients varies by hospital type. In 2017, deemed DSH hospitals reported an aggregate Medicare payment-to-cost ratio of 92.8 percent, which was higher than the Medicare payment-to-cost ratio for other hospitals (90.6 percent) (MedPAC 2019).¹⁸ One reason why deemed DSH hospitals report less shortfall for Medicare patients than other types of hospitals may be because safety-net hospitals are eligible for additional payments from Medicare, such as Medicare DSH payments.¹⁹

FIGURE 2-3. Illustrative Example of Medicaid Shortfall for Patients Dually Eligible for Medicare and Medicaid Under Different Methods of Counting Third-Party Payments, 2015



Notes: CMS 2010 policy refers to the policy described in CMS’s 2010 subregulatory guidance (CMS 2018). March 2018 district court ruling refers to the policy described in *Children’s Hospital Association of Texas v. Azar*. The numbers used in this figure are based on data from 2015. At that time, the average hospital cost for a Medicare inpatient stay was \$13,168 and the Medicare Part A deductible was \$1,260.

Source: MACPAC, 2019, analysis of MedPAC 2018, AHRQ 2017, and CMS 2015.

Medicaid shortfall for privately insured patients

In 2017, 8.8 million Medicaid enrollees were also enrolled in private insurance (SHADAC 2019). This number includes individuals who had private insurance for their acute medical needs but had Medicaid coverage for services not covered by their private insurance, such as home- and community-based services. Also included were individuals who were automatically eligible for Medicaid based on their health status, most notably low-birthweight babies.

Individuals not enrolled in Medicaid at the time of hospital discharge are not typically counted in DSH audits because it is administratively difficult for hospitals to know that these patients are Medicaid-eligible.²⁰ If a hospital helps a patient enroll in Medicaid while hospitalized, the patient must be counted on the hospital's DSH audit even though private insurance might cover the hospitalization. Although hospitals are not required to do so, enrolling high-need patients in Medicaid while they are hospitalized might help the patient gain access to services after discharge that are not covered by most private insurance plans.

Payments from private insurers often exceed the costs of hospital care, but the cost sharing required for private insurance is often much higher than Medicaid. In 2016, payments to hospitals from private insurance and self-pay patients totaled 144.8 percent of hospital costs (AHA 2018). In 2018, the average insurance deductible was \$1,573 and the average hospital coinsurance was 19 percent for single-coverage employee plans (KFF 2018).²¹ Any co-payments and deductibles that patients do not pay by the time the DSH audit is conducted are not counted as hospital revenue and thus increase the amount of shortfall that hospitals report for Medicaid-eligible patients with private coverage.²²

Under CMS's 2010 policy, any surpluses a hospital received from Medicaid-eligible patients with

private coverage were subtracted from the Medicaid shortfall the hospital reported for Medicaid-only patients. For example, according to an amicus brief filed by the Children's Hospital Association in support of hospitals opposing CMS in its appeal of the March 2018 district court ruling, data reported by the Children's Hospital of the King's Daughters in Virginia showed that the hospital's \$13.1 million surplus from Medicaid-eligible patients with private insurance reduced the amount of DSH payments that the hospital was eligible to receive from \$16.4 million (the hospital's shortfall for Medicaid-only patients) to \$3.3 million in 2013 (Table 2-3).²³ For some other children's hospitals, the CMS 2010 policy entirely eliminated the amount of DSH funding that the hospital was eligible to receive (CHA 2018).

In contrast, under the district court ruling, a hospital is able to report the full costs of care for hospital services provided to Medicaid-eligible patients with private insurance coverage, and it does not have to reduce its Medicaid shortfall by the amount of the private insurance payments received for these services. For the Children's Hospital of the King's Daughters, the court ruling would have substantially increased the amount of Medicaid shortfall it reported in 2013, from \$3.3 million to \$37.0 million (CHA 2018).

Hospitals with neonatal intensive care units are particularly affected by this policy because, as noted above, low-birthweight babies are automatically eligible for Medicaid and often have complex medical needs that require costly hospital stays. A small number of low-birthweight babies can have a large effect on overall hospital costs. For example, in 2013, the Children's Hospital of the King's Daughters served 2,199 Medicaid-eligible children with private coverage and 108,347 children covered only by Medicaid. The average cost of care for children with Medicaid and private insurance at this hospital was \$9,367 per patient, which was more than nine times the average cost of care for children with Medicaid only (\$1,006 per patient) (CHA 2018).

TABLE 2-3. Illustrative Example of Medicaid Shortfall for Medicaid-Eligible Patients with Private Coverage Under Different Methods of Counting Third-Party Payments (millions)

Method of calculating Medicaid shortfall	Medicaid-eligible patients with private coverage				Medicaid shortfall for Medicaid-only patients	Total Medicaid shortfall
	Medicaid payments	Private insurance payments	Medicaid allowable costs	Medicaid shortfall (surplus)		
	A	B	C	D = C - A - B		
Count all payments and costs (CMS 2010 policy)	\$0	\$33.7	\$20.6	(\$13.1)	\$16.4	\$3.3
Do not count third-party payments, but count third-party costs (March 2018 district court ruling)	0	N/A	20.6	20.6	16.4	37.0
Do not count payments or costs for patients with third-party coverage (MACPAC recommendation)	N/A	N/A	N/A	N/A	16.4	16.4

Notes: N/A is not applicable. CMS is Centers for Medicare & Medicaid Services. CMS 2010 policy refers to the policy described in CMS's 2010 subregulatory guidance (CMS 2018). March 2018 district court ruling refers to the policy described in *Children's Hospital Association of Texas v. Azar*. Illustrative example is based on 2013 costs and payment data for the Children's Hospital of the King's Daughters in Virginia included in an amicus brief filed by the Children's Hospital Association in support of hospitals opposing CMS in its appeal of the March 2018 district court ruling. The brief also noted that the Virginia hospital had \$3 million in costs for Medicaid-eligible patients with third-party coverage and \$22 million in costs for Medicaid-only patients that were not recognized as Medicaid allowable costs.

Source: MACPAC, 2019, analysis of CHA 2018.

Effects of the Court Ruling on States and Providers

Although the March 2018 district court decision does not affect DSH allotments to states, it has the potential to change the distribution of DSH funding within states by changing the total amount of funding that individual DSH hospitals are eligible to receive. Specifically, states with unspent DSH funds are expected to spend more of their DSH allotments and the distribution of DSH payments is expected to change in states that distribute DSH payments based on hospital uncompensated care as defined on DSH audits.

Changes in total state DSH spending

Although the court ruling does not change the total amount of DSH funds allotted to states, it is expected to increase DSH spending in states that have not previously spent their full DSH allotment. In FY 2016, \$1.2 billion in federal DSH funds went unspent, and about half of these unspent funds were attributable to four states (Connecticut, New Hampshire, New Jersey, and Pennsylvania) and the District of Columbia. All of these states had DSH allotments that were larger than the total amount of uncompensated care in their state, as reported by hospitals on Medicare cost reports.²⁴ Because the court ruling is increasing the amount of shortfall reported, it could increase the amount of DSH funds these states can spend. However, it is important to note that states must provide their non-federal share of such payments to draw down additional federal DSH funds.

Changes in the distribution of DSH payments

The court ruling is also expected to change the distribution of DSH payments within states that currently distribute DSH payments based on hospital uncompensated care costs. Based on MACPAC's compendium of state hospital payment policies in 2018, about half of states (24) distributed DSH payments based on hospital uncompensated costs (MACPAC 2018b).²⁵ For example, Ohio distributes DSH payments to a hospital based on its share of total uncompensated care in the state as reported on DSH audits. Thus, hospitals that report more uncompensated care under the court ruling will receive larger DSH payments in this state.

In Texas, which also distributes DSH payments and other uncompensated care supplemental payments based on hospital uncompensated care costs, early reports suggest that the court ruling will result in large shifts in the distribution of payments within the state.²⁶ For example, Texas Children's Hospital reported \$45 million in additional revenue in 2018 as result of the court ruling, because the ruling allowed the hospital to retain DSH payments that were previously subject to recoupment (Texas Children's 2018). In contrast, the state's preliminary estimates project a \$166 million decline in uncompensated care payments to large public hospitals between 2017 and 2018, a 25 percent decline (THOT 2018).²⁷ Although many of the children's hospitals and large public hospitals in Texas are deemed DSH hospitals, children's hospitals tend to serve more Medicaid-eligible patients with third-party coverage and thus report more Medicaid shortfall as a result of the court ruling. Prior to CMS's 2010 guidance, Texas did not count payments or costs for Medicaid eligible patients with third-party coverage when calculating Medicaid shortfall for Medicaid DSH purposes (HHSC 2019).

States can change their method of distributing DSH payments if they want to minimize the district court ruling's expected redistribution of DSH payments, but we have not identified any states that have done so. Specifically, states can use

factors other than uncompensated care costs to distribute DSH payments or they can choose to distribute DSH payments using a different definition of uncompensated care than the one used to audit compliance with the hospital-specific limit.

Commission Recommendation

In this chapter, the Commission recommends that Congress make a statutory change to reverse the effects of the recent court ruling and ensure that DSH payments do not pay for costs that are paid for by other payers. The rationale and implications of this recommendation are described below.

Recommendation 2.1

To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

Rationale

The intended purpose of Medicaid DSH payments is to pay for hospital uncompensated care costs that are not paid for by other payers. However, the U.S. District Court for the District of Columbia decision in *Children's Hospital Association of Texas v. Azar* allows hospitals nationwide to receive DSH payments to cover costs that are paid for by third-party payers, such as Medicare and private insurance. The court's decision was based on a strict reading of the DSH statute and did not fully consider the potential effects of this policy change on DSH payments to providers.

Although this decision and others from related cases are currently under appeal, the court ruling is already affecting DSH payments in some states. Overall, the ruling is expected to increase DSH spending in states that have not previously spent their full DSH

allotment and result in a large redistribution of DSH payments in states that distribute DSH payments based on hospital uncompensated care costs (about half of all states).

A statutory change to clarify the treatment of third-party payments in the DSH definition of Medicaid shortfall is needed to avoid this redistribution of DSH funding. Action by Congress would also provide more certainty to states and providers about how uncompensated care should be calculated. Even if the district court decision is reversed on appeal, such a decision would likely be appealed further, continuing to create uncertainty for states and providers.

In developing this recommendation, the Commission considered how the DSH definition of Medicaid shortfall could be changed to advance additional policy goals. Specifically, instead of counting all payments and costs for all patients with third-party coverage as under CMS's 2010 policy, the DSH definition of Medicaid shortfall could be revised to exclude some or all Medicaid-eligible patients with third-party coverage from the DSH Medicaid shortfall calculation.

The Commission separately examined the effects of counting shortfall for Medicare and privately insured patients in relation to three policy goals:

- making more DSH funds available to hospitals that serve a high share of Medicaid and uninsured patients;
- not creating a disincentive for hospitals to either serve Medicaid-eligible patients with third-party coverage or help patients enroll in Medicaid; and,
- promoting administrative simplicity.

Ultimately, the Commission concluded that it would be preferable to have a policy that does not count payments or costs for any Medicaid-eligible patients for whom Medicaid is not the primary payer. Such a policy would remove the disincentive for hospitals to help privately insured patients enroll in Medicaid and it is administratively simple because it removes

the need for DSH auditors to collect information about third-party payments. Moreover, in states that distribute DSH payments based on hospital uncompensated care costs, this policy is likely to result in larger DSH payments to hospitals that serve more Medicaid-only and uninsured patients.

During the discussion, some Commissioners raised concerns that not counting shortfall for patients who are dually eligible for Medicare and Medicaid could create a disincentive for hospitals to serve these patients. However, we do not have any evidence that Medicaid DSH payment policy affects hospital decisions to serve dually eligible patients. Furthermore, Medicare already makes several special payments to hospitals to help offset hospital costs for these patients, including Medicare DSH and bad debt payments.

Design considerations. In most third-party coverage scenarios, Medicaid is the payer of last resort. However, this is not the case for services provided by the Indian Health Service, the Ryan White HIV/AIDS Program, and state and local indigent care programs, in which Medicaid is the primary payer. Under the Commission's recommended policy, hospitals could continue to receive DSH payments for Medicaid-eligible patients in these programs, for whom Medicaid is the primary payer.

The same rules that are used to determine when Medicaid is a primary payer for the purposes of third-party liability could be used to determine whether Medicaid is a primary payer for DSH purposes (42 CFR 433.139). In general, private insurance is the primary payer for hospital services even if the patient does not pay the deductible or cost sharing required by the private plan. However, existing regulations establish a process for Medicaid to pay claims in circumstances where the third party does not pay for the service at all. The Commission's recommendation is not intended to change Medicaid's obligation to pay its share of costs for Medicaid-eligible patients with third-party coverage.

If Congress adopts MACPAC's recommendation, any statutory change to the DSH definition

of uncompensated care would likely apply prospectively to DSH payments made in future years. Thus, the outcome of *Children's Hospital Association of Texas* would continue to have an effect on any audits of DSH payments made before the statute is changed. DSH audits are not due until three years after DSH payments are made, so it will take time to observe the hospital-level effects of any policy change.

In MACPAC's March 2019 report to Congress, the Commission made several recommendations to restructure pending DSH allotment reductions, including a recommendation to apply DSH allotment reductions to unspent DSH funding first (MACPAC 2019a). In general, changes to the DSH definition of Medicaid shortfall do not affect DSH funding allotted to states. However, the district court decision in *Children's Hospital Association of Texas v. Azar* has the potential to reduce the amount of unspent DSH funding in some states, which could affect the distribution of DSH allotments among states under MACPAC's recommended policy.

Implications

Federal spending. The Congressional Budget Office (CBO) estimates that this policy will have an insignificant effect on federal spending. Specifically, although the policy may affect total DSH spending, particularly in states with unspent DSH allotments, the effect is too small for CBO to estimate.

States. The Commission's recommendation will not change the total amount of DSH funding allotted to states, but it may affect DSH spending in some states that historically have not spent their full DSH allotment because their DSH allotments were larger than the total amount of uncompensated care in their state. By increasing the amount of uncompensated care that hospitals report, the court ruling is expected to increase DSH payments in these states. The Commission's recommendation is expected to return the total amount of uncompensated care that hospitals report to levels similar to those previously reported under CMS's 2010 policy. This change is also expected to return state DSH spending to its previous levels.

Enrollees. It is difficult to predict how this change will affect enrollees because its effect depends on how states and hospitals respond. In theory, the Commission's recommendation removes the disincentive for DSH hospitals to help privately insured patients enroll in Medicaid and it may create a disincentive for DSH hospitals to serve patients dually eligible for Medicare and Medicaid. However, hospital behavior is affected by many different factors, and we do not have any evidence that it is affected by the DSH definition of Medicaid shortfall.

Providers. The Commission's recommendation will avoid the expected consequence of the district court ruling, that is, a large redistribution of DSH payments to providers in states that distribute DSH payments based on hospital uncompensated care costs. The Commission's recommendation is expected to result in more DSH payments for hospitals that serve a higher share of Medicaid-only and uninsured patients than were paid to these hospitals under CMS's 2010 policy.

Endnotes

¹ In subsequent rulemaking on this issue, CMS notes that it first clarified how shortfall should be calculated for patients with third-party coverage in a 2002 letter to state Medicaid directors (CMS 2017). However, CMS's 2010 subregulatory guidance addressed this issue more explicitly, and as a result, CMS's 2010 guidance has been the subject of recent lawsuits.

² *Children's Hospital Association of Texas v. Azar*, 300 F. Supp. 3d 190 (D.D.C. 2018), appeal docketed, No. 18-5135 (D.C. Cir. May 9, 2018).

³ Section 1923(g)(A) of the Social Security Act states that DSH payments cannot exceed "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section and by uninsured patients)." The phrase "under this title" refers to Medicaid (Title XIX) and the statute does not explicitly mention payments received by third-party payers. CMS's 2010 policy has also been challenged in other courts, but references in this chapter to the district court ruling refer to the March 2018 decision in *Children's Hospital*

Association of Texas v. Azar by the U.S. District Court for the District of Columbia.

⁴ States report hospital-specific DSH data on a SPRY basis, which often corresponds to the state fiscal year and may not align with the federal fiscal year.

⁵ This analysis is limited to hospitals that reported Medicaid shortfall based on CMS's 2010 policy. The analysis excludes 87 DSH hospitals that did not include payments from third-party payers when calculating Medicaid shortfall: 2 in Minnesota, all DSH hospitals in New Hampshire, 3 in Tennessee, 1 in Virginia, and all DSH hospitals in West Virginia.

⁶ These data do not reflect the full effects of ACA coverage expansions because SPRY 2014 ended on June 30, 2014, for most states. Additional analyses of the effects of the ACA on uncompensated care are provided in Chapter 3 of MACPAC's March 2019 report to Congress (MACPAC 2019b).

⁷ For example, between July 2012 and January 2018, the number of hospital-employed physicians increased 70 percent (PAI 2019). The DSH definition of uncompensated care includes hospital costs for inpatient and outpatient hospital services only and does not include costs for physician and clinic services.

⁸ SSI eligibility for children is based on income and disability status. A newborn is presumed to have a disability if its weight is lower than a set threshold, and if a child is hospitalized for more than 30 days, the family's income has no bearing on the child's SSI and Medicaid eligibility.

⁹ Most notably, the DSH audit rule clarified that DSH-eligible uncompensated care costs were limited to inpatient and outpatient hospital services and did not include the costs of physician services, clinics, or other services that hospitals provide. In addition, the rule defined uninsured individuals as those having no health insurance or any other source of third-party coverage. This definition was later broadened to include individuals who have health insurance but do not have coverage for the particular service that is uncompensated (CMS 2014).

¹⁰ In many states, recouped DSH funds are made available to other DSH hospitals in the state that have not exceeded their hospital-specific limit. DSH payments may exceed the hospital-specific limit for many reasons. For example, the

amount of uncompensated care that a hospital projects when the state is making DSH payments may be different from the actual amount of uncompensated care determined from retrospective DSH audits.

¹¹ *Children's Hospital Association of Texas v. Azar*.

¹² As of December 2018, CMS had lost four federal appellate cases related to the 2010 FAQs and three district court decisions related to the final rule, and other cases were pending in six states. The DC district court decision was the only one that applied nationwide (Eyman Associates 2018).

¹³ New Hampshire expanded Medicaid on July 1, 2014, so the effects of Medicaid expansion are not reflected in DSH audits for SPRY 2014, which in New Hampshire ended on June 30, 2014.

¹⁴ In addition, fewer than 200 individuals were enrolled in the qualified disabled and working individuals (QDWI) program, which provides Medicaid assistance with Medicare Part A premiums (MACPAC 2015). More information about all of the Medicare savings programs is available on MACPAC's website at <https://www.macpac.gov/subtopic/medicare-savings-programs/>.

¹⁵ Hospitals cannot track the costs of individuals who, although eligible for the QMB program, are not enrolled in it. In 2009 and 2010, only 53 percent of individuals eligible for the QMB program were enrolled (MACPAC 2017).

¹⁶ Analysis is limited to hospitals paid under the prospective payment system (PPS) and excludes critical access hospitals, which are paid 101 percent of allowable costs for most services. In 2016, Medicare paid PPS hospitals 91.2 percent of costs (MedPAC 2018).

¹⁷ The deductible for a Medicare inpatient stay was \$1,260 in 2015. Medicare enrollees are also required to make a co-payment for hospital stays that exceed 60 days.

¹⁸ This analysis excludes critical access hospitals and Maryland hospitals. Payment-to-cost ratios are based on Medicare-allowable costs, similar to how the Medicare Payment Advisory Commission calculates Medicare margins for all hospitals (MedPAC 2018).

¹⁹ Medicare DSH payments follow different rules than Medicaid DSH payments. Medicare also makes

uncompensated care payments for hospital charity care and bad debt. Many deemed DSH hospitals also receive other additional payments from Medicare that are not related to the share of low-income patients that a hospital serves, such as graduate medical education payments and indirect medical education payments.

²⁰ According to the statute, Medicaid DSH audits are supposed to include Medicaid shortfall for all individuals who are eligible for Medicaid, but in practice, hospitals can only track payments and costs for individuals who are enrolled. The category Medicaid-eligible also includes incarcerated individuals who would be eligible for Medicaid if they were not inmates of a public institution.

²¹ This analysis excludes plans that did not have deductibles or coinsurance for hospital care. In 2016, 85 percent of employees with employer-sponsored coverage had a general annual deductible and 68 percent had coinsurance for hospital care (KFF 2018). Deductibles are typically higher for family coverage than for single coverage.

²² DSH audits are completed three years after the end of the state plan rate year for which uncompensated care is calculated.

²³ The Children's Hospital of the King's Daughters also noted that it incurred \$25 million in costs for Medicaid-eligible patients with third-party coverage that were not recognized as Medicaid allowable costs; had these costs been allowed, the hospital would not have had any Medicaid surplus (CHA 2018).

²⁴ Medicare cost reports define uncompensated care as charity care and bad debt, including uncompensated care for individuals with insurance, which is not part of the Medicaid DSH definition of uncompensated care. Medicare cost reports do not include reliable information on Medicaid shortfall, which is part of the Medicaid DSH definition.

²⁵ Other methods that states use to distribute DSH payments to providers include lump-sum payments to particular providers based on a defined amount of a fixed percentage of the total DSH allotment (MACPAC 2017).

²⁶ Texas has an uncompensated care pool authorized under its Section 1115 demonstration that makes payments for uncompensated care according to Medicaid DSH definitions. Although these payments are made in addition to DSH payments to hospitals, they provide early evidence of how

DSH payments may change in other states as a result of the district court ruling.

²⁷ Large public hospitals in Texas are defined as the seven largest public health systems that collectively provide more than one-third of hospital unpaid costs of care to uninsured individuals.

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Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC § 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation on changing the definition of Medicaid shortfall in Section 1923 of the Social Security Act. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 2.1 on April 11, 2019.

Treatment of Third-Party Payments in the Definition of Medicaid Shortfall

2.1 To avoid Medicaid making disproportionate share hospital payments to cover costs that are paid for by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.

Yes: Bella, Burwell, Carter, Davis, Douglas, George, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno

Abstain: Gordon

Not present: Cerise

15	Yes
1	Abstain
1	Not present